Social Inclusion/Exclusion: Parents and Grandparents Participating in Community Development in Rural Alberta

by

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Abstract

Social inclusion/exclusion (SI/SE) has been described as a social determinant of health and an urgent matter of social (in)justice. SI/SE involves dynamic relational processes and structures that enable or constrain participation in community life. Many low-income families report barriers to participation and experiences of exclusion, yet limited Canadian research has examined the SI/SE dialectic or the relational processes and conditions enabling participation and inclusion. Participation in the programs and activities of a community organization may help reduce barriers to participation and promote inclusion. SI/SE has largely been explored in urban contexts in Canada and rural research is needed.

The purpose of this critical ethnographic study was to explore experiences of SI/SE among parents and grandparents with young children participating in the activities of a rural Family Centre in Alberta, Canada. Individual and group interviews were conducted with seventeen parents and grandparents, and individual interviews and one group interview were conducted with twelve key informants in leadership, staff, or volunteer roles. The relational processes and conditions supporting participation and SI/SE were explored. Three relational patterns (permanent strangers, newcomers, and boundary crossers) and transitions towards greater participation and inclusion were identified from parent and grandparent interviews. Insights into the meaning of participation and the key strategies of the Family Centre to promote participation and address SI/SE were identified from the perspectives of key informants. Challenges were identified for community-level efforts to address SI/SE. The implications for nursing and

community development practice are described, and recommendations for future research are identified.

Preface

This thesis is an original work by Sharon Yanicki. The research project of which this thesis is a part, received ethics approval from the University of Alberta Research Ethics Board, Project name "Social Inclusion/Exclusion: Low Income Parents Participation in Community Development in Rural Alberta[1]" (No. Pro00011594. Oct. 19 2010, renewed Oct. 12 2011). This research study also received approval from the Human Subject Research Committee, University of Lethbridge (No. 962, Nov. 16, 2010).[2]

Chapter 2 of this thesis has been published as Yanicki, S. M., Kushner, K. E., & Reutter, L. (2015). Social inclusion/exclusion as matters of social (in)justice: A call for nursing action. *Nursing Inquiry, 22*(2), 121-133. doi: 10.1111/nin.12076. The version of this paper included in the dissertation has been updated with reformatting of the text and slight corrections to reflect current referencing.

As lead author, I was responsible for data collection, data analysis, and manuscript composition. K. E. Kushner, the supervisory author, and L. Reutter, a committee member (and initially a co-supervisor), were involved in concept clarification and manuscript composition for papers 1 (Chapter 2), 2 (Chapter 3), and 3 (Chapter 4). D. Williamson, a committee member, supported concept clarification and manuscript composition for paper 3.

I have presented several of these papers at scholarly conferences and benefited from discussions with colleagues related to these papers. Paper 1 (Chapter 2) was

[1] The title of this dissertation was later changed to "Social Inclusion/Exclusion: Parents and Grandparents Participation in Community Development in Rural Alberta".

[2] Letters of support for this study were received from the Kids First Family Centre and their partner agencies: Livingstone Range School Division, Parents As Teachers, and Alberta Health Services (Contract No. AHS 1675 001).

presented (as a poster) at the Campus Alberta Student Conference on Health, in Banff (Sept. 2015). Paper 2 (Chapter 3) was presented (oral) at the Canadian Public Health Association Conference in Vancouver (May 2015). I received the Population and Public Health Student Award, at the Doctoral level, from the Canadian Institutes of Health Research and the Canadian Public Health Association for this presentation. Components of Papers 2 and 3 (Chapter 3 & 4) were presented (oral) at the Canadian Municipalities Against Racism & Discrimination Conference, Lethbridge (March 2014).

Dedication

This dissertation is dedicated to the mothers and grandmothers, the staff, board members, and volunteers of the Kids First Family Centre and it's community partners who shared their experiences with me and allowed me to observe many community programs and activities. Thank you for sharing your stories, insights, and hopes for the future with me. I am honored to have learned from your experiences and dedicated collaborative community efforts to reduce poverty and exclusion and to promote inclusion in rural Alberta.

Acknowledgements

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Many community colleagues supported this work and allowed me to observe their collaborative efforts for social inclusion in action. I owe a great debt of gratitude to the staff and board of the Kids First Family Center, Fort Macleod, Alberta for the invaluable opportunity they provided to me; special thanks to Susan, Tina, Vera, Ian, and Stasha for your guidance and assistance. Thanks also to all the partner agencies: Livingstone Range School Division, Parents as Teachers, and Alberta Health Services who enabled me to observe community programing in multiple shared spaces within the community. I greatly admire your efforts to enable all families and children to participate in your community.

A special thanks to the members of the Study Advisory Group who carefully considered the study recruitment process, the interview guides, and responded to early

findings and my questions as they arose during the course of the study. I greatly appreciated the insightful questions, stories, and observations of three First Nations elders: Rose, Veronica, and Peter, who provided support and advice for this study.

Finally, I would like to thank my family for their support and unwavering faith in me throughout the course of my doctoral studies. My husband George and my children, Greg, Gabriel, and Sarah provided unfailing support. Special thanks to Gabriel for your patience in working through many edits; your assistance was a great help when most needed.

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I. Introduction

The purpose of this critical ethnographic study was to explore social inclusion/exclusion (SI/SE) in a rural Alberta community. This study examined experiences of SI/SE and the processes and conditions enabling or constraining participation in a community organization and community life from the perspective of parents and grandparents. The meaning of participation and the strategies used to support participation and inclusion and to address the exclusion of low-income and Aboriginal families were explored from the perspective of key informants in leadership, staff, or volunteer roles with the organization. Finally, the influence of social, economic, cultural, and political contexts on these strategies was also explored. This is one of the first Canadian studies to explore SI/SE in a rural setting.

Social inclusion and exclusion are contested concepts that reflect earlier discourses on inequality, poverty, and deprivation (Labonte, 2009; Levitas, 2003; Sen, 2000). Little Canadian research has considered SI/SE as a dialectical concept (Labonte, 2009) or examined the processes and conditions enabling inclusion in rural settings. Exclusion has more frequently been reported by poor women (Raphael, 2011; Reid, 2004), Aboriginal peoples (Frohlich, Ross, & Richmond, 2006), and racialized groups in Canada (Galabuzi, 2006) in comparison to the general population. Moreover, racism and poverty intersect as sources of exclusion for Aboriginal peoples (Galabuzi, 2009). This study explored: (a) the experiences of SI/SE from the perspective of parents and grandparents and (b) the meaning of participation and the strategies used to support participation from the perspective of key informants involved in the Kids First Family Centre (hereafter referred to as the Family Centre) in the town of Fort Macleod, Alberta

in 2011/2012. Family Centre programs and activities provided a naturalistic setting for this qualitative study. This community organization and its intersectoral partners have engaged in community development (CD) over a period of years to support the participation of all families and to address SI/SE within this rural community (J. Bopp, 2009).

The key concepts explored in this dissertation are SI/SE, community development, and the linked concepts of empowerment, community participation, and social justice. SI/SE is explored as a dialectical concept involving the interaction of contradictory ideas (Labonte, 2009) and person-environment interactions (Chinn & Kramer, 2011). CD has been utilized as a process for health promotion or community health development (Labonte, 2012). CD is explored in the dissertation as a process for enabling participation, challenging social inequalities, and addressing unequal power relations (Labonte, 2012), and as an outcome to promote social justice and social equity (Labonte, 1993). Conceptually, CD, empowerment, and community participation intersect with Canadian discourses on SI/SE (Yanicki, Kushner & Reutter, 2015).

The dissertation includes six chapters presented in a paper-based format, as well as a cumulative reference list and appendices. In this introductory chapter (Chapter I), I present conceptual and methodological background to the study and an overview of the three papers developed for the dissertation as manuscripts for publication. These papers are presented in Chapters II- IV. In the discussion chapter (Chapter V), I present a summary of key study findings and contributions to knowledge development, implications for nursing practice and collaborative intersectoral CD efforts to address SI/SE in rural communities, and recommendations for future research. In the conclusion

(Chapter VI), I provide an epilogue addressing the emancipatory intent of the study, dissemination strategies and final reflections. The dissertation appendices (Appendix A to Appendix U) include documents that supported the conduct of the study, including: a biographical statement; the historical background of the Kids First Family Centre; the research notice; a letter of introduction; individual and group interview guides; program activities checklist; demographic form; tracking form; letters of support; study information sheets; and participant consent forms.

I use first person in this introduction and in the discussion and conclusion chapters to present my voice as author and principal investigator of my doctoral research. The three papers are written in collective voice ("we" rather than "I"). As a doctoral candidate, I led the dissertation work including proposal development, data collection and analysis, and development of the first draft of each paper; members of my supervisory committee contributed as co-authors to the subsequent development of each of the papers as manuscripts.

In the first section of this introductory chapter, I provide an overview of the philosophical and conceptual foundations of SI/SE, relevant empirical literature on SI/SE, and identified gaps in current knowledge. This overview includes interdisciplinary literature on SI/SE and CD from nursing, public health, public policy, political economy, and development. I suggest that while there is general agreement that participation in community life is foundational for social inclusion (Sen, 2000), less is known about the relational and structural processes leading to inclusion than about the processes and structures leading to exclusion.

Social Inclusion and Exclusion

SI/SE is a social determinant of health (Galabuzi & Labonte, 2002; Popay et al., 2008) and an urgent matter of social (in)justice and health (in)equity (World Health Organization, 2008; Yanicki et al., 2015). Health (in)equity is a priority issue for public health (Institute for Population and Public Health, 2009) and nursing research in Canada (Canadian Nurses Association [CNA], 2010; Cohen et al., 2013; Reutter & Kushner, 2010). Health inequities are unjust, unfair, and potentially modifiable differences in population health (Whitehead, 2000).

Lived experiences of social inclusion enable participation in community life (Freiler & Zarnke, 2002) and lived experiences of social exclusion constrain participation in community life (Popay et al., 2008). Experiences of everyday life may lead to a sense of belonging and inclusion and feeling welcomed, valued, and accepted (Bach, 2005; Freiler & Zarnke, 2002), or a sense of exclusion and shame (Sen, 2000), and feeling devalued (Reid, 2004), left out, or kept out (Reutter et al., 2009). As a dialectical concept (Labonte, 2009), SI/SE reflects a focus on both the relational processes and the structural conditions enabling or constraining participation (Mitchell & Shillington, 2005).

Discourse on SI/SE emerged within the European Union during the 1990s (Guildford, 2000). This emergence was preceded by earlier discourse focused on social exclusion, the term first used in France in the 1970s to describe groups of people who were being left out during a period of rising unemployment, racial tension, economic restructuring, and globalization (Guildford, 2000; Shakir, 2005). In French discourse, public debate focused on exclusion and on barriers to participation in social, economic, cultural, and political life (White, 1998). In Britain, discourse on exclusion emerged in

the 1990s and initially focused on addressing poverty and deprivation (Toye & Infanti, 2004), and by 1997 shifted to a broader discourse on SI/SE to reduce social inequalities and promote social integration (Guildford, 2000).

Discourse on social inclusion emerged in Canada in the early 2000s during a period of economic restructuring, fiscal constraint (Guildford, 2000), rising income inequality, globalization, and the introduction of neoliberal social policies (Harrison, 2005), prior to a more critical discourse on exclusion (Shakir, 2005). Social inclusion describes a normative ideal for social relations and conditions enabling participation (Bach, 2005). Respect for human dignity and recognition of diversity are foundational conditions for inclusion (Freiler, 2002). A sense of belonging is supported by intersubjective mutual recognition (Bach, 2005; Honneth, 1995) and feeling welcomed, valued, accepted (Freiler, 2002), and acknowledged by others (Bach, 2005). Additionally, social inclusion considers the societal conditions (socioeconomic, cultural, and political) that enable participation (Freiler, 2002) and equal citizenship (Labonte, 2009).

Social exclusion involves unequal power relations and social inequities within society that systematically advantage some groups while disadvantaging others (Labonte, 2009; Shakir, 2005). The dynamic relational processes and structures of exclusion occur within specific social, economic, cultural, and political contexts (Mitchell & Shillington, 2005; Popay et al., 2008), and at multiple levels of social relations (Percy-Smith, 2000). Canadian discourse on social exclusion incorporates earlier concepts of poverty, deprivation (Sen, 2000), racism, discrimination (Galabuzi, 2009), gender inequality (Reid, 2004), and oppression (Young, 1990). These social inequalities result in enduring

differences in "power and resources among individuals, and groups of people that influence the quality of their lives" (Raphael, 2011, p. 91).

Racism and discrimination, as sources of exclusion, intersect with poverty to create multidimensional disadvantage (van Roosmalen, Loppie, & Davidson, 2002). For example, Aboriginal peoples experience higher rates of poverty and exclusion in comparison to other Canadians (Raphael, 2011). Culture can be defined, from a critical collectivist perspective, as a dynamic relational process influencing values, beliefs, and patterns of behaviour (Browne, Smye, & Varcoe, 2005). In contrast, racism involves devaluing and subordinating a group of people (Anderson et al., 2003) based on their racial features and cultural characteristics (Browne et al., 2005). Exclusionary processes and structures involve: colonization, Eurocentrism, racialization, discrimination (Galabuzi, 2006) and racism (Allan & Smylie, 2015). Racialization is a form of structural inequality in which, "racial categories are constructed as different and unequal" (Galabuzi, 2006, p. 251). Eurocentrism privileges White European values, practices, and cultural standards (Galabuzi, 2006) and assumes that the English language and Christian values are the norm, while those who differ by race, ethnicity, language, and religious beliefs are labeled, subordinated (Reimer Kirkham, 2003), and devalued (Galabuzi, 2006). Eurocentrism subtly resists and undermines respect for diversity (Reimer Kirkham, 2003).

Limited nursing and Canadian research has explored SI/SE as a dialectical concept (Labonte, 2009), a determinant of health (Galabuzi & Labonte, 2002) or examined poverty and racism as underling sources of exclusion (Galabuzi, 2009). A few Canadian mixed methods and qualitative studies on poverty have described relational

processes of SI/SE involving participation, empowerment, and a sense of belonging (Ocean, 2005; Reid, 2004; Reutter et al, 2009; Stewart et al, 2009). In one study, experiences of inclusion among high- and low-income participants in mixed income neighbourhoods in two Canadian cities were associated with participation in "social, leisure, and volunteer activities, work, physical and family activities" (Stewart et al., 2009, p. 83). While participation was associated with an improved sense of belonging overall, less than half of the low-income participants reported an increased sense of inclusion in relation to participation (Stewart et al., 2008). Other processes of inclusion described in the literature include: empowerment (Reid, 2004; Wallerstein, 2006), group participation, critical reflection, gaining voice (Reid, 2004), and inclusionary othering (Canales, 2010, 2000).

Several studies have identified strategies to resist or manage stigma. Stigma is a process of labelling, stereotyping, devaluing, and distancing (Goffman, 1963, Link & Phelan, 2011) that involves relational processes of exclusion and macrolevel power relations (Reutter et al., 2009). Resistance to stigma has been described as a strategy to gain acceptance and inclusion (Reutter et al., 2009; Roschelle & Kaufman, 2004). Stigma management and the collective empowerment of low-income women have been described in relation to participation in a low-income women's group, sharing coping strategies, and exploring opportunities for collective action (Ocean, 2005; Reid, 2004;). In one study, women managed the stigma of being on social assistance by self-identifying as "legitimate' or deserving recipients, and resisting hegemonic discourse and social norms (Reid, 2004, p. 179). Other studies suggest that people living on a low-income resist or manage stigma in a variety of ways: confronting discrimination, managing the

negative attitudes of others, disregarding negative comments, withdrawing or self-isolating, concealing poverty status, distancing themselves from others, helping others, volunteering, advocating for change (Reutter et al., 2009) and claiming a positive identity as a good mother or good citizen (McIntyre, Officer, & Robinson, 2003; Reid, 2004).

Poverty has been associated with intersecting domains of exclusion that are economic (Stewart et al., 2008) or material (Reid, 2004), relational (Ocean, 2005; Reid, 2004; Stewart et al., 2009), institutional, cultural (Reid, 2004), and moral (Reutter et al., 2009; Kidger, 2004) in nature. Economic exclusion involves financial constraints that limit participation (Stewart et al., 2008), while material exclusion involves difficulties meeting basic needs for food, clothing, shelter, and transportation (Reid, 2004). Material exclusion is consistent with absolute material deprivation—lacking the basic necessities of life (Sen, 2000). Relational exclusion involves an inability to take part in valued activities (Sen, 2000), limited social relationships, or social isolation (Ocean, 2005; Reid, 2004; Stewart et al., 2009). Institutional exclusion involves organizational policies and practices that systematically stereotype and devalue a group, and limit their "access to resources" (Reid, 2004, p. 135). Cultural exclusion involves stereotyping, stigmatizing, judging and devaluing a group for deviance from hegemonic norms (Reid, 2004). Moral exclusion involves feeling judged as undeserving or as someone of lower worth based on characteristics of the individual (Reutter et al., 2009; Kidger, 2004). Negative remarks by others heightened low-income participants' conscious awareness of stigma and led to feelings of shame and an internalized negative social identity (Reutter et al.).

Globally, nursing research has also explored experiences of SI/SE among rural newcomers in Australia (Patten, O'Meara & Dickson-Swift, 2015), rural children with

disabilities in South Africa (Neille & Penn, 2014), psychiatric survivors in Canada (Benbow, Rudnick, Forchuk & Edwards, 2014), mental health service users in the United Kingdom (Clifton, Repper, Bans & Remnant, 2013), and newcomer immigrant children in Canada (Oxman-Martinez et al., 2012), Social inclusion has not been well defined within mental health nursing literature, and as Clifton et al. (20102) have noted, the dominant focus on individual agency fails to address the structural conditions that sustain exclusion (Clifton et al.). Benbow and colleagues (2014) applied a capabilities approach (Sen, 2000) to explore SI/SE among psychiatric survivors. Nussbaum's (2011) list of basic capabilities was used to identify and critique the unjust structural conditions (e.g., poverty, stigma and social exclusion) that limited the capability development and quality of life of psychiatric survivors.

Children's experiences of poverty and exclusion interact to limit opportunities for participation (Robinson, McIntyre, & Officer, 2005) and early child development (McCain, Mustard & McCuaig, 2012). A strong body of evidence links low-socioeconomic status with delayed child development and decreased life chances (Hertzman, 2002; McCain et al, 2012, 2007). Poor children report higher rates of exclusion in comparison to non-poor children (Phipps & Curtis, 2001). Aboriginal children experience higher rates of poverty, poorer living conditions, and greater developmental disadvantages in comparison to non-Aboriginal children in Canada (McCain et al., 2007). While a broad literature on resiliency, early child development and parent support have described the effectiveness of early interventions with low-income families (Hertzman, 2002; McCain, et al., 2012; Drummond et al., 2014), limited research has moved upstream to address the social determinants of health inequities

(SmithBattle, 2012). Participation in recreation activities has been associated with positive social integration and higher academic achievement for poor children (McCain et al, 2012; Phipps & Curtis, 2001).

In Canada, experiences of SI/SE due to racism have been understudied; however, a growing body of research suggests that racism and discrimination affects the daily lives and the health and wellbeing of many Aboriginal people (Allan & Smylie, 2015; Currie, 2012; Galabuzi, 2006; Loppie, Reading & Leeuw, 2014). Health disparities in Canada overwhelmingly reflect inequitable life chances based on inequalities in income, living conditions, and Aboriginal status (Frohlich et al., 2006). Racism and colonization are important social determinants of health for Aboriginal peoples (Loppie Reading & Wien, 2009; Royal Commission on Aboriginal People, 1996).

The trauma of residential schools has been associated with higher rates of social exclusion, and health inequities for survivors, and subsequent generations of Aboriginal families (Allan & Smylie, 2015; Truth and Reconciliation Commission of Canada, 2015). Discrimination due to income, race, ethnicity, age, sexual orientation, rurality, and gender create overlapping disadvantage (van Roosmalen et al., 2002). Findings from a US study suggest that having a positive identity as an Aboriginal person and a positive view of one's ethnocultural group helped to buffer the negative health impacts of discrimination (Chae & Walters, 2009). Participation in traditional Aboriginal cultural activities has been proposed as a promising approach to mitigate the impacts of historical trauma on health (Gone, 2013).

Nursing research has been relatively silent on issues of racism, racialization, and marginalizing health care practices (Reimer Kirkham, 2003). Processes of inclusion were

identified in a few studies such as affirming encounters, sharing power, demonstrating respect for Aboriginal peoples' knowledge and culture (Browne & Fiske, 2001), and negotiating and connecting "through difference" (Reimer Kirkham, 2003, p. 776). Processes of exclusion included: stereotypical and essentialized views of Aboriginal people (Reimer Kirkham, 2003; Tang & Brown, 2008), and assumptions that White, Christian, English speaking people belonged within Canadian society while difference was devalued (Reimer Kirkham, 2003). While health care professionals reported treating everyone equally, egalitarian discourses glossed over power inequalities and socially constructed differences.

Community Development

Community development (CD) is rooted in historical efforts to organize and mobilize communities to relieve poverty and to address oppression (Brown & Hannis, 2008; Ife & Tesoriero, 2006; Lee, 1994), and has more recently been used as a process to promote inclusion (United Nations Human Settlement Programe, 1999b). Rural development also was an early focus of CD in Canada (Mitchell-Weaver, 1990). A "just social order" and the elimination of "inequality, exploitation…and racism" are foundational conditions for human development and social progress (United Nations, 1969, p 1).

A variety of terms have been used to describe CD as a process including community development, community building, and asset-based community development. In health promotion, *community development* (CD) has been defined as a process that "strengthens public participation" and builds capacity to control the "fundamental conditions and resources for health" (WHO, 1986, p. 1-2). CD has often been

conceptualized as a grassroots process of organizing, identifying common problems or goals, mobilizing resources, and developing and implementing strategies for action (Minkler & Wallerstein, 2012). In contrast, *community building* or *asset-based community development* is the process of working with community members, identifying local assets, and enhancing community strengths (McKnight & Kretzmann, 2012). In this dissertation, CD includes these various conceptualizations.

A number of CD models have been used to promote community health development. A model reflects the approaches or community interventions used to promote social change (Rothman, 2008)[3]. Three CD models are considered—liberation education (Freire, 2007/1970), community capacity development—formerly known as locality development (Rothman, 1999/1995), and social advocacy–formerly known as social action (Rothman, 1999/1995). These models share a focus on promoting participation, empowerment, and social change.

As a basis for understanding the three CD models, it is important to clarify the concept of empowerment. Empowerment can be understood as a multilevel process and an outcome. *Empowerment* has been defined as "an incremental process through which individuals, families and communities gain the power, insight and resources to make decisions, and take action regarding their wellbeing" (Saskatoon District Health & Labonte, 1999). Labonte's (1993) empowerment holosphere depicts empowerment as an iterative process of capacity development involving: personal and small group development, community organization, coalition building, advocacy, and political action. At the intrapersonal level, empowerment starts from the power within each person

[3] Rothman (2008) proposed nine modes for community intervention. For this dissertation, I have chosen to focus on the basic strategies or models of intervention as integrated approaches, utilizing Rothman's updated terms.

(Labonte, 1993); gaining a sense of control, mastery, and feeling valued (Laverack, 2004) are thought to reduce internalized powerlessness (Labonte, 1993; Lee, 1994). At the interpersonal level, affirmative support, interdependence, and shared power are thought to support individual and group empowerment, while a shift in power relations is thought to support community empowerment (Labonte, 2012). Empowerment outcomes are thought to include: self-esteem and self-efficacy at the intrapersonal level, critical consciousness and interdependency at the interpersonal level, and "social equity at the intergroup" or community and societal levels (Labonte, 1993, p. 57).

The three models address different CD goals. *Liberation education* stimulates dialogue and critical consciousness of the structures in society that constrain human freedom, and enables people to act on their own behalf (Freire, 2007/1970; Minkler, 2012). This CD model focuses on promoting full human potential and resisting oppression to promote social change (Brown & Hannis, 2008). *Community capacity development* focuses on promoting participation, empowerment, solidarity, and developing local leadership and capacity (Rothman, 2008). Consensus-based decision-making is used to promote collective action to address locally defined goals (Rothman, 1999/1995). The outcomes of capacity development (Rothman, 2008) may include: access to external resources, actions to address local needs, development of social relationships, and a sense of belonging and solidarity (Brown & Hannis.2008). *Social advocacy* focuses on dialogue, rebalancing power relationships, and promoting social change at community or societal levels (Rothman, 2008). Pressure tactics and conflict are used to support social change to address social inequalities, oppression, and social

injustice at community and societal levels (Brown & Hannis, 2008). The goals of social advocacy include social justice and health equity (CNA, 2010).

Integrated CD approaches combine two or more CD models (M. Bopp & Bopp, 2001; Ife & Tesoriero, 2006; Lee, 1994; Rothman, 2008). Lee's (1994) integrated model incorporates Rothman's (2008) community capacity development and social advocacy models with an asset-based approach. The Four World Centre model is an integrated approach that incorporates community building or asset-based community development with an Aboriginal world view and the medicine wheel to promote human potential, healing, justice, and sustainable development (M. Bopp & Bopp, 2001). Ife and Tesoiero's (2006) integrated CD approach focused on social justice, human rights, ecology, and sustainable development. CD as an empowering process for social change is thought to support participation, individual and collective empowerment, health equity, and social justice (Community Health Nurses of Canada, 2011).

Several social movements have utilized CD processes to promote healthy and inclusive communities. The Healthy Communities (or cities) movement in Canada (Hancock & Duhl, 1986/1988) promoted partnerships to improve community health (Chalmers & Bramadat, 1996; Meagher-Stewart, 2001). The Inclusive Cities movement first emerged in Europe in the late 1990s (United Nations Human Settlement Programe, 1999) and later developed in Canada (Clutterbuck & Novick, 2003; O'Hara, 2006). Vibrant Communities initiatives have also been developed across Canada based on an integrated CD approach focused on community building and social advocacy to address poverty and promote inclusive communities (Born, 2008; Briggs & Lee, 2012).

In empirical research, CD and empowerment have been used as strategies to support the engagement and inclusion of poor women (Reid, 2004), young mothers (Greene, 2007; Kidger, 2004), minority mothers (McFarlane, Kelly, Rodriguez, & Fehir, 1994), seniors (Minkler, 2005), and members of low-income communities (Bent, 2003). A systematic review of the effectiveness of empowerment strategies identified evidence from a few multilevel studies supporting the effectiveness of empowerment as a process, an outcome, and an intermediary step to promote positive health and development outcomes (Wallerstein, 2006). Empowerment strategies were defined as participatory approaches that included group dialogue, leadership training, power transfer to participants, organizational development, advocacy and collective action (Wallerstein, 2006). Empowerment strategies to engage socially excluded populations have been associated with positive impacts on the health of women, the poor, and youth (Wallerstein, 2006). A key finding of this systematic review was that "participation alone" was "insufficient" to support positive health and development outcomes (Wallerstein, 2006, p. 4). The most effective strategies for empowering participation enabled: "decision-making, sense of community and local bonding, and psychological empowerment" (p. 5).

Inclusive Cities Canada initiatives in five cities addressed both the relational and structural processes of SI/SE (O'Hara, 2006). For example, in the city of Edmonton, an Urban Aboriginal Accord was signed with Aboriginal elders to improve social relations and to enhance the participation of Aboriginal peoples in community life, and a plan was developed to increase access to affordable housing (O'Hara, 2006). The Vibrant Communities movement has resulted in multi-sectoral collaborations and social policy

changes addressing poverty reduction in many Canadian cities (Born, 2008). While CD and empowerment have been promoted as important strategies for public health nursing practice (Community Health Nurses of Canada, 2011), limited nursing research has explored CD models as processes for promoting population health (Meagher-Stewart, 2001) or as strategies to address SI/SE.

Based on the theoretical models and empirical evidence presented here, I have tentatively concluded that integrated approaches to CD provide opportunities for participation that could contribute to collective action on SI/SE. Participation in CD activities is thought to influence experiences of SI/SE by linking excluded groups to resources and support. The consensus-based decision-making approaches used in community capacity development could help to promote trust and reconcile intergroup differences (Rothman, 2008). Social advocacy and liberation education could enable communities to gain a collective voice to challenge inequities (Freire, 2007/1970; Rothman, 2008). Collaboration and partnerships (Labonte, 1993) could support local capacity building (Community Health Nurses of Canada, 2011; Rothman, 2008) to address poverty and exclusion. Equitable participation, respect for cultural knowledge, and recognition of local processes are important for the inclusion of Aboriginal peoples (M. Bopp & Bopp, 2001; Ife & Tesoriero, 2006). CD also could support collective action to challenge stigma (Reutter et al., 2009), racism, discrimination, and exclusion (Galabuzi, 2009).

Community Participation and Social Justice

To provide a basis for exploring the concepts of community participation and social justice and given that a sense of belonging and inclusion can be experienced at

group or community levels, it is valuable to clarify the meaning of community. *Community* can be defined in relation to function, interest, and social organization; most people belong to many types of communities (Labonte, 2012). Communities also involve shared relationships (Sheilds & Lindsey, 1998) and identities (Toronto Department of Public Health 1994, cited in Labonte, 2012). Having a sense of community refers to sharing a bond and sense of identification with a place or social network (Wallerstein, 2006, p. 9).

Community participation refers to the active involvement of people in sharing their experiences, ideas, and concerns (Laverack, 2007). Participation is a multilevel concept involving multiple levels of social relations at intrapersonal, interpersonal, organizational, and community levels (Yanicki et al., 2015). Patterns of participation and routine social interactions are structured by social norms about how one "should" act in a given setting (Carspecken, 1996, p. 83). While all human actions are imbued with meaning (Carspecken, 1996), not all participation is experienced as meaningful or empowering (Wallerstein, 2006). Participation is not always associated with a sense of inclusion for those living in poverty (Stewart et al., 2008) as it is experienced in relation to the welcoming or unwelcoming behaviours of others (Reutter, et al., 2009).

Community participation offers opportunities for mutual obligation, contribution, and belonging (Ife & Tesoriero, 2006; Labonte, 2012). Meaningful participation—forms of participation that engage participants in an empowering process—is thought to involve opportunities for critical reflection, contesting ideas , exploring differences and commonalities, decision-making (Yamin, 2009), and negotiating shared power (Chatterjee et al., 2004; Shakir, 2005). In conceptual literature, non-participation is

thought to reflect resistance to dominant cultural norms (Shakir, 2005) or a lack of choice (M. Bopp & Bopp, 2001). In empirical research, Gingrich (2008) found that self-exclusion also involved choosing not to participate in order to preserve a unique identity and way of life. In the Canadian General Social Survey, rural and urban differences in civic participation have been reported (Turcotte, 2005). Rural residents more commonly reported volunteering, trusting their neighbours, participating in clubs or organizations, and having a sense of belonging to their community in comparison to urban residents (Turcotte, 2005).

Knowledge Gaps

From my review of literature about social inclusion and social exclusion and related concepts introduced above, I identified several knowledge gaps. Limited Canadian research has explored social inclusion or the SI/SE dialectic (Labonte, 2009; Stewart et al., 2008). Canadian research has predominantly examined the SI/SE dialectic in relation to poverty in urban centres (Reutter et al., 2009). Rural experiences of SI/SE may differ due to the limited resources and more conservative attitudes common in rural settings (Reutter et al.) and differences in rural patterns of civic participation, trust, and belonging (Turcotte, 2005). There is a need for Canadian research to examine CD as a process to promote the participation (Meagher-Stewart, 2001) and inclusion of marginalized groups in community life (Greene, 2007; Kidger, 2004).

Moreover, research is needed to explore the relational processes and conditions supporting participation and community-based approaches to addressing SI/SE. Multilevel interventions have been proposed to address SI/SE based on conceptual and empirical studies. At the intrapersonal level, affirming interactions are thought to

overcome internalized powerlessness (Labonte, 1993; Lee, 1994; Minkler, 2012) and shame (Sen, 2000) that constrain participation. At the interpersonal level, development of trusting relationships, dialogue on shared concerns (Freire, 2007/1970), group participation (Reid, 2004) and resistance to stigma and a stigmatized social identity (Reutter et al., 2009; Reid, 2004) reflect an empowering process which could address SI/SE At the institutional and community levels, individual and collective empowerment (Labonte, 1993) and capacity building (McFarlane et al., 1994) promote collective action to enable inclusion and address exclusion (Wallerstein, 2006). The development of formal organizations (Minkler, 2012), authentic partnerships (Labonte, 1993), and coalitions (Labonte, 1993; McFarlane et al., 1994) is thought to support advocacy and political action to address social and health inequities (Labonte, 1993). Critical research is needed to support emancipatory knowledge development linking experiences of SI/SE to the processes and conditions enabling participation and multidimensional inclusion. Emancipatory knowledge uncovers social inequalities and unjust relational and structural conditions, and identifies processes for social change and strategies to promote social justice and health equity (Chinn & Kramer, 2011).

Research Study

Two main research questions guided my study, with subsequent identification of additional questions relevant to each main question. The first main research question was: How was SI/SE experienced by parents and grandparents with young children (including low-income and Aboriginal participants) participating in the programs and activities of a rural Family Centre? A related question to the first main research question was: What process and conditions enabled or constrained the participation of and social inclusion of

low-income and Aboriginal parents, grandparents, and children in community life? The second main research question was: What strategies encouraged the participation and social inclusion, and addressed the exclusion of low-income and Aboriginal parents, grandparents and young children in the programs and activities of the Family Centre? And related to this second research question, an additional question was: How did social, economic and political conditions influence Family Centre strategies to encourage participation and to address SI/SE?

To answer the research questions, I undertook a study focused on the experiences of individuals who were current or past participants in the programs and CD activities of the Family Centre in Fort Macleod, Alberta. My intention was to explore experiences of SI/SE from the perspective of low-income parents and grandparents with young children or grandchildren (≤ 9 years of age), including those of Aboriginal[4] identity, along with the perspective of key informants in leadership, staff, or volunteer roles in the Family Centre. Key informants had participated in the collaborative CD strategies, intersectoral partnerships, programs, and activities of the Family Centre over time.

I conducted a critical ethnographic, qualitative study involving participant observation, multiple individual and group interviews and document review over a 13-month period between 2011 and 2012. A total of 29 study participants took part in individual or group interviews including 17 parents or grandparents who had participated in Family Centre programs and 12 key informants of the Family Centre. I sought to develop shared understandings of low-income parents' and grandparents' experiences of SI/SE. Shared understandings were supported through a process of reflection and critical

[4] Aboriginal identity refers to self-identification as an Aboriginal or First Nations person (Tang & Browne, 2008), including Indians registered with a band under the Indian Act (Government of Canada, 2010) and those without status under the Act.

hermeneutic meaning analysis (Carspecken, 1996). Consistent with Carspecken, following observations, the initial holistic impressions (tacit meaning) of interactions were described in field notes (the primary record). Selected passages of text are analyzed to clarify meaning (e.g., meaning reconstruction). The possible meanings of the text or interaction were documented in field notes. During the next participant observation session or in a formal interview with the person observed, tentative meanings were clarified to achieve shared understandings (Carspecken, 1996). Parent and grandparent participation in the programs and activities of the Family Centre provided the relational and organizational context for exploring SI/SE. I considered the programs of the Family Centre and their collaborative activities with intersectoral partnerships to serve as a natural experiment (Patton, 2002) at a community-level. A natural experiment involves observations in naturalistic settings and documentation of change (Patton, 2002). In my study, I sought to contribute to emancipatory knowledge development (Chinn & Kramer, 2011) and to gain insights for community nursing practice and interdisciplinary CD practice. The study was intended to develop emancipatory knowledge by identifying the underlying processes of SI/SE and local strategies to address SI/SE.

Community Context

Fort Macleod, a small town located in southwestern Alberta with a population of 3,117, was the setting for this study (Statistics Canada, 2012). Concerns about child poverty were identified in this community in 2000 (Dobek, 2004) and a number of initiatives were undertaken to address SI/SE (J. Bopp, 2009). Fort Macleod provided a unique historical, social, and cultural context. This town is the oldest incorporated town

in Alberta and the historic site of the first outpost of the North-West Mounted Police (Government of Alberta, 2006).

Fort Macleod is a destination community for the services and businesses used by residents of two First Nations reserves and rural residents in the surrounding Municipal District of Willow Creek. Two First Nations bands and reserve communities, the Piikani and the Kainai (also known as the Peigan and Blood reserves), are in close proximity to the town. Children from both First Nations communities attend schools in Fort Macleod. Twelve percent of residents of Fort Macleod are Aboriginal peoples, compared to 5.8% of the population of Alberta (Statistics Canada, 2009). The historical relationship between First Nations peoples and other town residents has been one of tension (Dobek, 2004).

The Family Centre is a collaborative community organization (J. Bopp, 2009). At the start of my study, their mission was "to promote the meaningful participation of all children and their families in the life of the community" (J. Bopp, 2009, p. 21). The Family Centre also sought to promote an inclusive community in which "all children and families have a sense of belonging" (J. Bopp, 2009, p. 21). Four objectives guided their programs and CD activities: (a) "supporting food security for all families", (b) "enhancing social inclusion, especially for the most vulnerable", (c) "supporting healthy early child development", and (d) "supporting parents" (J. Bopp, 2009, p. 21-22). During the study period, the Family Centre became a registered charity (Feb. 28, 2011) and the society objectives were revised to reflect the charitable purpose of relieving poverty. The Family Centre revised objectives included: (a) relieving poverty by providing basic amenities (e.g., food and clothing) to low-income families; (b) relieving poverty by

implementing subsidy programs for low-income children (e.g. for art and recreation); (c) advancing education for students (e.g. providing resources); (d) providing mentoring, training, workshops, and seminars for parents, children, and youth (e.g., meal preparation, life-skills, leadership skills); and (e) providing support and intervention groups for youth (e.g., teen pregnancy, at-risk young mothers) (Personal Communications, April 19, 2011).

Methodology

My approach to conducting the study was guided by Carspecken's critical ethnographic methodology (Carspecken, 1996). Critical ethnography directs attention to analysis and critique of the cultural, social, and political conditions constraining or enabling human potential (Street, 1992, cited in Allen, Chapman, Francis, & O'Conner, 2008). I took a focused approach to explore specific information about the chosen topic rather than the whole context of participants' lives (Harrowing, 2009).

Assumptions of critical social theory that guided my work in this study include recognition that: (a) all knowledge is developed within the social, political, and historical context (Habermas, 1984; Morrow & Brown, 1994); (b) oppression occurs in all societies (Carspecken, 1996; Freire, 2007/1970; Habermas, 1984); and (c) all human interactions involve power relationships (Morrow & Brown, 1994). Additionally, I assumed that parents and grandparents have the capacity to reflect on their experiences of SI/SE and to identify supports and barriers to their participation. I sought to balance power relations with community participants, recognizing my position as an educated White researcher and an outsider to the community, by engaging in conversational interviews and following the participants' leads (Carspecken, 1996).

Critical ethnography applies concepts from critical theory (Habermas, 1984) within an ethnographic inquiry to examine lived experiences, dynamic processes, and social interactions in the natural settings in which they occur (Thomas, 1993). Critical ethnography is uniquely suited to examining person-environment interactions (Bent, 2003) and dynamic processes (Madison, 2005), and to uncovering power relationships (Carspecken, 1996; Madison, 2005; Thomas, 1993). Critical ethnography differs from conventional ethnography by adding a focus on uncovering injustice and unfairness and stimulating collective action for social change (Hammersley, 1992; Madison, 2005; Morrow & Brown, 1994). As such, critical ethnography has a political (Harrowing, 2009; Thomas, 1993) and emancipatory purpose.

Study Design

Carspecken's (1996) methodology guided a multistage critical hermeneutic analysis to explore experiences of SI/SE in multiple social settings within the Family Centre initiative. Critical hermeneutics provided a systematic approach to the collection and documentation of thick descriptions of interactions, data analysis including an initial reconstruction of meaning from field notes, and validation of initial understandings during individual interviews involving member checks (Carspecken, 1996; Morrow & Brown, 1994). System relations and the interaction of individual agency and social structures (Morrow & Brown, 1994) were clarified during individual and group interviews. Additionally, Patton's (2002) approach to content and thematic analysis supported the coding of themes, and Miles and Huberman's (1994) qualitative data displays supported the identification of relational patterns.

Carspecken (1996) grounded his methodology in a modification of Habermas' (1984) theory of communicative action to uncover shared meanings and to examine speech claims in routine social interactions and social settings. Carspecken's five-stage iterative process guided the process of data collection, validation of shared meaning, and critical hermeneutic analysis in this study. The five-stages included: (1) compiling a primary record, (2) completing preliminary reconstructive analysis, (3) engaging in dialogical data generation, (4) describing system relations, and (5) explicating systems relations to explain findings (Carspecken, 1996; Cook, 2005; Hardcastle, Usher, & Holmes, 2006). Carspecken's critical methodology supported the identification of the relational processes and community conditions enabling and constraining participation, SI/SE, and a sense of belonging for parents and grandparents in this study. Table 1.1 provides a summary of the stages of data collection and critical hermeneutic analysis applied in this study (Carspecken, 1996; Harrowing, 2009).

Critical ethnography combines critical theory and traditional ethnographic data collection techniques (e.g., participant observation, interviews, and document review) to enable triangulation of theory and methods in analysis (Carspecken, 1993). In this study, I combined observations of social interaction [e.g., observing relational processes of SI/SE] with reflexive exploration of experiences [e.g., dialogue and reflection on lived experiences] to develop intersubjective understandings [e.g., the meaning of experiences] (Habermas, 1984). Individual interviews (for both parent/grandparent and key informant participants) were used to explore individual/personal perspectives and experiences on SI/SE or the strategies used to address SI/SE. Group interviews were used to explore my initial interpretations (from observations in different settings and individual interviews)

and to stimulate participant discussions on shared or different perspectives and insights. I used critical hermeneutics analysis to reconstruct meaning and interpret dialogic interaction based on Carspecken's adaptation of Habermas's (1984) theory of communicative action. Patton's (2002) approach to the coding of content, themes, and patterns of observed interaction was used in coding the primary record and dialogic interviews in stage two, three, and four analyses (see Table 1.1).

A Study Advisory Committee (SAC) of ten members was established to guide the study. Members of the SAC included: seven representatives from the Family Centre board and staff (i.e., a nurse, a teacher, a grandparent, an early childhood/parenting support worker, and an Aboriginal staff member from a collaborating agency and two staff), and three First Nations elders (i.e., one member of Kainai and two members of Piikani First Nations). The SAC supported the recruitment of participants and provided advice on the interview questions and interpretation of initial findings.

Consistent with the emergent design of this qualitative study, changes were made to the study inclusion criteria following participant observations. The initial focus of the study was on English speaking, low-income parents (annual family income < before tax Low Income Cut Offs) with young children (≤ 9 years of age) participating in Family Centre programs, events, and CD activities. Based on observations, I noticed that grandparents frequently participated in programs with their young grandchildren. Several programs included mixed groups of participants who varied by income, ethnocultural origins, and age. Given that experiences of SI/SE occur across income groups (Reutter et al., 2009; Stewart et al., 2008, 2009), the study inclusion criteria were expanded to include participating parents and grandparents of all incomes with young children and

grandchildren. This change in study inclusion criteria supported a broader exploration of experiences of SI/SE within this rural community (diverse participants by income, ethnocultural group, and age). Experiences of SI/SE were explored from the perspectives of parents and grandparents, including low-income and Aboriginal participants. The strategies used to support participation and to address SI/SE for low-income and Aboriginal families were explored from the perspective of key informants.

Sample of Participants

A purposeful sample (Miles & Huberman, 1994) of parents and grandparents was recruited for individual interviews following observations of the participants in Family Centre programs and the programs of collaborative community partners. Details of the recruitment process are provided in the second paper (Chapter 2, Paper B).To reflect the diversity of program participants, I recruited a maximum variation sample with particular attention to recruiting low-income participants and Aboriginal participants. All parents and grandparents interviewed had participated in Family Centre programs or events in the town of Fort Macleod for at least six months during the study period or during the previous three years. All parent and grandparent participants spoke English and were residents of the town of Fort Macleod or the surrounding rural area. Purposeful and snowball sampling techniques were used to recruit key informants. Key informants included current or past Family Centre staff, board members, or volunteers with at least six months of experience during the study period or the previous three years.

My Voice as a Researcher

In qualitative research, the researcher is viewed as a primary instrument for data collection and the credibility of the researcher affects the rigor of the study (Patton,

2002). As an educated white female, I acknowledge my position of privilege in relation to low-income and Aboriginal participants. I also acknowledge that my emancipatory interests are grounded in my own experiences of growing up in a low-income family, my years of experience as a community health nurse working with low-income and Aboriginal peoples, and my ongoing commitment to promoting social justice. My experience and background are described in the biographical statement (see Appendix A. Biographical Statement).

As a researcher, I was committed to exploring and documenting multiple perspectives, to confirming understandings, and to providing a balanced report of findings (Patton, 2002). I tried to take a neutral position in exploring SI/SE and an empathetic and respectful position towards the active role of study participants. I sought to explore experiences and processes of SI/SE as part of routine social interactions.

As someone from outside the community, I acted as a "friendly stranger" (Hammersley & Atkinson, 1995) and expressed my interest in understanding everyday life in the community. Cultural humility, a stance of "not knowing" and expressing interest in participants' experiences (Racher & Annis, 2008), was used to support the process of validating shared meanings through member checks. I hoped to convey respect for difference and to provide participants with opportunities to take the lead in telling the story of their experiences of SI/SE. Journaling and critical reflection were used to help me remain sensitive to these issues throughout the process of the study.

I sought to balance power relations with study participants through several data collection processes intended to promote dialogue (Carspecken, 1996). Unequal power relations can distort communication (Habermas, 1984), and as Wallerstein (1999) and

Reid (2004) have cautioned, creating a balance in power relations is an ongoing challenge. During interviews, shared understandings of the meaning of experiences of SI/SE were supported through dialogue and member checks consistent with Carspecken's (1996) stages two and three analysis (see Table 1.1). A shared understanding involves agreement on validity claims—possible meanings were verified through the use of clarification questions during interviews and inviting clarification of preliminary meaning analysis at the second individual interview or a group interview (Carspecken, 1996; Habermas, 1984) yet it is recognized that shared meaning is fallible and subject to correction (Carspecken, 1996). As the interviewer, I sought to balance power relations to create opportunities for dialogue that were free from coercive power relations (Habermas, 1984). Paraphrasing was used in individual interviews to support clarification of meaning and to provide participants with the opportunity to verify or contest meaning. Contradictions were explored in several stages of dialogic data generation. Group interviews provided opportunities to clarify conflicting claims by participants, to challenge or deepen initial understandings of the meaning of SI/SE from earlier analysis, and to explore relational patterns across several social sites. Three Study Advisory Committee meetings also provided opportunities for reflection by me as a researcher, checking for bias, and dialogue to explore early findings.

Overview of the Papers Presented in the Dissertation

Social Inclusion/Exclusion as Matters of Social (In)Justice: A Call for Nursing Action

In the first paper, we describe the emergence of Canadian discourse on SI/SE and a proposed framework for nursing action to promote social justice and health equity. Three Canadian SI/SE discourses are identified and provide a conceptual and ethical

analysis of SI/SE as matters of social (in)justice. An Integrated Framework for Social Justice, based on Canadian SI/SE discourse, is presented. The Integrated Framework for Social Justice is then compared to conceptualizations of social justice within foundational Canadian nursing documents and nursing literature. A broader conceptualization of social justice including both relational and structural dimensions is proposed for nursing. This paper has been published in *Nursing Inquiry* (Yanicki et al., 2015).

Social Inclusion/Exclusion: Participation and Belonging in a Rural Alberta Community

In the second paper, we address the first main research question with findings from participant observation and interviews with mothers and grandmothers who participated in Family Centre programs and CD activities with their young children and grandchildren. Three relational patterns (permanent strangers, newcomers, and boundary crossers) are identified based on participants' patterns of participation in Family Centre programs and the programs of partner agencies, as well as participants' experiences of SI/SE. Low-income and Aboriginal participants were represented in all three relational patterns. Transitions in relational patterns that support increased belonging and inclusion are identified for some participants. Parents' and grandparents' experiences of SI/SE largely reflect the discourse on recognition and the discourse on equity and citizenship identified in the first dissertation paper (Yanicki, et al., 2015). Multiple domains of SI/SE are identified including: relational, cultural, moral, and economic domains.

Community Development and Social Inclusion/Exclusion: Supporting the Participation of Low-Income and Aboriginal Parents, Grandparents and Children in a Rural Alberta Community

In the third paper, the second main research question is explored from the perspective of key informants. We report findings from relevant documents and

interviews with key informants who had actively engaged in the collaborative efforts of the Family Centre to promote the participation and inclusion of low-income and Aboriginal parents, grandparents, and children in community life. Key informants described a meaningful change in patterns of participation, social relations, and the diversity of participants over time. Key strategies to promote participation and to address the SI/SE dialectic are identified that could be tailored to support local development and social change in other rural communities. Constraints and challenges are identified in relation to social, economic, historical, and political contexts. Findings from this study identify both opportunities and challenges for local community-level efforts to address SI/SE.

Table 1.1 Carspecken's Stages for Critical Qualitative Research[5]

Stage	Core Activities and Aims
Preliminary Steps	Identify critical research questions and social routines of interest and examine researcher value orientation
Stage 1 Compiling a Primary Record	Data generation through observations and documentation in the primary record and field journal Intensive passive observation[6] - Document and describe activities, social routines, behaviour, interaction, tone of voice, and body language using detailed descriptive low inference language (thick descriptions) and draw a diagram of the social site and people's positions - Record dialogue verbatim (tape recordings and field notes)[7] - Document and describe the context for each session (context notes) - Record observer comments [OC] in brackets in the primary record Casual observation and informal interviews - Document 'things seen and heard' during day to day activities to document 'not-so-thick' descriptions (field journal) of events and describe the broader context - Engage key informants or participants in informal conversations and document these
Stage 2 Preliminary Reconstructive Analysis	Preliminary reconstructive analysis of observational data Thematic and pattern analysis - Read and code transcripts, identify key ideas, and cluster codes to describe cultural themes (cultural typifications) and patterns Critical hermeneutic analysis - Read transcribed primary record files and code objective, subjective, and normative-evaluative claims Identify a range of possible meanings - Identify agreement and disagreements on normative-evaluative validity claims, values and norms (meaning reconstruction)

[5] This table is adapted from Carspecken (1993) and Harrowing (2009).

[6] I began with passive observation to develop a detailed third-person descriptive account of social routines in the research setting.

[7] This data collection strategy was modified. Observation and participant observation sessions involved note taking during or after sessions, but no audio recording was used as I viewed this to be too intrusive.

Table 1.1 Carspecken's Stages for Critical Qualitative Research (cont.)

Stage 3 Dialogical data generation	Data generation through dialogue with individuals and groups Formal interviews - Explore participants' experiences within the context of institutional, community, and societal conditions - Verify Stage 2 analysis by exploring inconsistencies and conducting member checks Concurrent intensive reconstructive analysis of transcribed interviews - Read through and code cultural themes and systems relations Group discussions - Facilitate discussion to clarify cultural themes, patterns, and systems relations - Conduct consistency checks & peer debriefing
Stage 4 Describing system relations	Concurrent comparative analysis of the social site and related social sites (e.g., cultural group) - Read transcripts of the primary record, interviews and focus groups - Code themes and patterns as per Stage 2 and Stage 3 analysis - Compare field notes describing related social sites (stage two and three analysis). - Identify patterns of interaction specific to cultural groups, specific to sites and generalized patterns across sites (across social site comparisons). - Conduct member checks to verify stage three analysis, and peer debriefing
Stage 5 System Relations as explanations of findings	Describe how study findings are influenced by power relations and broader systems (social, cultural, political and historical) - Compare themes and key findings to the conceptual and theoretical framework for the study, macro-level social theories, and the published literature & identify new insights

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II. Social Inclusion/Exclusion as Matters of Social (In)Justice: A Call for Nursing Action[8]

"Being included in the society in which one lives is vital to the material, psychosocial, and political aspects of empowerment that underpin social well-being and equitable health" (World Health Organization [WHO], 2008, p. 33). Participation in community life enables the development of capabilities and wellbeing (Sen, 2000). As such, social inclusion/exclusion (SI/SE) can be understood as a social determinant of health (Galabuzi & Labonte, 2002). As a dialectical concept (Labonte, 2009), SI/SE provides an instructive example of the just and unjust relational processes and social structures that enable or constrain opportunities for participation (Galabuzi & Labonte, 2002; Labonte, 2009). Experiences of SI/SE and everyday living conditions are shaped within local social, economic, cultural, and political contexts (Mitchell & Shillington, 2005; Popay et al., 2008), and by global forces (Percy-Smith, 2000).

In this paper, we examine SI/SE as a matter of social (in)justice within Canadian society. Following an overview of the emergence of the SI/SE discourse in Canada, we identify three SI/SE discourses in Canadian literature—discourses on recognition, capabilities, and equality and citizenship—and describe how each presents a different view of the causes of exclusion and the conditions supporting inclusion. By exploring the interaction of diverse ideas within the SI/SE dialectic, a more complete representation of the underlying issues of social (in)justice is identified. An Integrated Framework for Social Justice (the Integrated Framework) that incorporates the three discourses is

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presented. Canadian nursing conceptualizations of social justice are critiqued within foundational Canadian Nursing Association (CNA) documents. A multidimensional conception of social justice with structural and relational dimensions is proposed for nursing within Canadian and global contexts. While we focus on the Canadian context, the historical and global concern for SI/SE and for social justice makes this work relevant to other nursing jurisdictions. We suggest that social justice is a foundation for ethical nursing practice and health equity.

Discourse on Social Inclusion/Exclusion

The Canadian discourses emerged in the late 1990s from earlier SI/SE discourses in Europe. The term *social exclusion* first appeared in France in the 1970s (Guildford, 2000) during a period of significant social and economic change and globalization (Galabuzi, 2009; Labonte, 2009; Shakir, 2005). The European Commission introduced the concept of SI/SE in 1989 in relation to the social rights of citizens (Barata, 2000). Social inclusion in European discourse involved citizens' rights to a basic standard of living and to participation in social and economic opportunities. Policies on social exclusion were developed to address economic deprivation (Shakir, 2005). During the early 1990s, the focus of European social policies shifted from poverty and deprivation to social exclusion (Levitas, 1999) and social inclusion (Guildford, 2000; Levitas, 2003). Equality, social rights, freedom from discrimination, capabilities, recognition, and participation were identified as major themes within the European discourse (Levitas, 2003).

Globalization has resulted in rising social inequities by race/ethnicity, gender, and social class across the western capitalist economies of Europe and North America

(Harrison, 2005). Within Canada, neoliberal social policies became prominent during the 1990s with privatization, deregulation, and a reduction in welfare program benefits (Labonte, 2009). Policies of fiscal restraint (Guildford, 2000) and economic restructuring led to a decline in stable full-time employment (Guildford 2000; Shakir 2005). The income gap between the rich and the poor increased (Dunn, Hargreaves, & Alex, 2002), and the labour market became increasingly racialized (Galabuzi, 2006). A demographic shift in immigration patterns began during the 1970s, and by the 1990s, 75% of immigrants were from non-European countries (Galabuzi 2006). Racialized groups increasingly received fewer opportunities for socioeconomic and political participation (Galabuzi, 2006). These social conditions set the stage for the emergence of a Canadian discourse on SI/SE.

A discourse on social inclusion emerged in Canada prior to a more critical discourse on social exclusion (Shakir 2005). In the early 2000s, the concept of social inclusion generated significant interest within non-governmental organizations including the Canadian Council on Social Development (CCSD, 2001), the Laidlaw Foundation (Freiler & Zarnke, 2002), the Canadian Policy Research Networks (Papillon, 2002), the Roeher Institute (2003), and the Inclusive Cities movement (Clutterbuck & Novick, 2003). The Laidlaw Foundation sponsored a series of papers to explore SI/SE and the participation of families and children in Canadian society (Freiler & Zarnke, 2002). These influential papers drew attention to "poverty…racism, disability, rejection of difference and historic oppression" as sources of exclusion (Freiler, 2002 vii). Five crosscutting dimensions of SI/SE were identified: (a) "valued recognition", (b) "human

development", (c) "involvement and engagement", (d) "proximity", and (e) "material well-being" (Freiler & Zarnke 2002, 5).

Guildford's (2000) paper on SI/SE stimulated policy debate within Health Canada; however, limited federal policy uptake occurred (Noël, 2002; Shakir, 2005). Canada is the only developed country within the Organization for Economic Cooperation and Development (OECD) without a comprehensive policy framework to address poverty and social exclusion (Conference Board of Canada, 2008), yet participation and citizen rights are firmly grounded in Canadian law. "Exclusion from membership and participation in Canadian society" is considered a breach of "equality rights" (Eliadis & Spicer, 2004 1) under the Canadian Charter of Rights and Freedoms (Government of Canada, 1982). Since 1982, several Supreme Court rulings have reversed government policies judged to have excluded individuals or groups from participating. Several provinces have implemented anti-poverty policies; however these strategies have resulted in only "modest" changes and have failed to address underlying social inequalities (Raphael, 2011). Two senate reports have recommended a national poverty reduction strategy (Fairbairn & Gustafson, 2008) and integrated social policy action to reduce health disparities (Keon & Pepin, 2009). Poverty rates in Canada remain higher "than in most other wealthy developed nations" (Raphael, 2011, p. 407).

The lack of a national policy framework to address poverty and SI/SE may reflect the dominance of neoliberalism within Canadian political ideology (Faid, 2009; Hay, 2009). From this perspective, poverty and exclusion are viewed as individual troubles (Labonte, 2009; Mills, 2000), and responsibility for solutions is downloaded to families and communities (Dobek, 2004; Jaffe & Quark, 2006). Individuals are assumed to be free

to pursue their goals, and competition in the marketplace is thought to be the basis for a just society (Browne, 2001). However, neoliberal ideology fails to consider systematic inequalities by "race, class or gender as structural constraints on opportunity and human development" (Browne, 2001, p. 122).

Three Canadian Discourses

What follows is a synthesis of the conceptual and philosophical foundations of three SI/SE discourses identified within Canadian literature: (a) the discourse on *recognition*, (b) the discourse on *capabilitie*s, and (c) the discourse on *equality and citizenship*[9]. The SI/SE discourses were identified within Canadian literature in nursing, public health, political economy, and development. These discourses are rooted in much older debates on social theory and moral and political philosophy (Fraser & Honneth, 2003; Sen, 2000; Young, 1990). The Canadian SI/SE discourse draws from a broader global discourse (WHO, 2008). Table 2.1 provides a summary of key concepts in the three Canadian discourses on SI/SE.

Discourse on recognition. In this discourse, SI/SE involves experiences, processes, and conditions that enable or constrain intersubjective mutual recognition and human dignity. Social inclusion involves recognizing, respecting and valuing each person, unique identities, and group differences (Bach, 2005; Freiler, 2002). In contrast, social exclusion involves rejecting the 'other'—those who differ from dominant social norms (Bach, 2005). Misrecognition, disrespect, stigma, and fear of difference are forms of social injustice that sustain exclusion. This discourse is grounded in critical social

[9] This discourse also has been described in political philosophy as the "redistribution" discourse (see Fraser and Honneth 2003), and predominantly focuses on social justice as distributive justice.

theory including the philosophies of Honneth (1995), Habermas (1984), Young (1990), and postcolonial feminist theory (Reimer Kirkham & Browne, 2006).

Social inclusion is a normative concept describing an ideal for just social relations (Bach, 2005). Inclusion "envisions forms of social identity, reciprocity and solidarity that provide a foundation for rights to be realized in relation to others for a life well-lived in community" (Bach, 2005, p. 130). Relational processes of inclusion promote a sense of belonging and acceptance (Freiler, 2002). Having a sense of belonging means feeling comfortable (Young, 1990), welcomed, and valued (Freiler, 2002). Acceptance involves feeling acknowledged as a person and as a member of a group or community (Bach, 2005).

Valued recognition or intersubjective mutual recognition is a foundational condition for human dignity (Honneth, 1995; Bach, 2005). In Honneth's theory (1995), recognition occurs at multiple levels of social relations. Recognition is first experienced within intimate loving relationships (interpersonal level). Recognition is assured in society through legal structures that institutionalize rights (institutional and societal levels), and is strengthened through opportunities for social esteem (community level) and social solidarity (societal level). Thus, SI/SE is embedded in (un)just relational processes and social conditions at multiple levels of interaction within everyday life.

Recognition acknowledges our shared humanity by valuing the moral worth and dignity of all persons (Honneth, 1995; Bach, 2005), honouring the 'other' (Bach, 2005), and attributing a positive meaning to unique group identity (Young, 1990, p. 157). Acknowledging difference enables the unique needs of individuals and groups to be recognized and addressed. "Equal respect for everyone…extends to the person of the

other in his or her otherness. And solidarity with the other as one of us refers to the flexible 'we' of a community" (Habbermas, 1998). Recognition at a community level enables the participation and inclusion of all.

In contrast, social exclusion involves the denial of mutual recognition and human dignity. Certain groups are viewed as being less worthy than or inferior to the dominant group (Freiler, 2002). Relational processes of misrecognition, disrespect, and fear of difference devalue diversity and uniqueness, while oppression, domination (Young, 1990), and stigma (Goffman, 1963) sustain structural inequalities. The social norms and values of the dominant group (e.g., white Canadians of European descent) are privileged while those of non-dominant groups are devalued. Oppression is a form of misrecognition involving institutionalized structures and "the unconscious assumptions and reactions of well-meaning people in ordinary interactions" (Young, 1990, p. 41).

Subordination and stigma are also important forms of social exclusion. Critical postcolonial theories challenge the systematic ways in which difference has been constructed and how non-European peoples have become viewed as "the essentialized, inferior, subordinate Other" (Anderson et al., 2003, p. 200). Difference is feared as unacceptable deviance and viewed as an essential characteristic of the 'other'—essentialism (Bach, 2005; Young, 1990). Stigma is a powerful source of exclusion involving labeling, discrediting, stereotyping (Goffman, 1963), discrimination, status loss, and unequal power (Link & Phelan, 2001). Stigma is a relational process involving external acts and internalized responses (Reid, 2004; Reutter et al., 2009).

Resistance to misrecognition and oppression can take a number of forms. Societal attitudes and beliefs, unequal power, and multidimensional disadvantage need to be

addressed to overcome stigma (Link & Phelan, 2001). Recognition of individual and group difference, as a process of inclusion, is required to address discrimination (Habermas, 1998). Voice, critical awareness (Freire, 2007/1970), participation and empowerment are foundation conditions for social inclusion and social justice in this discourse.

Discourse on capabilities. In this discourse, SI/SE involves processes and conditions that enable or constrain participation, freedom, and opportunities for capability development. Social inclusion involves having opportunities for personal development, wellbeing and a minimally decent life (Sen, 1992, cited in Mitchell & Shillington, 2005; Sen, 2000). Exclusion constrains the development of basic functionings and the complex capabilities required for full participation in community life (Sen, 2000). Social conditions that fail to provide equality of opportunities for human development are fundamentally unjust. This discourse is grounded in Sen's liberal egalitarian capabilities approach to social justice (Mitchell & Shillington, 2005; Wilmot, 2012).

Social inclusion provides a broad normative framework for evaluating the social arrangements enabling capability development and wellbeing (Robeyn, 2005, cited in Alkire & Deneulin, 2010). Inclusion is rooted in the Aristotelian concept of a good life—having social relationships and the Smithian concept of being able to participate "without shame" (Sen, 2000, p. 4). Sen's normative claim is grounded in shared values and respect for human rights (United Nations, 1948, 1986). Social exclusion both causes and results from poverty and deprivation and is an instrumental cause of capability failure (Sen, 2000). Capability failure involves lacking the functionings required to meet one's basic needs (Sen, 2000), while capability deprivation involves constrained life choices and

limited freedom to develop the complex functionings required for full participation (Mitchell & Shillington, 2005). Functions refer to the things one can do or be (Sen, 1999). Poverty may be: (a) absolute—lacking the basic necessities of life, (b) relative—lacking a minimally decent standard of living in comparison to others, and (c) relational—lacking the ability to participate in valued activities (Sen, 1982/1981). Social exclusion is a relational process leading to impoverished lives (Sen, 1999).

Active processes of exclusion involve the acts of agents and the processes and policies of institutions (Mitchell & Shillington, 2005) that result in certain groups being "left out" or "kept out" (Sen, 2000, p. 29). Socioeconomic conditions such as high unemployment are passive processes of exclusion (Sen, 2000). Inclusion enables human freedom and opportunities for capability development and wellbeing (Sen, 1990, 2000).

Discourse on equality and citizenship. In this discourse, SI/SE involves conditions that enable or constrain equal citizenship and distributive justice—the just distribution of wealth, resources, benefits, and burdens in society. Social inclusion involves opportunities for citizens to realize their rights and responsibilities (Beauvais, McKay, & Seddon, 2001), the presence of just social structures and distributions (Labonte, 2009), and freedom from oppression (Galabuzi, 2006). Social exclusion results from structural inequalities (Labonte, 2009; Raphael, 2011) and oppression (Galabuzi, 2009). Critical public health, conflict theory (Labonte, 2009), critical race theory (Galabuzi, 2006), political economy (Raphael, 2011), and political philosophy (Fraser, 2003) are prominent in this discourse.

Social inclusion is focused on transformational social change and creating a just and equal society. A combined focus on SI/SE is required to create the social conditions

necessary for equal citizenship and to address the structural inequalities sustaining exclusion (Chatterjee et al., 2004; Labonte, 2009; Shakir, 2005). Equal citizenship means having opportunities for full participation in the economic, social, cultural and political life of society (Labonte, 2009).

Social exclusion results from unjust social conditions, unfair distribution of resources and unequal citizenship (Galabuzi & Labonte, 2002; Galabuzi, 2006, 2009). Social inequalities result in multilevel barriers to participation (Galabuzi & Labonte, 2002; White, 1998). Equal citizenship is restricted when citizens are excluded from: (a) participation in civil society (political participation), (b) fair access to social goods (e.g., social resources and benefits), (c) participation in social production (e.g., social and cultural expression), and (d) economic participation (e.g., paid work) (Galabuzi & Labonte, 2002).

Oppression is another source of exclusion. Oppression involves systemic structural inequalities due to Eurocentrism, racialization, and discrimination (Galabuzi, 2006). Eurocentric bias privileges white European values, practices, and cultural standards and constructs these as 'normal' for society while devaluing those of non-dominant and racialized groups (Galabuzi, 2006). Racialization maintains white privilege and systematically disadvantages 'others' through "social, economic and political consequences" (Galabuzi, 2006, p. 251). Similarly, discrimination involves actions or practices that systematically disadvantage a group of people based on assumptions about the characteristics of a group (Galabuzi, 2006).

Creating a just society requires a focus on the social conditions required for inclusion and the institutionalized inequalities sustaining exclusion (Raphael, 2011). An

uncritical focus on social inclusion as a presumed social good has been critiqued (Labonte, 2009; Shakir, 2005) as it fails to address the structures of exclusion embedded in ideologies, policies and laws (Galabuzi, 2006; Raphael, 2011). A narrow focus on reducing economic exclusion through labour participation may lead to exploitation—forcing marginalized workers to adapt to the needs of the market under unequal or unfair terms (Galabuzi, 2009; Labonte, 2009; Shakir, 2005). In this discourse, structural change is required to promote social justice and equal citizenship.

While these three SI/SE discourses have been outlined as distinct views, we suggest that they are not as disparate as they may seem. In Table 2.1, the core concepts of each discourse are compared, thereby presenting shared concepts. When these SI/SE discourses are considered together as complementary views, a more comprehensive understanding of SI/SE and social (in)justice emerges.

Social Inclusion/Exclusion as Social (In)justice

Social justice is at the heart of the three Canadian SI/SE discourses. Just social relations and societal conditions include: (a) valued recognition, respecting unique group identities, and valuing difference; (b) freedom and equality of opportunities to participate in valued activities, to develop one's capabilities and wellbeing; and (c) equal citizenship, just distributions of society's goods and resources, and freedom from oppression. SI/SE is experienced through just or unjust relational processes and social structures within local, societal, and global contexts.

Social exclusion is a matter of social injustice involving a breach of ethical principles, human rights (United Nations[UN], 1948), and civil rights (Government of Canada, 1982). More specifically, unjust social relationships involving misrecognition,

disrespect, fear of difference (Freiler & Zarnke, 2002), and stigma display a disregard for the ethical principles of human dignity and justice (CNA, 2008). Capability deprivation, limited freedom, and limited opportunities for wellbeing (Sen, 2000) are a breach of human rights (UN, 2004). Civil rights are breached when unjust social structures lead to unequal opportunities, participation (Labonte, 2009), power, prestige, wealth, (Raphael, 2011), and access to resources (Galabuzi, 2009).

Integrated Framework for Social Justice

An Integrated Framework for Social Justice that incorporates the three Canadian SI/SE discourses (see Figure 2.1) is proposed to inform ethical nursing actions to promote health equity. SI/SE is defined as both a relational and a structural dialectical concept. As a *relational concept*, SI/SE involves experiences and dynamic relational processes enabling or constraining participation and (un)just social relations. As a *structural concept*, SI/SE involves structures that shape equitable or inequitable access to wealth, resources, rights, power, and prestige, as well as the structures that sustain (in)equities, oppression, and differential opportunities.

In Figure 2.1, the Integrated Framework incorporates a focus on inclusion on the left side, and exclusion on the right side. The three discourses are integrated across multiple levels of social relations. This framework reflects a socioecological perspective, expanding upon the work of Percy-Smith (2004, p. 5) who described "social exclusion in context" at local, national and global levels. We extend this socioecological perspective by considering the SI/SE dialectic at multiple levels: (a) intrapersonal (experiences, feelings and internalized responses to interactions), (b) interpersonal (relational

processes), (c) organizational (person-institutional interactions and structures), and (d) community, societal and global (social routines, structures and contexts).

Social (in)justice is central to this conceptualization of SI/SE. The following key concepts are integrated within Figure 2.1 (moving from the bottom to the top): (a) power/powerlessness; (b) respect and valued recognition/misrecognition, stigma and fear of difference; (c) capability development/capability deprivation; and (d) equality and citizenship/social inequality and oppression. Additionally, participation, empowerment, and globalization are intersecting concepts that occur at multiple levels and multiple contexts (cultural, social, economic and political) within the framework.

Interventions addressing the relational processes and structures of SI/SE are identified. In Figure 2.1, interventions promoting inclusion and social justice are listed to the left, while interventions addressing exclusion and social injustice are listed to the right. Relational interventions (from bottom to the top of the figure) include actions to: (a) promote individual and group empowerment and shared power (e.g., reduce internalized powerlessness, promote voice and negotiate power relations), (b) promote respect and valued recognition (e.g., build relationships of trust, and intersubjective mutual recognition), (c) reduce stigma, misrecognition, and fear of difference (e.g., facilitate interaction across difference), and (d) promote participation and create inclusive environments (e.g., respect for diversity). Structural interventions include actions to: (a) create formal programs to promote capability development, (b) reduce structural barriers to social, cultural, economic and political participation (e.g., review institutional processes and policies), (c) create just social structures (e.g., assure respect for human and civil rights and equality), and (d) engage in social action to reduce social inequalities

(e.g., distributive justice). The interventions identified in Figure 2.1 will be discussed further in a later section and opportunities for nursing action will be considered.

The dialectical reasoning (Gadow, 1995) applied in the Integrated Framework overcomes some of the critiques or limitations of a singular discourse focus to address social (in)justice. A focus on recognition supports actions to create just social relations and mutual recognition; however, this approach may not address the distributive injustices associated with globalization and the neoliberal social policies of advanced capitalist economies. A focus on capabilities supports interventions to create freedom of opportunity, capability development, and wellbeing; however, the relational processes of misrecognition and the unequal power relations sustaining structures of oppression are not addressed. A focus on equality and citizenship supports social action on structural inequities, but may not address the relational processes sustaining misrecognition, stigma, racism, and oppression.

Canadian Nursing Discourse on Social Justice

Social justice has been described by the Canadian Nurses Association (CNA, 2010) as a foundation for nursing. Promoting social justice is consistent with nursing's historical and philosophical roots (Reutter & Kushner, 2010). Nurses routinely witness the impacts of social injustice in the lives of their clients and play a key advocacy role (Falk-Rafael & Betker, 2012b). Some have argued that the nursing profession has a moral imperative to support collective social action promoting social justice and health equity at a societal level (Cohen & Reutter, 2007; Davison, Edwards, Webber, & Robinson, 2006; Reutter & Kushner, 2010). CNA discussion papers on social justice (CNA, 2006, 2010)

and the CNA Code of Ethics for Registered Nurses [the Code] (CNA, 2008) were reviewed to compare conceptualizations of social justice.

The CNA discussion papers on social justice were developed to guide CNA policies and encourage debate on nursing action to promote health equity (CNA, 2006, 2010). Both the relational and the structural dimensions of social justice were described; social justice was described as both a means and an end. As a means or a guide for just social relations in society (the relational dimension), social justice involves respect and dignity for all. As an end point or goal, social justice involves just social structures and fair distributions (the structural dimension) enabling people to meet basic needs and to realize their potential (CNA, 2006). Social justice was defined as the "fair distribution of society's benefits, responsibilities and their consequences", considering one's "relative position…in society" (CNA, 2006, p. 7). This definition of social justice emphasized John Rawls' (1985) liberal view of fairness and "distributive justice" (CNA, 2010, p. 13). Human rights and freedoms (Government of Canada, 1982) and the right to health (UN & WHO, 2008) were identified as foundations for social justice at national and global levels (UN, 1948).

The assumptions of critical social theory (Smith et al., 2003) were evident in the CNA discussion papers. Inequities and oppression were assumed to occur "in all societies" and it was assumed that "every individual" has an obligation to act to "eliminate systematic forms of inequity and oppression" (CNA, 2006, p. 7). Social justice was framed as a normative concept (CNA, 2010) underpinning nursing actions to address social inequalities. Nursing actions to promote health equity and a just society included: "advocacy, partnering", "policy change", "leadership", "research", and collective efforts

(CNA, 2010, p. 15-16). Reducing and eliminating inequities and unjust social structures was required to promote "a just society" (CNA, 2010, p. 15) and to advance "global health and equity" (CNA, 2006, p. 2).

Social justice also was a core element in the Code of Ethics (CNA, 2008). The relational domain of social justice was emphasized in Section I of the Code while the structural domain of social justice was emphasized within Section II. In Section I, justice was defined as a primary value involving the equal treatment of all persons. Nurses' core ethical responsibilities were to provide "safe, compassionate, competent and ethical care" (CNA, 2008, p. 5). In this section, the recipients of nursing care were defined inclusively as "individuals, families, groups, populations, communities and society" (CNA, 2008, p. 8), yet, there was a prominent focus on caring within individual nurse-person relationships (Davison et al., 2006). Caring involved relating "to all persons with respect" and considering the "unique values, customs", "spiritual beliefs" and socioeconomic "circumstances" of persons in their care (CNA, 2008, p. 13). Section II of the Code (CNA, 2008, p. 1-2) described the ethical endeavours that nurses 'should' or 'may' undertake to promote health equity. These endeavours at a population level were not defined as core ethical responsibilities; however, nurses were "as much as possible" encouraged to act, "individually and collectively, to advocate for and work towards eliminating social inequities…" (CNA, 2008, p. 20). The weak language in Section II framed social action as "optional" (Falk-Rafael & Betker, 2012b) and implied that reducing health inequities was not considered part of "the everyday work of nurses" (Davidson et al., 2006, p. E23).

In summary, both the structural and relational dimensions of social justice were evident in foundational CNA documents (CNA, 2006, 2008, 2010). Nevertheless, a tension was identified between the clear mandate of nurses' core responsibilities to provide ethical care and the potentially optional mandate of nurses' moral and ethical responsibilities to reduce social inequities. While the dominant focus on ethical nursing care and the relational dimensional of social justice in the Code (CNA, 2008) is valuable, it is not sufficient to promote just social relations, and just social structures. The weak language of Section II of the Code may act as a barrier to nursing action to "reduce and eliminate inequities" (CNA, 2010, p. 15). While nurses are called to recognize "the significance of social determinants of health" (CNA, 2010, p. 20), they also have a key role to play in acting to change the social, economic and political conditions that sustain health inequities (CNA, 2010). We suggest that the Integrated Framework explicitly supports the identification of opportunities for multilevel nursing action to address both the relational and structural dimensions of social justice.

Alternative Conceptualizations of Social Justice in Nursing. Although social justice predominantly has been described as a matter of distributive justice in nursing literature (CNA, 2006, 2010), multidimensional conceptions also have been proposed. Other dimensions of social justice identified include: (a) recognition (Fraser, 2003; Reimer Kirkham & Browne, 2006); (b) relational/contextual (Falk-Rafael & Betker, 2012b); (c) critical caring (Falk-Rafael & Betker, 2012b), or caring (Liaschenko 1999); and (d) participatory (Liaschenko, 1999), or "parity of participation" (Fraser 2003 cited in Reimer Kirkham & Browne, 2006, p. 36). A uni-dimensional focus on distributive justice has been critiqued from postcolonial (Reimer Kirkham & Browne, 2006), critical (Falk-

Rafael & Betker, 2012b), and feminist (Falk-Rafael, 2005; Falk-Rafael & Betker, 2012b) perspectives in nursing. The limitations of a uni-dimensional focus on distributive justice include: (a) a focus on fair distribution without a consensus on the goods to be distributed, (b) a focus on unequal access instead of the root causes of social inequalities, and (c) a focus on changes in distribution rather than on the transformation of society (Reimer Kirkham & Browne, 2006).

Nursing actions have been proposed that reflect a multidimensional understanding of social justice involving multiple levels of interaction. Critical caring has been described as a multilevel theory for ethical community nursing practice (Falk-Rafael & Betker, 2012b) to promote health equity (Reutter & Kushner, 2010) . As a mid-range theory, critical caring explicates nurses' roles and responsible actions for social justice (Falk-Rafael, 2005; Falk-Rafael & Betker, 2012b) at multiple levels of nurse-person interaction congruent with the Integrated Framework presented here.

Cohen and colleagues (2013) described a conceptual framework to promote Organizational Capacity for Public Health Equity Action (OC-PHEA). This framework, grounded in social justice and capacity building, described organizational and community levels of intervention as identified by public health equity champions. "Shared values" supported organization capacity for equity action; "fair distributions of power, respectful relationships, [and] shared societal responsibility for equitable opportunities for health" strengthened health equity action (Cohen et al., 2013, p. 265). Both intra- and extra-organizational factors influenced organization capacity including: awareness and attitudes on equity issues, opportunities for knowledge and skill development, organizational will and commitment to action, leadership, equity champions and intersectoral partnerships.

The themes identified in the OC-PHEA framework highlight the importance of attending to power relations, intrapersonal attitudes, interpersonal relations, and the intra- and extra-organizational factors that enabled the development of supportive environments. These themes were consistent with interventions to address the relational and structure dimensions of social justice of the Integrated Framework that we propose.

Challenges. We suggest that social justice should be a foundation for all nurse-person interactions. While public health nurses are ideally positioned to address both the relational and structural dimensions of social justice through critical caring interventions and partnerships with individuals, families, groups and communities (Reutter & Kushner, 2010), all nurses have a role to play. Our Integrated Framework is proposed as a strong framework to guide ethical nursing care for social justice. A multidimensional and multilevel conceptualization of social justice presents opportunities for nursing action across diverse settings and contexts.

Yet, a variety of factors may constrain nursing action at individual, organizational, and societal levels. Nurses may feel unprepared (Browne & Tarlier, 2008; Cohen & Reutter, 2007) or unsupported (Falk-Rafael & Betker, 2012b; Meagher-Stewart, 2001) in addressing the relational processes and structures of SI/SE and social inequality (WHO, 2008). The dominant focus on individual accountability for health in Canadian society reflects the dominance of a biomedical or behavioural model of health rather than a socioenvironmental model of health (Labonte, 1993) that emphasizes social determinants of health and equity (Raphael, Curry-Stevens, & Bryant, 2008). Many nurses face heavy workloads related to clinically mandated services, and have limited opportunities for policy advocacy (Cohen & Reutter, 2007; Reutter & Kushner, 2010).

Despite these challenges the CNA discussion papers suggest that national nursing organizations can play a key role in raising nurses' awareness of the professions' moral and ethical imperative to act both individually and collectively to promote health equity (CNA, 2010). Indeed, many Canadian nurses continue to act for social justice in spite of these challenges (Falk-Rafael & Betker, 2012a).

Implications and Recommendations

Examining the Canadian discourse on the SI/SE dialectic highlighted both the relational and structural dimensions of social (in)justice as matters of importance for the nursing profession. Multiple opportunities for interventions to promote social justice and health equity were identified within the Integrated Framework. The ecological focus of the framework enabled critical exploration of the relational and structural dimensions of social justice across multiple contexts of everyday life and intersecting sources of (in)justice and (in)equality. Our review of foundational Canadian nursing documents identified a more limited conceptualization of social justice. Although both structural and relational dimensions of social justice were identified, foundational documents provided limited guidance for integrating equity action at individual, group and population levels. Canadian nursing literature provided evidence of more inclusive conceptualizations of social justice, a perspective we advocate. We suggest that more emphasis should be placed on the structural dimension of social justice as a mandated role within nursing.

We propose a multilevel, multidimensional conceptualization of social justice to provide a strong foundation for ethical nursing practice and action to promote health equity. While the Integrated Framework was applied here within the Canadian context, we suggest that given the important global discourse on social justice and SI/SE (WHO,

2008), this framework may be of interest to nurses seeking to promote health equity action in other countries. A broader conceptualization of social justice for nursing at local, national and global levels may expose further opportunities for nursing interventions. Nurses work at multiple levels of social relations and have the opportunity to influence change within and outside of the organizations in which they are employed. Consistent with the function of the CNA (2006, 2010) discussion papers we hope to stimulate a broader debate on how to operationalize a broader view of social justice within nursing to promote health equity. So how should we proceed to address this challenge?

First, we suggest a greater emphasis on social justice in nursing curricula, including awareness of the relational and structural dimensions of social justice, the root causes of health inequity and the capacity to identify multilevel strategies for action. Second, nursing leadership is required to challenge environments that limit nursing actions in promoting just social relations or just social structures. We call on organizations to create supportive environments and to build organizational capacity for health equity action. Third, we propose dialogue among nursing organizations to stimulate sharing of best practices for social justice and equity action. Nursing organizations should take a leadership role in promoting equity action at local and global levels. Fourth, we recommend critical scholarship to develop nursing knowledge on multilevel and multidimensional approaches to address social justice within differing practice settings and country contexts.

Critical scholarship (Mill, Allen, & Morrow, 2001) and emancipatory knowledge development (Chinn & Kramer, 2008), which seek to uncover the processes and

conditions that sustain injustice within everyday life, would inform and support operationalizing the Integrated Framework in practice. Critical scholarship and emancipatory knowledge are needed to promote participatory and collaborative social action to challenge social inequalities, to give voice to those most affected by injustice, and to identify effective interventions. By uncovering the power relations that are created and recreated in society (Chinn & Kramer, 2008) and clarifying the intersecting sources of SI/SE and injustice, social action can be developed with community partners to promote multilevel social change.

Conclusion

A dialectical analysis of SI/SE highlights multiple sources of injustice and opportunities for nursing action to address SI/SE as a matter of social (in)justice. Our Integrated Framework promotes a focus on both the relational and structural dimensions of social justice. We propose a multilevel, multidimensional conceptualization of social justice as a foundation for ethical nursing practice. We hope to stimulate dialogue on social justice as a means to address growing health inequities around the world (WHO, 2008). Given the global call for bottom-up and top-down strategies to address health inequities within and between countries (WHO 2008), there is an urgent need for nursing actions and emancipatory knowledge development to promote greater health equity. Nurses, as trusted professionals, are uniquely positioned to act for social justice in their everyday interactions and in their collective acts.

Table 2.1 Summary of Social Inclusion/Exclusion Discourses and Interventions

Canadian discourses	Social inclusion	Social exclusion	Intervention to address SI/SE and (In)justice
Recognition	- Mutual recognition - Respect for diversity - Valuing difference - Social esteem - Social solidarity - Critique of dominance and oppression - Consciousness - Voice Universal values (Human dignity)	- Misrecognition - Disrespect - Stigma - Fear of difference - Denial of difference - Dominance - Oppression - History of colonialism - Silencing of voice - Dominant values (Hegemony)	- Consciousness raising - Mutual recognition - Respect for human dignity - Valuing difference - Respect for unique group identity - Decrease stigma - Voice - Social interactions across difference - Opportunities for belonging and acceptance - Opportunities for social esteem - Promote social solidarity
Capabilities	- Capability development - Equality of opportunity - Universal values (Freedom) - Opportunities for wellbeing for all	- Capability deprivation - Capability failure - Inequality of opportunity - Lack of freedom - Shame - Self-exclusion - Impoverished lives	- Equality of opportunities for capability development - Address sources of inequality (e.g., income, gender, race/ethnicity and ability) - Freedom and opportunities for development and wellbeing as human rights - Opportunities for choice among valued activities
Equality and Citizenship	- Equal citizenship - Distributive justice - Universal values (Equality) - Respect for diversity - Freedom from oppression	- Denial of equal citizenship - Unjust distribution of wealth, resources, benefits and burdens - Intersecting inequalities - Oppression	- Fair access and distribution of wealth, resources, benefits and burdens - Address sources of inequality (e.g., income, gender, race/ethnicity, religion, sexual orientation and immigrant status) - Challenge oppression - Affirmative action to promote equality
Shared Concepts across Canadian SI/SE Discourses	- Social justice - Supports for participation - Human and civil rights - Equality - Shared power	- Social injustice - Barriers to participation - Inadequate realization rights - Powerlessness	- Just social relations - Just social structures - Multidimensional participation - Empowerment (individual and collective) - Shared power

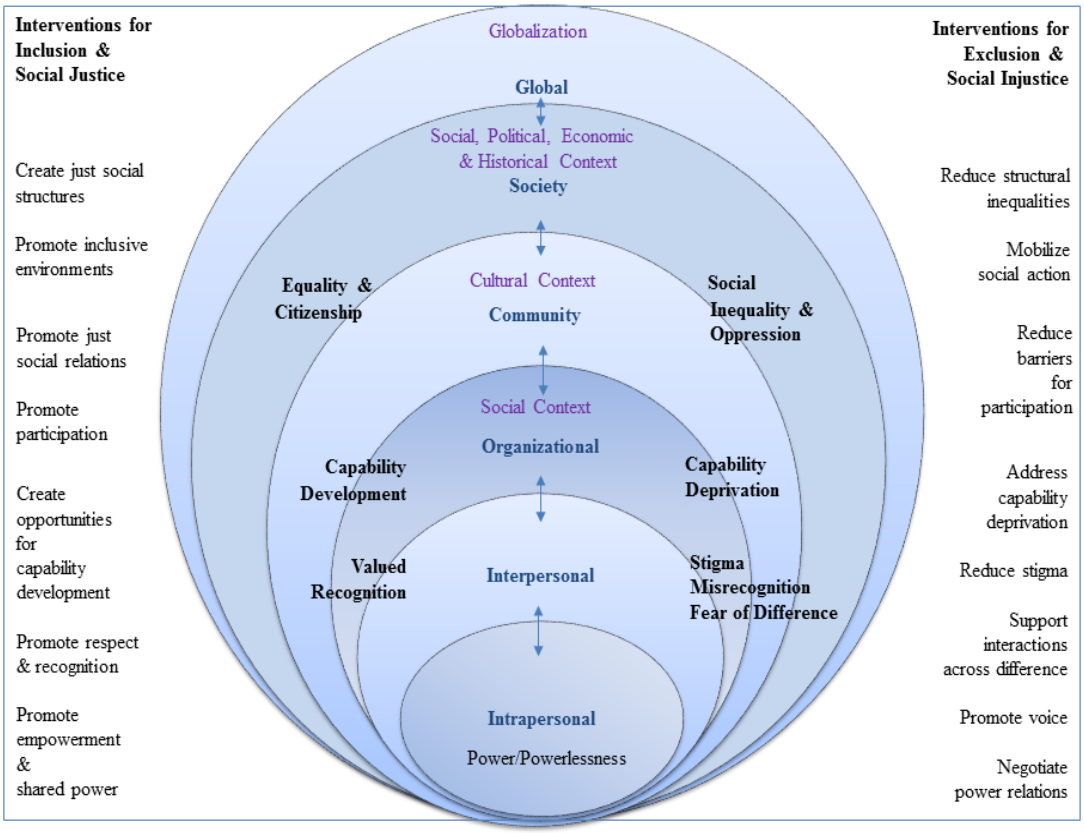

Figure 2.1 Integrated Framework for Social Justice

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III. Social Inclusion/Exclusion: Participation and Belonging in a Rural Alberta Community

Social inclusion/exclusion (SI/SE) is a social determinant of health (Galabuzi & Labonte, 2002; Raphael, 2009) that is integral to social (in)justice. Inclusion and exclusion are contested concepts rooted in earlier discourses on poverty, deprivation, and inequality (Labonte, 2009; Levitas, 2003; Sen, 2000). Social inclusion has been described as an ideal for social relations (Freiler, 2005), yet exclusion is not simply the mirror image of inclusion (Labonte, 2009; Mitchell & Shillington, 2005). Social exclusion results from barriers to participation in community life and from social inequalities (Labonte, 2009) related to income, race, ethnicity, age, and gender (Galabuzi, 2009). SI/SE involves lived experiences (Freiler & Zarnke, 2002), relational processes, and everyday living conditions that enable or constrain participation (Popay et al., 2008).

Discourse on SI/SE arose in Canada within the context of growing inequalities and neoliberal social policies (Labonte, 2009). Canadian discourses on SI/SE (Yanicki et al., 2015) have focused on opportunities for recognition (Bach, 2005), capability development (Sen, 2000), equal citizenship (Labonte, 2009), and health and wellbeing (Mitchell & Shillington, 2005; Sen, 2000). Research has more commonly examined exclusion rather than inclusion or the SI/SE dialectic (Labonte, 2009; Reutter et al., 2009; Stewart et al., 2008). Exclusion has been studied predominantly with a focus on income inequalities in urban settings (Reutter et al., 2009). Exclusion is more commonly reported among poor women (Reid, 2004), Aboriginal peoples (Frohlich et al., 2006), and racialized groups (Galabuzi, 2006) in comparison to the general population.

Participation in community development (CD) may support empowerment (Labonte, 2005; Wallerstein, 2006), yet participation does not always lead to a sense of

social inclusion, especially for low-income people (Stewart et al., 2008). Participation is influenced by shared understandings of the expected behaviour within a given social setting (Carspecken, 1996) and constrained by experiences of exclusion due to shame (Reid, 2004; Sen, 2000), stigma (Reutter et al., 2009), racism, and discrimination (Browne & Fiske, 2001; Galabuzi, 2009; Tang & Browne, 2008). Stigma involves "stereotyping" and "discrediting" human differences (Goffman, 1963, p. 13), as well as the discriminatory processes of "labelling", "status loss", and "separation" (Link & Phelan, 2001, p. 363).

Experiences of participation and SI/SE may differ in urban and rural settings. Rural residents are more likely to know their neighbours, to volunteer, and to report a sense of community belonging in comparison to urban residents (Turcotte, 2005). Rural communities in Canada are facing challenges due to a declining economic base, increased competition for resources, government cutbacks and neoliberal social policies (Jaffe & Quark, 2006). With a decline in human and economic resources, informal processes for mutual aid and volunteerism may be compromised (Jaffe & Quark, 2006). Based on Australian research, newcomers moving to rural communities may face challenges gaining acceptance (Hillman, 2008). Minimal Canadian research has explored the relational processes and structures influencing SI/SE in rural settings.

This paper reports on a qualitative study that examined the SI/SE dialectic in relation to participation in the Kids First Family Centre (hereafter referred to as the Family Centre), a community organization[10] in the town of Fort Macleod, Alberta, Canada. The following research questions were addressed: How was SI/SE experienced by parents and grandparents with young children (including low-income and Aboriginal

[10] Community organizations are formally incorporated organizations run by local community members.

participants) participating in the programs and activities of a rural Family Centre? And additionally, what processes and conditions enabled or constrained the participation and social inclusion of low-income and Aboriginal parents, grandparents and children in community life?

Background

Fort Macleod, originally an outpost of the North-West Mounted Police, was settled by predominantly European immigrants in the late 1880s (Town of Fort Macleod History Book Committee, 1977). The majority of the town's population (3,117 in 2011) is English-speaking (97.2%) (Statistics Canada, 2012), 12% is of Aboriginal identity, and 1.8% is of Filipino, and Chinese origin (Statistics Canada, 2010a). Two First Nations—the Piikani and Kainai—are located in close proximity with populations of 1,300 and 4,177, respectively (Statistics Canada, 2010b). Children from both First Nations and the surrounding rural area attend schools in Fort Macleod.

In the fall of 1999, the local health region initiated a community meeting to discuss concerns about child poverty (M. Bopp, 2004; Dobek, 2004). In 2001, the child poverty rate was 21% in Fort Macleod and area (Chinook Health Region, 2002, cited in Dobek, 2004) compared to 16.2% in Alberta (Poverty Reduction Coalition, 2007). An intersectoral collaboration (including health, education, family, and community support services and First Nations) and community development initiative emerged in 2000 to address child poverty and food insecurity (M. Bopp, 2004). A community organization (hereafter called the Family Centre)[11] was developed in 2006 with a focus on parenting, early child development, poverty, and SI/SE; interagency collaboration and CD strategies

[11] The Kids In Need (KIN) coalition formed in 2000 and the Society for Kids First formed in 2003 preceded the development of the Fort Macleod Kids First Family Centre (M. Bopp, 2004).

were used to increase access to parent/preschool programs and children's recreation (J. Bopp, 2009). This community provided a naturalistic setting in which to examine participation and SI/SE.

Methodology

The findings reported here are based on participant observation and interviews with mothers and grandmothers as part of a larger critical ethnographic study. Critical scholars seek to uncover the meaning of experiences, relational processes, social interactions, and social structures within naturalistic settings (Morrow & Brown, 1994; Thomas, 1993). Critical ethnography provides an iterative process for linking individual experiences and relational processes at the local level to larger systems in society (Harrowing, 2009). Critical ethnography has been applied in nursing (Harrowing, 2009) to systematically uncover and challenge unequal power relations (Carspecken, 1996; Cook, 2005; Harrowing, 2009).

Harrowing's (2009) application of Carspecken's (1996) five-stage qualitative methodology, adapted from Habermas' (1984) theory of communicative action, guided data generation and analysis. Carspecken's iterative stages include: (1) primary documentation—observation and field notes, (2) preliminary reconstructive analysis—thematic pattern and meaning analysis, (3) dialogical data generation[12]—individual and group interviews to explore experiences and meaning, (4) system relations description—comparing observed patterns of interaction at several social sites through cross-case analysis, and (5) systems relations—comparing power relations to a theoretical framework and social theories to explain findings. Early steps in data generation and

[12] The meaning of observed interactions was clarified during individual interviews. The patterns of participation and relational patterns of SI/SE were then verified in dialogue with community stakeholders during group interviews, community advisory group meetings, and community presentations.

analysis were repeated during later stages of the process (e.g., stages 3-5) to clarify and validate findings.

This study received ethics approval from relevant university ethics committees and study approvals from collaborating organizations. A Study Advisory Committee (SAC), including community members, professionals, and First Nations elders, provided guidance for the interview questions, participant recruitment, and review of early findings. Entry into the community involved an extended period of informal observation with the Family Centre board (> 2 years) by the first author, followed by 13 months of fieldwork and data generation. Purposive sampling was used to select adult participants with the experiences of interest. Study participants were parents and grandparents with young children or grandchildren (9 years of age or younger), who had taken part in the programs and services of the Family Centre and their collaborative community development activities with partner agencies (for ≥ 6 months). To reflect the demographics of program participants, recruitment focused on participants from varied income (i.e., low-income, middle or high income participants) and ethnocultural backgrounds (i.e., self-identified Aboriginal participants and participants from other ethnocultural groups). Posters and written invitations were distributed by the Family Centre, partner organizations, and the first author.

Participant observation took place during routine parent and preschool programs with participants' verbal consent[13]. While fathers were observed during program activities, only mothers and grandmothers volunteered to take part in formal interviews. Participant observation involved observing the interaction of parent, grandparent and

[13] The letter of introduction (Appendix D), parent and grandparent interview guides (Appendix F and T), consent information sheet and consent forms for interviews (Appendices K, N, O, P and Q) are attached.

child in multiple social settings, programs and in mixed groups over a period of time. Observations provided important context for parent and grandparent interviews. For example, observing low-income families with young children attending programs during the winter, highlighted the everyday challenges of having no public transportation system in a rural community.

Field notes and observations were documented by the first author in the primary record to develop a detailed third-person descriptive account of social routines in several settings. The primary record was then reviewed to develop an initial understanding of the meaning of observed dialogue and relational patterns in each social setting (Stage 1 analysis).

Two individual interviews were conducted with 14 participants. Interviews were conducted in English in a variety of settings (e.g., homes, school, library, and offices) or by phone. A participation survey and a demographic questionnaire were completed with individual interview participants as part of the first interview (see Appendix G & H). Questions were asked orally to address any literacy issues. Building on initial understandings from observations, the first individual interview explored perspectives on participation and experiences of SI/SE. After each interview, the transcribed interview was reviewed and coded for meaning, program participation, relational patterns, and subjective and normative-evaluative claims (Carspecken, 1996). Normative-evaluative claims reflect participants' shared understandings of what was right, good, or appropriate in a particular social setting; thus, these claims reflect underlying values, norms, and cultural beliefs (Carspecken, 1996). The second individual interview explored community participation, sense of belonging, and SI/SE, providing an opportunity to

clarify shared understandings (confirming the researcher's interpretations) from the first interview (Stage 2 analysis). Cultural themes, relational patterns, and structural factors also were coded throughout analysis (Stage 3 analysis).

Group interviews were completed to further explore initial findings and to stimulate additional insights. Two group interviews (with a subset of five participants) were conducted with a convenience sample of community kitchen participants (two individual interview participants and three new participants). Many of the participants in individual interviews had moved or could no longer be contacted by phone by the time of the group interview. Interviews were audio-recorded and transcribed verbatim by a transcriptionist.

Critical hermeneutics analysis was used to code preliminary understandings of the meaning of speech claims within dialogue (Carspecken, 1996; Habermas, 1984). Subjective claims and normative-evaluative claims were of particular interest. Interviews were reviewed in text segments to explore speech claims and possible meanings. For example, "Being a young mom, I kind of stay low key 'cause (sic) I didn't like going to programs . . . because people around here do judge." Three types of claims were identified in this text segment: a normative claim—people judge young mothers, an objective claim—I don't attend programs (staying low key or not drawing attention), and a subjective claim—I don't like going to programs (because people might judge me). A sense of moral judgment or stigma was suggested: People judge young mothers or assume they are irresponsible parents. Tentative interpretations of meaning were explored in a second interview.

Power relations (Stage 4 analysis) were explored and coded throughout analysis at organizational, community, and societal levels, and systems relations (Stage 5 analysis) were examined within socioeconomic, cultural, political, or historical contexts (Carspecken, 1996). For example, a participant described community-level social divisions: "They [the rich kids] didn't like First Nation people associating with them." Content analysis (Patton, 2002) and qualitative data displays (Miles & Huberman, 1994) were used to identify crosscutting relational patterns through cross-case comparisons. For example, reported participation and observed interactions were compared across cases and social sites. NVivo 10 (QSR International, 2012), a qualitative software program, was used to manage data.

Participants

A total of 17 mothers and grandmothers participated in individual or group interviews. Individual interview participants (n = 14) had a mean age of 34.9 years (range = 24–53) and family size of four people living in the household (range 2–6). Eight participants perceived themselves to have a low income (range: annual family income [AFI] = $18,000–$50,000), although two of these participants reported AFI above pre-tax Low-Income Cut Offs (LICO) (Statistics Canada, 2010c). Six participants reported a self-perceived middle or high income; only three of these participants reported their AFI (range = $80,000–$130,000). Most study participants were engaged in some form of paid work; two were on maternity leave and one was receiving social assistance benefits. Eight individual interview participants self-identified as Aboriginal. See Table 3.1 for a summary of participant demographics.

Group interview participants (n = 5) were slightly older than individual interview participants with a mean age of 37.6 years (range 24–59 years), and four participants reported an Aboriginal identity. Two participants with older children (≥ 10 years of age) who were regular community kitchen participants were included in this convenience sample, rather than excluding them from the interview. Based on advice from First Nations elders, income status was not assessed in group interviews, as family income was thought to be a sensitive issue. See Table 3.1 for a summary of participant demographics.

Results

Participants reported that they and their young children and grandchildren were able to take part in a range of activities including community kitchens, parent/preschool programs, cultural activities, and community events. The types and patterns of participation varied widely; some participants reported occasional participation while others reported regular participation in multiple programs (see Table 3.2). Supports and barriers for participation, relational patterns, and transitions are presented in the following sections. Relational patterns refer here to relatively stable patterns of social relations. Transitions reflect internal shifts[14] or a gradual change in relational patterns and participation.

Supports and Barriers for Participation

Supports and barriers for participation were described at intrapersonal, interpersonal, organizational, and structural levels (see Table 3.3). Intrapersonal factors involved individual feelings, experiences, and internal responses to social relations and

[14] Transition involves internal psychological processes in response to a change in the external environment (Bridges, 2009). In nursing literature, transition theory focuses on person-environmental interactions, individual experiences of transitions, and opportunities to enable healthy transitions (Meleis, Sawyer, Im, Hilfinger Messias, & Schumacher, 2010)

environmental conditions. Interpersonal factors reflected social interactions with community members. Organizational factors involved social interactions with staff, programs, and organizational routines. Structural factors reflected the socioeconomic, ethnocultural, historic, and political context of everyday life. Overall, organizational factors were the most commonly identified support for participation. As one Aboriginal mother noted: "They were friendly, and they know how to involve you a lot. They suggested a lot of stuff . . . for my kids. So that's how I just kind of got my interest and involvement." Intrapersonal factors were the most commonly identified barrier. One young mother commented, " Anything to do with children, I can fit in . . . but some of the older programs . . . I don't think I can . . .fit because of the cliques."

Relational Patterns

Data analysis revealed three relational patterns of SI/SE and participation that crossed income and ethnocultural identity groups: (a) permanent strangers, (b) newcomers, and (c) boundary crossers. While the term "permanent strangers" was not used by interview participants, participants at a community presentation of initial findings readily identified with this term and relational pattern. One individual commented that "it feels permanent" at the time. Permanent strangers described a dominant pattern of limited participation or non-participation and a provisional sense of belonging or inclusion. Newcomers self-identified as being new or still feeling like a newcomer. Newcomers described participating in community programs and activities, feeling welcomed, and having a sense of belonging within specific groups, yet they also reported having difficulty making close friends. Boundary crossers described participating in mixed groups that included participants from different socioeconomic, ethnocultural, and age

groups and most reported having a sense of community belonging and inclusion as well as an awareness of stigma. Several participants described transitions from one relational pattern to another; these transitions will be described in a later section.

Permanent strangers. Four of the 14 individual interview participants (three mothers and one grandmother) described a relational pattern of limited participation and a limited sense of belonging and inclusion. Permanent strangers all reported self-perceived low incomes; three were lone mothers and three reported an Aboriginal identity. These participants reported not actively seeking to participate in community programs or activities, yet most had grown up in the area (in town or a nearby First Nations community) or had lived in the community for several years.

Supports for participation. Organizational—interactions with agency staff or program participants—and interpersonal—interactions between individuals—factors were commonly cited supports for the participation of permanent strangers. Organizational and interpersonal factors were closely related; outreach contacts and positive interactions with an Aboriginal community support worker helped to build trusting relationships that enabled participation in group activities. Direct invitations to attend, volunteer, or share cultural knowledge and accessible programs that were free or subsidized also supported participation. An Aboriginal mother noted, "I was probably more likely to attend because she [the outreach worker was] . . . counting on me, and I didn't want to let her down." Outreach workers helped to link isolated parents to those who were attending programs. Permanent strangers reported feeling most comfortable interacting in a small group (≤ 6 people) with their young children or grandchildren and with people they knew. One Aboriginal grandmother noted the importance of eliminating

financial barriers: "They gave us a [family] pass . . . for the swimming pool . . . things . . . that really count." Participating also supported a sense of shared responsibility:

> I grew up here . . . [and] coming back here . . . I was kind of that skeptical person . . . you don't bother with anybody they won't bother with you. Well, it doesn't work like that here. . . . I watch out for my neighbors more or less. . . . That's just how it is.

Participation in the Family Centre provided access to tangible assistance (e.g., Secret Santa and the Good Food Box [15]) and group support (e.g., community kitchen), which reduced the impacts of poverty and supported stability. A grandmother noted, "[I]f there wasn't [support], I don't think I'd be able to manage to stay here . . . and, you know, make some kind of roots for myself."

Cultural participation (e.g., participation in dance, drumming, crafts, or ceremonies)was supported through organizational intersectoral partnerships such as formal children's programs. Group interview participants suggested that having opportunities for cultural participation was very important for parents and young children. Two Aboriginal participants chose to participate after being invited to lead a cultural activity and share their cultural knowledge. A non-Aboriginal mother described her child's participation in a First Nations cultural program: "He was the only non-Native boy there . . . he felt a bit different at first, but he continued on with it and he really enjoyed it . . . they really accepted him." Permanent strangers reported gaining a sense of self-esteem or group belonging by participating in valued cultural activities.

[15] The Secret Santa program provided a food hamper and gifts for low-income families at Christmas time, while the Good Food Box provided a monthly low-cost box of fresh fruits and vegetables.

Barriers to participation. Intrapersonal barriers constrained participation; permanent strangers reported feeling uncomfortable, shy, or anxious in groups. One mother talked about managing her anxiety to support her children's participation:

> Sometimes I get really shy, like to be in big groups, like unless I know someone or I'm going with someone, but I wouldn't really do it by myself. . . . Like, I suck it up [for the kids] . . . but just for me to just go out and go to some big function or something I don't think I would be able to do it. I'd, like just freeze and freak out.

Trust issues also were common. Two mothers reported having difficulty trusting nonfamily members to care for their young children. An Aboriginal grandmother reported having difficulty trusting people in the community: "I'm still having problems going out . . . [and] associating with . . . [town] people." She often preferred to stay home in her "comfy zone" and declined to participate even when personally invited to free programs.

Intrapersonal and interpersonal barriers were closely linked. For some participants, intrapersonal barriers involved internalized responses to past interpersonal trauma; negative experiences set the stage for limited participation. Three Aboriginal participants reported a history of trauma (e.g., family conflict, separation, abandonment, or a significant loss), bullying, or racism. For two mothers, growing up and living in a small town meant not being able to avoid contact with bullies from their past. Sometimes experiences of bullying in the past coloured experiences and the meaning of social interactions in the present. One mother described walking into a children's program and observing an adult yelling at her children. She wondered if this bully from her past was targeting her children:

> I kind of felt like maybe she was being mean to them because when I was growing up . . . we had . . . our differences and so . . . maybe it's because of me . . . 'cause in high school . . . we hung around with white people . . . and . . . all these people . . . [from the] reserve . . . they didn't know us, and they used to call us

> Apple Indians[16] . . . and it's crazy now though. When I see them, they smile at me, wave. . . . Can't be mean to me now, I guess.

Memories of past experiences of being bullied were strongly evoked by observing this negative encounter. She later reported a change in her children's interest in participating in community programs: "Lately, it's been them not wanting to go anywhere, just staying home." The children's self-exclusion following negative encounters appeared to be a learned pattern.

Intrapersonal barriers such as personal preferences and structural barriers such as the demands of working or going to school constrained participation. One Aboriginal lone mother described herself as a "quiet person" who had lived "like a hermit" for several years, having almost no contact in the community outside of her job and school, yet she hoped to participate in the future. A non-Aboriginal lone mother who was employed full-time was not seeking to participate. She described herself as "not a really sociable person. . . . It's nice to get a break from the kids but . . . I don't find it necessary to go out and find a group of people." Permanent strangers commonly spent leisure time with extended family.

Organizational barriers such as program fees, and structural factors such as a lack of public transportation (e.g., no in-town bus service), limited rural employment, and limited education opportunities were barriers to community participation. Parents who lacked a vehicle had difficulty attending programs with their young children during bad weather as there was no bus service in this rural community. Many low-income participants experienced time constraints as they juggled the demands of parenting,

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[16] "Apple" is a local term derogatorily used to refer to being Aboriginal ("red") on the outside and Caucasian ("white") on the inside (Dobek, 2004).

employment, going to school, or combinations thereof. Limited employment and education opportunities within the community resulted in mobility (moves between town, reserve, and cities) and presented a barrier to participation. One participant was considering moving to find employment. A young Aboriginal mother contemplated going back to school: "I've been kind of wanting to move, but if I move then I'm moving [my child] away from . . . friends and . . . I know what that feels like because I was moved at a young age." Mobility disrupted participants' social relationships and opportunities for social support.

Cultural participation was limited for two Aboriginal mothers who had grown up in town or urban settings. They described having had limited opportunities to develop cultural knowledge: "I am illiterate [in my language]. I know nothing. . . . I grew up in . . . white society." As children, these participants had not had the opportunity to learn their First Nation's language or to participate in cultural activities. Several participants expressed interest in learning their ancestral language. One Aboriginal grandmother enjoyed participating in traditional ceremonies on nearby reserves but felt uncomfortable participating in community activities in town.

Summary. For permanent strangers, organizational and interpersonal factors enabled participation; they were most comfortable participating in small groups with young children and engaging in free accessible programs and valued cultural activities. Intrapersonal and structural barriers limited participation in larger groups or community activities, while interpersonal, organizational, and structural barriers sustained only a provisional sense of group belonging.

Newcomers. Four of the 14 individual interview participants reported seeking to take part in community activities, yet being or still feeling new to the community. Two newcomers reported self-perceived low-income status and two reported self-perceived middle-income status. Three of these participants were married non-Aboriginal mothers, and one was an Aboriginal lone mother. Newcomers had moved to town or the surrounding rural area as adults and had resided in the community for a year or more (1–6.5 years of continuous residence). Newcomers reported feeling left out or feeling like an "outsider" at times.

Supports for participation. Organizational factors including formal programs and church activities provided formal structures of support that enabled participation. At the interpersonal level, participation in formal programs enabled parents and children to develop social connections. Newcomers often attended formal programs with their children: "It's mostly had to do with my kids, the different programs that I have been involved in." Preschool programs and play groups supported the inclusion of newcomers by providing a regular meeting time, a welcoming social space, and a structure for informal social interactions. Recreation subsidies reduced financial barriers for children's participation in sports. An Aboriginal mother (perceived low-income) described regularly attending sports programs with her children: "I'm definitely meeting . . . parents . . . . [I] have to find people that I have things in common with." Church attendance provided unique opportunities for social relationships and networking. One low-income mother reported, "It's been really good actually. We've come to know a lot of people at the church." One middle-income mother commented, "[It's] a large mechanism of connectedness . . . for families, for friendships, for business, for trades. . . . It really is . . .

a big, big, big component here." Thus, church attendance was thought to be a key mechanism for developing social connections. Parents also used formal programs to support their young children in making friends. For example, "play dates" were arranged with acquaintances from formal programs. This mother noted that newcomers tended to connect with other newcomers at formal programs: "[M]ost of the people that . . . we have play dates with have been here kind of less than 10 years."

Barriers to participation. Intrapersonal (e.g., feeling uncomfortable, overwhelmed, different), interpersonal (e.g., closed social networks), and structural barriers (e.g., mobility) limited opportunities for newcomers to move beyond casual social relations. One lone mother reported feeling uncomfortable when people asked others about her: "It can be very gossipy. I'm friends with my neighbor . . . and, uh, there's been people that have asked her about me. . . . That's just a small community." In contrast, a low-income mother suggested that people were interested in newcomers: "People are more welcoming in a small town. . . . They actually look at you in the face and have a conversation with you as opposed to in the big city."

Intrapersonal barriers such as difficulty making close friends were closely linked to structural barriers such as closed social networks. One middle-income newcomer described trying to meet people at the swimming pool:

> I went to sit in those bleachers, and . . . I'd be just ready to meet whoever I could meet. . . . And so people are kind of telling stories and maybe I'd go, oh yeah, and ask a question, and they'd look at me like, 'I don't have to talk to you. Just 'cause I'm on the bench with you doesn't mean I have to talk to you' . . . so that's what I tried. It didn't work very well.

As this mother observed, "It took me a little while to understand that, that making friends really can take a much longer period of time" in a small town. Three mothers described

feeling both different from others and shut out from close relationships. A low-income mother commented, “I haven't gotten to really know anybody;” the parents she met were “just into their own cliques.” One middle-income mother noted that her children had limited opportunities within their neighbourhood to interact with children their own age: “I found that really interesting in a small community that those kinds of naturally occurring phenomena are really sparse.”

Structural barriers interacted with barriers at other levels. Newcomers who did not share the dominant religious beliefs (Christian) of the community described feeling left out or censored. One middle-income mother who did not belong to a church suggested that not attending church was noticed in a small town: “In [a larger community] I never, ever felt out of line for not going to church on Sundays; here . . . there might be a handful of families that are doing that [not going to church].” Feeling censored and closed out of social networks, this mother wondered if attending church was the only way to make friends in this town.

Structural barriers limited low-income newcomers’ opportunities to socialize with adults. One mother suggested, “There’s (sic) different things I’d like to try [adult fitness programs] but they all cost money.” Another mother lacked childcare and was only able to attend programs with her children. Two newcomers described making friends with other newcomers; however, they also described having a new friend move away. Limited employment and housing contributed to mobility among newcomers.

Summary. Newcomers were able to participate in a range of programs and activities with their young children and reported a sense of group belonging. Organizational and interpersonal factors supported participation. Formal programs

enabled regular group-based interaction. However, intrapersonal, interpersonal and structural barriers were also identified. Newcomers experienced challenges in breaking into established social networks and making close friendships.

Boundary crossers. Six of the 14 participants (four mothers and two grandmothers) reported having a sense of belonging and inclusion in at least one group and most felt included in the community. Boundary crossers chose to participate in programs with diverse participants. Most boundary crossers described an awareness of stigma or difference, an appreciation of having opportunities to meet people from all "walks of life", a shared interest in program activities, and an interest in reducing social divisions. Two participants reported a self-perceived low income and four participants reported a self-perceived middle or high income. Four participants reported an Aboriginal identity and two were non-Aboriginals. Three participants had grown up in a neighboring community and three were long-term residents. Boundary crossers and their children or grandchildren participated in mixed groups that were characterized by diversity in socioeconomic status, ethnocultural background, age, and settings (e.g., including the programs of partner agencies).

Supports for participation. Intrapersonal, interpersonal, and organizational factors supported participation in mixed groups. Participants were sensitive to social divisions within the community, yet they also challenged boundaries. Illustrating intrapersonal, interpersonal, and organizational factors supporting participation, a high-income mother expressed appreciation when a middle-income Aboriginal mother joined a parent–preschool program:

> I remember thinking, like good for you for coming out, 'cause it is stepping out a little bit more. I mean, it's different for us that grew up in town, and we know

> each other . . . [and] most of us are the same demographic. . . . But for someone to . . . come in . . . that's great that she's putting herself out there and—she's very friendly and open.

"Stepping out a little" referred to crossing socioeconomic and ethnocultural boundaries. This mother expressed an awareness of difference and openness in welcoming the "other" (anyone who was not a White long-term resident of similar socioeconomic status): "I was so happy to see her because, yeah, we need more diversity in the group for sure. I think that's great."

Organizational factors such as the creation of mixed groups by the Family Centre and their partner organizations that were of interest to participants from diverse backgrounds provided new opportunities for social interaction across difference. A middle-income grandmother suggested that "nobody worries about who you are [in a playgroup]. . . . The focus is having the children be happy and accepted, and learn to play together." She expressed appreciation for programs with mixed groups: "[They] have really done an awesome job to bring these programs out there to all walks of life." Additionally, she commented:

> I don't think it's just any particular walk of life . . . a lot of the people that come to some of the programs aren't poor, but they need it. The children need to be involved . . . so that they have interaction with other children. It . . . makes a real difference in their lives if they're started when they're really young.

Participation in free universal programs which included community kitchens, preschool, school, and parenting programs, and cultural activities was felt to be important in reducing stigma and racism. A low-income Aboriginal mother noted, "I find a lot of the Native kids hanging with the White kids . . . in the school, they're doing an awesome job because they're mingling more . . . [in comparison to] when I was in school."

Barriers to participation. While a number of boundary crossers felt progress was being made in bringing diverse groups together, barriers were still evident. Interpersonal along with structural barriers (e.g., a historical income and racial divide) were reflected in boundary crosser's descriptions of stigma and racism. Closed social networks and cliques were identified in both individual and group interviews. A long-term resident suggested that, in a small town, "Everyone's so tight knit . . . [they've] got their group of friends, and it's almost like no more joiners." One low-income Aboriginal mother described occasionally feeling left out in mixed groups:

> [B]eing a young mom . . . I really felt kind of awkward at moments . . . a lot of the parents that are there, they have money and they're able to be there in the first place, where . . . I was still going to school . . . some of the conversations I didn't really fit in, like their trips.

Intersecting sources of stigma and stigma consciousness, an awareness of difference, a sense of judgment or feeling devalued, and discomfort in groups, were evident across relational patterns; however, boundary crossers described choosing to participate, seeking to manage their feelings of discomfort or anxiety, and trying to fit in despite this awareness. Boundary crossers reported having supportive relationships with family, friends, and community professionals or spiritual leaders (i.e., a First Nations community support worker, an early childhood/parenting support worker, a doctor, or church minister). These positive relationships may have helped to moderate experiences of stigma.

Interpersonal and structural barriers were evident in linked experiences of poverty stigma and racism. One low-income Aboriginal mother suggested:

> [I]t is . . . always that feeling that's there because you don't know who's going to be judging you and you want to make the right impressions . . . I feel it a lot . . .

> because . . . we look white but we have . . . Native [features] . . . people can tell around here, and that socio-economic part too.

While this mother described having a sense of community belonging, at times she also felt judged for accessing needed services:

> Overall, I'd think it would be a love/hate relationship. I love to live here, but I also hate it at the same time. I love to live here because there's a lot to offer for the younger generation . . . but I also hate it too because as a town that's supposed to be family-based there's a lot of things we don't offer and when people do need help [e.g., from the food bank] . . . they're looked down upon.

As this mother noted, having a sense of community belonging may involve ambivalent feelings, as participation in community life included experiences of both inclusion and exclusion.

Racism was described as an interpersonal and structural issue. Several boundary crossers described the need to resist racism. A low-income Aboriginal grandmother expressed resistance to racism:

> To me it's a fact that there [are] always racial prejudices. [However] we're all created equal in the sight of God . . . we're not different. We're no better or no less. . . . You do see people making an effort . . . welcoming one another . . . like in our town.

This grandmother claimed a positive identity as an Aboriginal community member of equal value, reflecting her sense of belonging. She denied difference—a racialized and devalued identity—and identified her shared humanity. Nevertheless, she suggested that ongoing societal efforts were required "to teach our communities . . . how to better build a bridge between each race." Societal efforts here implied changing community attitudes and opposing racism within community social structures.

Bullying was a shared concern for boundary crossers across income and

ethnocultural differences. A middle-income Aboriginal mother reported taking action when her child was bullied in elementary school:

> I called [the] parents. And the parents came over to our house . . . and we just sat down and talked to them about it. I think more parents need to start doing that with their kids instead of just saying kids will be kids.

A high-income non-Aboriginal mother spoke up about her child being "picked on" at preschool. She thought, however, that teachers were "doing a good job trying to nip things in the bud."

Summary. Most boundary crossers participated in mixed groups, reported diverse participation, and described a sense of belonging and community inclusion. Participation in free universal programs provided structures of support that enabled interaction across diversity. Despite stigma awareness in mixed groups, low-income Aboriginal boundary crossers chose to participate; actively resisted stigma, racism, and bullying; and claimed a positive identity as parents or as equal community members.

Transitions

The three relational patterns identified in this study illustrate a progression toward greater participation and inclusion from permanent strangers and newcomers to boundary crossers. Permanent strangers described a shift from non-participation to periodic participation and gained a provisional sense of group belonging, whereas newcomers participated in and gained a sense of group belonging. Boundary crossers described a greater openness to participation and engagement in community life and most gained a sense of community belonging and/or inclusion.

Transitions from one relational pattern to another were enabled by changes in social relations (e.g., a trusting relationship) and opportunities in the environment (e.g.,

free or subsidized programs). Transition experiences involved an internal shift in awareness, attitudes, interests, self-perception, or identity that influenced relational patterns.

A few permanent strangers described transitions from non-participation to periodic participation. For example, one low-income Aboriginal mother described a shift in her interests:

> I was still a little young and not really wanting to participate very much in the community . . . and I was working a lot [and] . . . I was going to school . . . so I didn't have that time . . . I'm really hoping now that I can attend more because I do like it. . . . I get to know them.

For this participant, getting to know people sparked a greater interest in participation.

Interpersonal factors that supported participation, such as building relationships of trust with a community outreach worker preceded shifts in participation among permanent strangers as they transitioned towards periodic participation. Outreach contacts from a First Nations community support worker enabled one low-income Aboriginal grandmother to join a community kitchen: "When I first started the program I felt like . . . how come they're picking on me . . . kind of . . . defensive . . . and then after a while . . . I felt like I belonged somewhere. It took me steps to get comfortable." Experiencing positive interactions in a small group supported a transition from self-exclusion to periodic participation. Choosing to participate enabled greater access to community support:

> You know . . . being on social assistance, it takes time to get off. . . . I knew I was capable and strong enough to get out and do stuff on my own. . . . Now that I [can] reach out for that support . . . it doesn't have to be through social services.

This participant was able to access recreation subsidies (e.g., a family swim pass) and other Family Centre resources that supported her child's participation.

Cultural participation was associated with changes in self-perception, self-esteem, and social esteem among permanent strangers as they transitioned. An Aboriginal grandmother described a shift in self-perceptions by leading a traditional cultural program for children and sharing cultural knowledge: "I was kind of shy and nervous but it kind of gave me that responsibility . . . that positive self-esteem, you know, that I could share what was taught to me." Contributing provided a sense of being recognized as a valued community member; however, this participant's sense of group or community belonging remained provisional, suggesting that negative encounters could lead back to self-exclusion.

Several newcomers also described gradual changes toward a greater sense of belonging as interpersonal and organizational factors supported a transition enabling participation. One Aboriginal mother with perceived low-income described initially feeling reluctant to participate: "I'm just uncertain I guess . . . the stigma of being a single mom. . . . It's just hard." Stigma also was evident in the negative comments of a family member: "You're not a welfare mom [you shouldn't be accepting handouts]!" Participating in formal programs supported social connections: "It was nice just chatting with women" and "making friends and acquaintances." Another mother described feeling "pretty isolated" as a rural resident and still felt like an "outsider," as she had not grown up in this community. However, participating in preschool and sports programs with her children helped her to get to know people: "I run into two or three parents [regularly] . . .

so there is kind of a sense of belonging." Newcomers reported a provisional sense of community belonging even after 3–7 years of residence.

Several boundary crossers reflected on their past experiences and revealed a history of transitioning from an earlier relational pattern of permanent stranger to the current pattern of boundary crosser. For one low-income Aboriginal grandmother, recovering from a loss and regaining a sense of spiritual balance preceded a transition from permanent stranger to boundary crosser. Participation in a community kitchen supported a sense of belonging and an interest in contributing: "I think going to the community kitchen sparks ideas. . . . It's just so nice to have that group environment and everybody's sharing and . . . not just the cooking aspect but the friendship connections." This grandmother described working with a friend to prepare some meals to share with her low-income neighbours. "[T]his cooking experience has been motivating us . . . to do more."

For a young Aboriginal mother with perceived low-income, having a trusting relationship with a community worker supported her participation in mixed groups: "It was mainly . . . [a community worker] that really got me into going to any of these programs." Participation in parenting, preschool and community kitchen programs then enabled her to challenge a stigmatized identity: "I just kind of let go and joined . . . and had more confidence. I didn't see myself as a young mom as I had [before]. . . so I participated more." This young mother felt recognized in the community and claimed a positive identity as a good parent: "I think they've seen . . . [that] as a parent I've done a good job."

For a middle-income Aboriginal participant, feeling welcomed and valued as a preschool/school volunteer supported a transition from group belonging to community belonging: "I think . . . the community helped me do that." This mother gradually began to participate in community activities. Changes in interpersonal relations such as developing trusting relationships and feeling accepted in a group, and changes in the environment such as having access to free programs that supported diversity, enabled shifts in self-perception, identity, participation, and relational patterns among some participants.

Discussion

This critical ethnographic study identified three relational patterns—permanent strangers, newcomers, and boundary crossers—that enabled or constrained participation in Family Centre programs and community life and reflected different experiences of SI/SE. Low-income and Aboriginal participants were identified in each of the three relational patterns. Newcomers and boundary crossers often described multiple forms of participation, while permanent strangers reported more limited participation. Supports for transitions to greater participation and inclusion differed by relational pattern. Despite many opportunities for participation, poverty, stigma and racism continued to constrain opportunities for community belonging and equal citizenship for permanent strangers. Mothers' and grandmothers' experiences of SI/SE largely reflected recognition or misrecognition, consistent with the SI/SE discourse on recognition (Yanicki, Kushner, & Reutter, 2015). Within the context of participation in a rural Canadian community, these experiences demonstrate the relational, cultural, material, and moral domains of SI/SE. Relational, economic and moral dimensions of SI/SE have been identified in previous

research (Reutter et al., 2009; Kidger, 2004), as well as material, cultural, and institutional dimensions (Reid, 2004). In the following discussion, key findings are presented in relation to theory and systems relations (following Carspecken, 1996), and unique findings and similarities to previous research in the domains of SI/SE are presented. Recommendations for future action and research also are identified.

Recognition and Stigma

In the current study, consistent with Kidger (2004), *relational inclusion* involved having opportunities to engage in affirming social interaction, feeling valued and recognized, and having a sense of belonging. Affirming encounters—positive encounters in interpersonal interactions with staff and program participants —enabled mothers and grandmothers to build trusting relationships and to participate in, contribute to, and feel welcomed and accepted in a group or community program. For permanent strangers, outreach contacts often were required to build trusting relationships and to reduce intrapersonal barriers to participation. Being invited to participate and contribute helped low-income and Aboriginal participants to feel recognized and valued. For newcomers, participating in children's programs enabled social connections and supported a sense of group belonging. For boundary crossers, feeling welcomed and accepted supported a sense of belonging for diverse participants in mixed groups. Additionally, some boundary crossers claimed a positive identity as parents, grandparents, or equal community members through their participation in universal programs. Children's participation was supported by addressing material deprivation and economic barriers and providing accessible universal programs.

In previous research, participation in women's groups helped women to challenge poverty stigma and a stigmatized identity (Reid, 2004). Consistent with previous research, affirming encounters promoted trust (Yanicki, 2005; Browne & Fiske, 2001) demonstrated respect for Aboriginal culture, and reduced social distance (Browne & Fiske, 2001). The transitions identified in this study contribute to current knowledge by linking experiences of participation to processes and structures of SI/SE across three relational patterns.

Current study findings revealed that a sense of group or community belonging was supported through different forms of participation. For some permanent strangers, participating in a community kitchen provided some sense of group belonging. For newcomers, participating in formal programs or engaging in church-based activities provided a sense of group belonging. For some boundary crossers, participating in formal programs with mixed groups and in school-based activities supported a sense of community belonging and for some a sense of community inclusion. These findings are similar to results from an urban study by Stewart et al. (2009), who found that participation in community agencies, schools, and places of worship and perceptions of reciprocity supported a sense of belonging. As such, current study findings advance knowledge by contributing a rural perspective.

Cultural inclusion meant having opportunities for valued cultural participation and feeling respected for one's cultural identity. Some school and Family Centre programs provided opportunities for cultural participation and promoted respect for First Nations cultures. Cultural participation supported recognition of cultural identity and a

sense of belonging, while contributing cultural knowledge and leading a cultural activity supported recognition as a volunteer and community member.

Cultural participation and inclusion may have supported recognition of unique identity, respect for group differences (Bach, 2005; Freiler, 2002; Young, 1990), and equal citizenship (Galabuzi & Labonte, 2002; White, 1998). Identity and culture play an important role in the health and wellbeing of Aboriginal peoples (Gone, 2013), Both valued recognition—mutual recognition and respect in interactions (Bach, 2005) —and social esteem at a community level (Honneth, 1995) were identified in relation to cultural participation in this study.

Relational exclusion involved choosing not to participate, feeling left out of existing social networks, or feeling isolated. While permanent strangers often chose not to participate to avoid shame, judgement and negative encounters, newcomers at times felt socially isolated or left out of established social networks and friendships. Self-exclusion—an inability to participate without shame (Sen, 2000) —constrained permanent strangers' development of competencies. However, participation, even in small groups, exposed some permanent strangers to enacted stigma—negative comments or discriminatory behaviours (Reutter et al., 2009; Scambler, 2012). The closed social networks described by newcomers reflected fear of difference (Freiler & Zarnke, 2002), stigma and social distancing (Reutter et al., 2009) by long-term residents. Participation in mixed groups heightened boundary crossers' awareness of difference and stigma consciousness (Reutter et al., 2009; Goffman, 1963). While participants across all relational patterns described experiences of stigma, boundary crossers were more likely to transcend these differences.

Relational exclusion has previously been defined as an inability to participate in valued activities (Sen, 2000), having a sense of social isolation (Kidger, 2004; Ocean, 2005; Reid, 2004; Stewart et al., 2009), feeling unequal in social relationships (Ocean, 2005), and feeling like an outcast (Stewart et al.). In previous research, stigma was addressed by: speaking out against unfairness, confronting discrimination, disregarding negative comments, withdrawing or self-isolation, and concealing poverty (Reutter et al., 2009).

Cultural exclusion involved having limited opportunities for cultural participation or cultural exchange and contribution. Several low-income Aboriginal participants reported having had limited opportunities to learn their ancestral language or to participate in cultural activities. For several Aboriginal participants who had grown up in a small town or urban settings, cultural exclusion included feeling distanced from their Aboriginal culture through negative encounters at school which discredited their Aboriginal identity (e.g., being labeled an Apple Indian, bullying or racism), a lack of school-based First Nations language programs, and having limited opportunities to participate in traditional cultural activities with elders. In this study, resistance to racism and discrimination was described by boundary crossers as speaking out on racism, bullying, and cliques at school and by confronting bullying, and by permanent strangers as choosing not to participate.

In this study, gaining a sense of belonging in a mixed group, claiming a shared positive identity in a universal program, and participating in cultural activities that supported an Aboriginal cultural identity may have helped some boundary crossers to engage in resistance to stigma and racism. In previous research, an awareness of racism

and a sense of cultural identity—a shared world view within a cultural group—buffered stress (Harrell, 2000; Reading, 2014), and mitigated some of the health damaging effects of racism and discrimination (Allan & Smylie, 2015; Chae & Walters, 2009).

Moral exclusion involved feeling judged, devalued, or censored by others for deviance from social norms and the characteristics of the dominant group. Multiple forms of difference were stigmatized and devalued, in the current study. Stigma consciousness was described in relation to poverty, Aboriginal identity, single status, young motherhood, and non-church attendance. At the community level, some participants who differed from the dominant demographic characteristics of the community felt marginalized. In this community, middle- and high-income, White, Christian, long-time residents were presumed to belong, while those from other groups were marginalized. These assumptions helped to sustain the closed social networks described by newcomers. In previous research, moral exclusion has been described as feeling judged by others as "undeserving" or of lower moral worth based on personal characteristics or weaknesses (Reuter et al., 2009, p. 307). In this study, participants noted, that in a small town it was not always possible to avoid experiences of judgment, stigma, and racism, or the bullies from one's past. Choosing to participate meant risking experiences of both inclusion and exclusion.

Participants in this study resisted a stigmatized identity by: participating in universal programs (i.e., parenting programs), claiming a positive identity as parents or grandparents, helping other low-income people, acting as a volunteer, contributing cultural knowledge, leading a cultural activity, or being recognized as a valued community member. In previous research, stigma has been described in relation to

poverty (McIntyre et al., 2003; Reid, 2004; Reutter et al., 2009), young lone motherhood (Greene, 2007; Kidger, 2004), race or racialized difference (Brown & Fiscke, 2001; Reimer Kirkham, 2003; Tang & Browne, 2008), age, gender and marital status (Greene, 2007; Kidger, 2004).

Based on current study findings, we speculate that programs that enabled participation in mixed groups may have reduced social distance across difference (e.g., by income, ethnocultural identity, age, and marital status), and participation in First Nations cultural activities may have promoted cultural appreciation. However, preschool–parenting programs did not always reflect Aboriginal values and culture. This finding reinforces the need for action to redress these sources of social exclusion and not simply to acknowledge that Aboriginal peoples in Canada have experienced social exclusion due to colonialism (Loppie Reading & Wien, 2009; Royal Commission on Aboriginal People, 1996; World Health Organization, 2008), racism (Allan & Smylie, 2015; Galabuzi, 2009), and the devaluing of Aboriginal culture and identity (Fiske & Browne, 2006).

Equality and Unequal Citizenship

In the community context of the current study, economic barriers to participation and material deprivation were reduced to enable children's participation; low-income parents and grandparents noted that free accessible programs and program subsidies supported their children's participation. While some participants were able to transition toward greater inclusion through the reduction of economic barriers (and through experiences of relational and cultural inclusion), others continued to experience barriers to participation. Permanent strangers who were employed in low-paying jobs with non-

standard work hours (e.g., casual work) had time constraints and more limited patterns of participation in programs with their young children. As well, not all low-income participants accessed the resources or program subsidies that were available.

In the current study, *material exclusion* involved lacking opportunities to earn an adequate income, being unable to meet basic needs (material deprivation), or being unable to participate in desired activities due to economic constraints. Material deprivation, low employment opportunities, and economic barriers to participation contributed to the high mobility of low-income families in this community. One permanent stranger suggested that having access to Family Centre programs and resources had enabled her family to stay in the community. Similarly, two low-income participants (a newcomer and a boundary crosser) described being able to access needed material assistance, yet accessing these resources lead to a sense of judgment, embarrassment, or shame that constrained participation. Low-income newcomers described being unable to participate in desired adult recreation due to program fees, or a lack of child care and transportation. In a small town, the lack of public transit (local bus service) and limited access to resources meant low-income families were visible in the community as parents pushed a stroller in the snow or stood in line at the food bank. Consistent with previous research, material exclusion in this study was closely linked to a sense of shame (Reid, 2004; Sen, 2000), and moral exclusion (Reutter, et al., 2009). Unique to the rural setting of this study, low-income participants felt visible in the community when they accessed needed services and this added to their sense of moral exclusion. The current study extends current knowledge by identifying the factors supporting or constraining participation and material exclusion in a rural context.

Directions for Future Research

This paper is the first Canadian study to explore the SI/SE dialectic within a rural setting. Our study findings suggest that long-term community collaborations and CD efforts may support transitions in relational patterns at a community level; this has particular importance for future research on factors that influence poverty stigma, racism, and SI/SE. A limitation of the current research was the small sample size and the inclusion of only those who had participated in a Family Centre. Future research is recommended to explore SI/SE in relation to: (a) participation and non-participation (e.g., a 5-year prospective cohort study exploring the participation of school-aged children in sports and recreation programs based on participation/non-participation in preschool programs), (b) participation and relational patterns in other rural communities (e.g., a survey to identify patterns of participation and relational patterns among culturally diverse families), and (c) low-income and Aboriginal women's experiences of participation in community life, and intersecting sources of SI/SE (e.g., a qualitative study informed by feminist and intersectional theory to identify intersecting sources of SI/SE that enable or constrain women's participation base on income, Aboriginal identity and gender). The identification of relational patterns and transitions in other communities and Canadian contexts may enable the development of community-specific strategies to support belonging and inclusion. Critical research is required to explore the relational and structural conditions supporting transitions to greater participation and a sense of inclusion. Rural communities are facing many challenges, and strengthening belonging and inclusion may be essential not only for creating healthy inclusive communities but also for supporting the sustainability of rural communities.

Conclusion

Three relational patterns of social interaction reflected different relational experiences of SI/SE and opportunities for participation in the Family Centre and community. Attention to these relational patterns may support tailored strategies to address barriers to and supports for participation within a specific rural context. Transitions between relational patterns of increasing inclusion were supported through building trusting relationships and changes in the external environment which enabled internal shifts in identity. This study provides encouraging evidence that sustained collaborative community-based efforts to promote the participation of parents, grandparents, and children may help to challenge poverty stigma and racism and support a sense of community belonging and inclusion. These findings could be used to tailor interventions to support collective efforts to promote inclusion in other rural settings.

Table 3.1 Participant Demographics

Interview Participants	Individual Interviews n=14	Group Interviews[17] n=5[18]
Mothers	10	4
Grandmothers	4	1
Perceived Income		
Perceived low-income	8	
Perceived middle or high income	6	
Education (completed)		
Some High School	3	2
High School diploma	6	1
College diploma or University degree	5	2
Family		
Lone-Parent Household	5	3
Two-Parent Household	9	2
Ethnocultural Identity Reported		
Aboriginal	8	4

[17] Three of five participants were new to the study and two had participated in individual interviews.
[18] Income information was not collected for group interviews.

Table 3.2 Types of Participation

Type of Program	Child Participation	Adult Participation
Community Events	√	√
Community Kitchen	√	√
Children's Story Time	√	
Children's Summer Programs	√	
Clothing Exchange – Schools	√	√
Good Food Box	√	√
Parenting Classes[19]		√
Preschool Developmental Screening	√	√
Preschool Programs[20]	√	√
Other Community Activities	√	√
School Breakfast or Lunch Program	√	
Secret Santa	√	√
Skate & Helmet Program	√	
Volunteer Activities		√

[19] Parenting Classes were offered by two community organizations in partnership with the Family Center.
[20] Preschool programs were offered by three community organizations in partnership with the Family Center.

Table 3.3 Summary of Supports for and Barriers to Participation

Supports for Participation	Barriers to Participation
Intrapersonal Factors	Intrapersonal Factors
- Feeling comfortable, welcomed, and accepted - Feeling proud or honoured for sharing cultural knowledge or making a contribution - Feeling grateful for programs and services - Having a sense of shared identity	- Feeling uncomfortable, shy, judged, intimidated, embarrassed, or overwhelmed - Feeling mistrustful of others - Past experiences of trauma, bullying or racism - Feeling self-conscious of differences or stigma related to income, race/ethnicity, age, marital status or spiritual beliefs
Interpersonal Factors	Interpersonal Factors
- Welcoming behaviours of others - Respectful interactions—getting to know people and making friends - Receiving and giving support—sharing parenting strategies, encouragement, and childcare Maintaining confidentiality Interacting across groups - Attending with a friend or as a family	- Negative action of others—gossiping, making negative comments, asking intrusive questions, leaving people out, and lack of welcoming behaviour - Closed social networks—cliques, difficulty making friends, insular cultural and religious groups and racial barriers - Experiences of loss, conflict, bullying, or racism
Organizational Factors	Structural Factors
- Program design—free, accessible programs - Staff approach—making personal contact, linking community programs, engaging low-income, Aboriginal parents and youth and inviting volunteers Staff competencies—building trusting relationships, and being knowledgeable about parenting, First Nations language and culture - Program focus—promoting group diversity, cultural appreciation and First Nations cultural activities	- Geographic— rural location and added travel costs - Financial—lack of transportation, program fees, low-paying jobs and food insecurity - Lack of access—services and post-secondary education - Community attitudes and racism

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IV. Community Development and Social Inclusion/Exclusion: Supporting the Participation of Low-Income and Aboriginal Parents, Grandparents, and Children in a Rural Alberta Community

Social inclusion/exclusion (SI/SE) is an urgent matter of social justice/injustice (WHO, 2008; Yanicki et al., 2015). SI/SE involves (un)just social conditions (Labonte, 2009a) that enable or constrain opportunities for participation in community life (Sen, 2000). Whereas inclusion addresses the relational processes and structures enabling full participation (Freiler & Zarnke, 2002), exclusion draws attention to multilevel barriers to participation (Mitchell & Shillington, 2005) and social inequalities (Labonte, 2009a). In this paper, we report results from a critical ethnographic study exploring the strategies used to support the participation of low-income and Aboriginal parents, grandparents, and children in a rural Family Centre and to address SI/SE in a rural Alberta community.

Participation is enabled or constrained at multiple levels of social relations from the intra- and interpersonal to the organizational (Yanicki et al., 2015), community, and societal levels (Percy-Smith, 2000). Participation is a meaningful act reflecting cultural expectations and social norms in a given setting (Carspecken, 1996). Invited spaces—formal programs or social settings—may enable participation in activities or create spaces for dialogue and decision making (Cornwall, 2007). Programs are goal-directed interventions designed either by professionals or collaboratively with community members (Laverack & Labonte, 2000). Meaningful participation involves experiences of mutual recognition (Bach, 2005), opportunities to explore difference and contest dominant values (Chatterjee et al., 2004; Yamin, 2009), and shared power and decision-making (Labonte, 2012). Non-participation may involve a lack of choice or freedom, shame (Sen, 2000), or resistance to dominant cultural norms (Shakir, 2005).

Community development (CD) is a participatory process used to enable inclusion (United Nations Human Settlement Programe, 1999) and empowerment (Wallerstein, 2006). Empowerment is the capacity to make choices and to influence the conditions of everyday life (Labonte, 1993). CD engages community members in identifying local issues, mobilizing resources (Minkler & Wallerstein, 2012) and assets (McKnight & Block, 2010), and building capacity for social change (M. Bopp & Bopp, 2001). CD has been used to support the inclusion of young mothers (Greene, 2007; Kidger, 2004), and the participation and empowerment of low-income women (McFarlane & Fehir, 1994; Meagher-Stewart, 2001; Wallerstein, 2006) and Aboriginal peoples (M. Bopp & Bopp, 2001). However, not all forms of participation are empowering (Wallerstein, 2006) or provide a sense of belonging and inclusion (Bach, 2005; Freiler, 2002). For example, for those living on a low-income, participation in a community organization may not always support a sense of inclusion (Stewart et al., 2008).

Integrated and empowering models of CD (M. Bopp & Bopp, 2001; Rothman, 2008) may help citizens to gain the power and resources needed to address SI/SE. Integrated models of CD combine a variety of strategies, such as community capacity development and social advocacy, to support development and change. Rothman's (1999/1995) models of community intervention have been described as empowering (English, 2000) processes for shifting power relations within the community (Laverack & Labonte, 2000). Empowerment may occur at individual and collective levels through an iterative process of personal and small group development, community organizing, coalition building, advocacy, and political action (Labonte, 1993). Empowering

participation is grounded in trusting relationships (Meagher-Stewart, 2001; Yanicki, 2005) and cultural respect (Browne & Fiske, 2001).

Little Canadian research has examined the SI/SE of low-income and Aboriginal peoples in rural settings. Aboriginal peoples—First Nations, Metis, Inuit and non-status Indian peoples (Royal Commission on Aboriginal People, 1996)—experience higher rates of poverty and racism as intersecting sources of exclusion in comparison to non-Aboriginal Canadians (Galabuzi, 2009). Racism involves falsely constructed assumptions, beliefs, or behaviours based on racial characteristics (Loppie, Reading, & de Leeuw, 2014). Colonization, residential schools, and racism have resulted in exclusion and health inequities among Aboriginal peoples (Allan & Smylie, 2015). Canada lacks a national strategy to address SI/SE (Fairbairn & Gustafson, 2008) despite sustained levels of child poverty (Raphael, 2011) and rising food insecurity (Tarasuk, Mitchell, & Dachner, 2013). Rural communities have been negatively impacted by a declining tax-base, government funding cuts, and the offloading of social responsibilities from higher levels of government (Jaffe & Quark, 2006). Community-level and charity-based initiatives have proliferated to fill this gap (McIntyre & Rondeau, 2009; Raine, McIntyre, & Dayle, 2003). While rural residents are more likely to report volunteering, participating in community groups, and having a sense of belonging (Turcotte, 2005), little research has considered rural experiences of SI/SE.

Community Context

Fort Macleod, a rural community of about 3,000 residents in Alberta, Canada (Statistics Canada, 2012), was the setting for this study. This community was settled in the late 1880s and originated from an outpost of the North-West Mounted Police (Town

of Fort Macleod History Book Committee, 1977). Residents of this community are predominantly English-speaking (97.2%) and of European descent (Statistics Canada, 2010a); in 2006, 12% reported an Aboriginal identity (Statistics Canada, 2010b), and 1.8% reported Chinese or Filipino descent (Statistics Canada, 2010a). Children from two nearby First Nation communities attend schools in Fort Macleod. First Nations communities refer to status Indians living on reserve (Royal Commission on Aboriginal People, 1996). The Piikani and Kainai Nations have populations of 1,300 and 4,177, respectively (Statistics Canada, 2010b).

The child poverty rate for Fort Macleod and area in 2001 was 21% (Chinook Health Region, 2002 cited in Dobek, 2004) compared to 16.2 % for Alberta, based on Statistics Canada's 2001 before tax Low Income Cut Offs[21] (Poverty Reduction Coalition, 2007). A community stakeholder consultation on child poverty was hosted in Fort Macleod in the fall of 1999 by the health region (M. Bopp, 2004). The *Kids in Need* coalition (hereafter referred to as the Coalition) was formed in early 2000 to address local child poverty and local community initiatives were developed (Dobek, 2004). Initially, food insecurity was selected by community stakeholders as the focus for a school-based project.

To address food insecurity, a universal snack and breakfast program was implemented in two elementary schools in 2001 (Dobek, 2004). A universal program[22] was developed as project organizers sought to avoid stigmatizing hungry children;

[21] The Low-Income Cut Offs (LICO) represent the income threshold below which a family spends 20 % more on basic necessities such as shelter, food, and clothing in comparison to the average Canadian family (Statistics Canada, 2013).

[22] Universal programs focus on providing services to a "defined population" such as school-aged children, while targeted programs are provided to specified groups based on "selection criteria" such as "income" (National Collaborating Centre for Determinants of Health, 2013, p. 1).

however, this early program met with some community resistance. Several parents opposed the universality of the school feeding program and suggested that not all children needed the program, while others suggested that the program was really developed for poor Aboriginal children (Dobek, 2004, p. 17-18). Child hunger was viewed by these opponents as a parent responsibility and a private family matter, rather than a community issue appropriately addressed in a school setting. This resistance reflected community values of individualism and self-reliance (Dobek, 2004), and suggested deeper issues of social exclusion.

Participants in Dobek's study (2004) described an income and racial divide within this rural community that went beyond the early focus on child hunger. Low-income children had limited opportunities for participation in sport or community recreation programs. Aboriginal and non-Aboriginal children often remained separated in social settings. Thus, both income and racial barriers constrained children's participation and inclusion in this community (Dobek, 2004).

In 2003, the *Fort Macleod Society for Kids First* (hereafter referred to as the Society) was formed to address both the impacts and root causes of child poverty and SI/SE (M. Bopp, 2004). Intersectoral partnerships and external funding supported school feeding programs, community kitchens, and community gardens. In 2006, the Society merged with a Parent Link Centre (a provincial initiative) to create the *Fort Macleod Kids First Family Centre* (hereafter referred to as the Family Centre), helping to stabilize funding. The Family Centre partner agencies included a health authority (Chinook Health Region and later Alberta Health Services), a school district (Livingstone Range School District), and a preschool and parenting organization (Parents as Teachers). The Family

Centre board included: teachers, nurses, community workers, Aboriginal staff from partner agencies, parents, and grandparents. A transition in board leadership, from health to education leadership, occurred after the merger. The Family Centre mandate to enhance food security and social inclusion was integrated with the Parent Link Centre mandate to deliver universal programs to support parents and early child development (J. Bopp, 2009, p. 21-22). The Family Centre sought to "promote the meaningful participation" of and "a sense of belonging" for all families and children (J. Bopp, 2009, p. 21). *Meaningful participation* meant having opportunities for engagement in multiple dimensions of community life including "economic, social, cultural and political" dimensions (J. Bopp, 2009, p. 21).

In April 2011, during a period of fiscal constraint and limited grant funding in the not-for-profit sector (Imagine Canada, 2010), the Family Centre became a registered charity. This change enabled expanded opportunities for fundraising to sustain delivery of free programs. The guidelines of the Canada Revenue Agency provided a specific list of approved charitable purposes for registered charities (Canada Revenue Agency, 2006). Officially, the Family Centre charitable purposes were: (a) relieving poverty, (b) advancing the education of children, and (c) providing support programs and services for parents, children, and vulnerable youth (Board Meeting, personal communication, April 19, 2011). Poverty relief replaced social inclusion as one of the Family Centre main areas of focus because social inclusion was not considered an approved charitable purpose. The Family Centre board also chose to drop policy advocacy to comply with federal government policies for a registered charity (Canada Revenue Agency, 2003).

Research Questions

This study addressed two research questions. First, what strategies encouraged the participation and social inclusion and addressed the exclusion of low-income and Aboriginal parents, grandparents and young children in the programs and activities of the Family Centre? Second, how did social, economic, and political conditions influence Family Centre strategies to encourage participation and to address SI/SE?

Study Design and Methods

This critical ethnographic study was guided by Carspecken's (1996) critical qualitative methodology, in which analysis of meaning and structure (Morrow & Brown, 1994) links individual experiences and relational processes to larger social systems (Carspecken, 1996; Harrowing, 2009). Critical scholars assume that human communication is the basis for knowledge development (Habermas, 1984) and that all knowledge is developed within social, political, and historical contexts (Morrow & Brown, 1994). Critical theory is combined with other theories of interest, and ethnographic data collection techniques include participant observation, interviews, and document review (Morrow & Brown, 1994). This study was intended to contribute to knowledge about local efforts to address SI/SE and to emancipatory knowledge development—knowledge of the processes supporting social justice and equity (Chinn & Kramer, 2011).

Ethics approval was received from relevant university ethics committees, and study approvals were received from the Family Centre and three partner organizations. Partner agency approvals enabled the first author to engage in observations in multiple settings as Family Centre programs took place in schools, partner agency meeting rooms,

and community halls. Study participants provided verbal consent prior to observation or informal interviews (e.g., Family Centre board meetings) and written consent prior to formal interviews (e.g., individual and group)[23]. Confidentiality was assured by assigning and using participant codes in all study materials, storing participant identifiers separately, removing all personal identifiers from interview transcripts, and storing study information in password protected electronic files or a locked filing cabinet. Only the first author and a transcriber had access to interview transcripts.

Validity and rigour were guided by the principles of trustworthiness (Lincoln & Guba, 1985, cited in Carspecken, 1996; Morse & Richards, 2002), verification (Carspecken, 1996; Morse & Richards, 2002), and authenticity (Guba & Lincoln, 2005). A trustworthy account—validation of researcher interpretations (Carspecken, 1996)—was supported by multiple observations, meaning checks, a group interview, peer debriefing, and audit trails. Verification strategies involved maintaining methodological coherence (Morse & Richards, 2002) across ethnographic data collection techniques and analysis strategies (Carspecken, 1996). Authenticity—a balanced account of multiple perspectives (Guba & Lincoln, 2005)—involved the representation of diverse ideas and critical reflection with a study advisory committee (hereafter referred to as SAC). The SAC was composed of ten members including seven representatives from the Family Centre board and staff and three First Nations elders. The SAC supported recruitment, refinement of the interview guide, feedback on early study results, and critical reflection.

The Family Centre programs and activities provided a naturalistic setting in which to explore SI/SE. A naturalistic inquiry explores "real-world situations as they unfold"

[23] The letter of introduction (Appendix D), key informant interview guides (Appendix E and U), consent information sheet and consent forms for interviews (Appendices L, M, R and S) are attached.

without seeking to change study outcomes (Patton, 2002, p. 40). The current study took place in 2011-2012, following the global economic recession of 2008–2009. This was a period of financial uncertainty involving cuts in federal funding that left not-for-profit organizations and many rural communities struggling to adapt (Imagine Canada, 2010). During this period, demands for community support grew as many Canadian families faced hardships (Labonte, 2009b).

The first author's entry into the community and interactions with the SAC reflected the emancipatory intent of this study (Chinn & Kramer, 2011). As a former community health manager, the first author (SY) had attended the first community consultation in 1999, and later as an academic had attended community planning sessions in 2007 and 2009. SY informally observed Family Centre board meetings for 2 years in preparation for this study. During the 13-month study period, SY formally observed Family Centre board meetings and engaged in participant observation of the programs and activities of the Family Centre or those of agency partners. As an outsider to the community and an educated White female, SY sought to balance power relations with study participants and the SAC by inviting dialogue and clarification (Carspecken, 1996). Consistent with a naturalist inquiry (Patton, 2002), SY observed board meetings without seeking to influence decision-making.

Study participants (key informants) were purposefully selected (Miles & Huberman, 1994) based on their board, staff, or volunteer roles. Snowball sampling also was used to recruit participants with current or past Centre affiliation who had historical knowledge of the Family Centre intersectoral partnerships, CD and program strategies,

and governance. Carspecken's (1996) critical qualitative strategies guided the iterative process of data collection and analysis.

Ethnographic data collection techniques included participant observation, informal and formal interviews, and document review. Participant observation occurred routinely during the Family Centre board meetings and programs, the preschool programs of a partner organization, and co-sponsored activities with intersectoral partners. Informal individual interviews were conducted during or after participant observation. Formal interviews were conducted with key informants to develop thick descriptions of the strategies used to support participation and inclusion and to address exclusion. Interviews were conducted in English, audio-recorded, and transcribed verbatim by a transcriptionist. Field notes were hand written and transcribed by the first author or saved as audio recordings and uploaded in NVivo10, a computer software program used to manage qualitative data. Documents including Family Centre program reports, pamphlets, and media articles, were reviewed.

Carspecken's (1996) critical qualitative strategies and iterative process for data collection and analysis using critical hermeneutic analysis were combined with content analysis (Patton, 2002). Critical hermeneutic analysis involved analysis of the speech claims in interview transcripts (Carspecken, 1996; Habermas, 1984) to identify meaning, values, and power relations. Normative evaluative claims, suggesting something is right, good, or appropriate (Carspecken, 1996), were of particular interest. Social exclusion may involve normative claims about appropriate or inappropriate behaviour in a given setting based on values. Values conflicts involve disagreements about what is right or wrong, good or bad (Carspecken, 1996). In critical hermeneutic analysis, background

claims imply that something is "assumed" to be a matter of "common sense" that all reasonable people would mutually agree upon (Carspeken, 1996, p. 119). Content analysis was completed on field notes (the primary record), interview transcripts, and program documents. Content analysis examined the factors enabling and constraining participation and inclusion. Critical reflection with the SAC and feedback from the presentations of early findings to study partners supported the validation of meaning.

Data collection and analysis occurred in five iterative stages (Carspecken, 1996). In stage one, strategies for addressing SI/SE were identified through participant observation and document review (the primary record). Stage two involved preliminary reconstruction analysis of the meanings of participation in the primary record. In stage three, impressions from participant observation were explored in formal interviews (dialogic data collection). Strategies to enable participation and address SI/SE were identified in early themes and contradictory claims were explored to identify varied meanings. Themes were validated in a group interview. In stage four, analysis examined system relations through cross-case analysis of strategies. Strategies to address SI/SE and program discourse were compared through cross-case analysis of themes to identify changes over time. In stage five, system relations were analyzed to compare study strategies to scholarly literature and broader socioeconomic, political, and historical contexts. Strategies to address SI/SE were compared to theory and Canadian discourse on SI/SE (Yanicki et al., 2015). Shifts in Family Centre discourse and strategies were considered in relation to socioeconomic, cultural, historical, and political contexts.

Results

Participants

Twelve key informants participated in individual interviews, and nine of these informants also participated in the group interview. Key informants were current or past leaders, employees, or volunteers of the Family Centre with knowledge of the organization's current and past programs and collaborative CD efforts. Participants in individual interviews (n = 12) included nine board members and three employees or volunteers (in current or past roles). Six participants were original members of local intersectoral collaborations who had been involved in the Coalition or the Society, for 7–11 years and six participants had joined the Family Centre in the last 1–6 years. All except one participant were female. Nine participants reported their age (mean 54; range = 42–60 years). Seven participants had a college diploma or university degree, four had completed high school, and one had completed Grade 10. All participants spoke English. Three participants reported an Aboriginal identity and were fluent in Blackfoot. Eight participants were town residents, two resided in the surrounding rural area, and two resided outside of the area.

To address the first research question—the strategies used to enable participation and inclusion—key strategies were identified through content analysis of individual and group interviews, participant observation, and critical reflection. *Key strategies* incorporated an array of strategies to enable multilevel participation and inclusion, address barriers and exclusion, and promote local development and social change to address SI/SE. Key strategies reflect the range of strategies described by key informants including the early strategies of the Coalition and Society (2000–2005) and the Family

Centre early (2006–March 2011) and later (April 2011-2012) strategies. Findings highlighted the contribution of the study to emancipatory knowledge development (Chinn & Kramer, 2011) by uncovering the strategies used to enable participation and inclusion and to address exclusion as matters of social (in)justice. Key strategies included a focus on multiple levels of social relations at intrapersonal (individual), interpersonal (between individuals), organizational (with staff and program participants), community, and societal levels (social, economic, cultural, and political contexts). First, the meanings and forms of participation identified in study data are presented to provide context for the findings on key strategies. Then, the strategies used to enable participation and inclusion are described, followed by the strategies used to reduce barriers and address exclusion.

To address the second research question about the influence of social, economic, historic, and political conditions on the Family Centre strategies, the influence of context is considered. Themes in Family Centre discourse were identified through critical hermeneutic analysis. These themes are explored by considering the Family Centre early and later strategies within broader societal contexts.

Participation

Key informants described participation in a number of ways reflecting different meanings. Participation involved: (a) nonattendance, (b) attendance, (c) comfortable participation, (d) diverse participation, and (e) meaningful participation. *Nonattendance* involved not coming to programs: “People who aren’t here but could be participating.” *Attendance* involved showing up: “They [low-income families] use a lot of our programs that are free . . . [including children’s recreation] subsidies.” *Comfortable participation* involved providing accessible and culturally acceptable programs and creating social

spaces that enabled participants to "feel safe and comfortable." Feeling comfortable in a group was thought by key informants to enable a progression to other forms of participation. *Diverse participation* involved interactions in mixed groups with participants who varied by income, ethnocultural background, age, or gender: "You have to get them [diverse participants] together for it to begin to change." Diverse participation was intended to challenge income and racial divisions in the community; participants moved "out of their comfort zone" by interacting with "a group of people . . . not like them."

Meaningful participation involved contributing to, leading, or influencing decisions or volunteering: "Giving them all meaningful roles." For example, contributing in a community kitchen involved engaging the shared tasks of preparing, cooking and clean-up. Some First Nations parents or grandparents were invited to lead cultural activities; this involved sharing cultural knowledge as part of program activities. Youth were invited to participate in leading children's activities and to lead an advocacy initiative. Parents and grandparents were invited to act as program volunteers for the school feeding program, for community activities and for fundraising events. A few grandparents attended board meetings and participated in decision-making. For some key informants, meaningful participation was also described as broader participation in community life. One key informant suggested that the training provided at a community kitchen enabled a few participants to gain employment. Attending a play group also support social connections and linked participants to other community social and cultural activities. Consistent with later definitions of meaningful participation, in a Family

Centre report, meaningful participation was described as "economic, social, cultural, and political" participation (J. Bopp, 2009, p. 21).

Overall, key informants described participation as a process of enabling isolated families to move from nonattendance to meaningful participation in community life. This process, however, was iterative as key informants observed program participants' ventures into greater engagement interspersed by nonattendance. Progression occurred from social isolation or nonattendance to attendance involving marginal participation, to comfortable participation in small groups or valued cultural activities, and to diverse participation in mixed groups, leading to meaningful participation reflected in active forms of participation and a shift in roles. A shift in roles involved moving from being a participant in programs and activities to being a contributing community member.

The meaning of participation also varied between key informants who had been involved in early collaborative initiatives in the community and those who became involved in the Family Centre collaborative efforts. Early intersectoral collaboration (between 2000 and 2005) was guided by a focus on empowerment and an integrated model of community development (M. Bopp, 2004; M. Bopp & Bopp, 2001; Rothman, 2008). Key informants who had participated in early intersectoral collaborations commonly focused on promoting empowerment and meaningful participation in community life through the following progression: nonattendance to attendance; attendance to comfortable participation in small groups by developing skills and building individual or group capacity; to meaningful participation by volunteering, contributing to, or leading activities or influencing decisions. Key informants who became involved with the Family Centre collaborative efforts after 2006 predominantly focused on a

progression from nonattendance to attendance in universal programs: comfortable participation in small groups or culturally acceptable activities; diverse participation; and meaningful participation as contributing, volunteering, or leading cultural activities. The distinction raised here is that key informants who had participated in early collaborative initiatives in the community conceptualized the progression from non-participation to meaningful participation as a process of empowerment leading to full participation in community life. In contrast, key informants who became involved with the Family Centre after 2006 conceptualized the progression from non-participation to meaningful participation as a process of bridging difference particularly across socio-economic and cultural diversity, and shifting roles to become a contributing community member.

Strategies to Enable Participation and Inclusion

The key strategies to enable participation and inclusion involved: (a) building trust and positive interactions, (b) creating opportunities for multiple forms of participation, (c) providing accessible, culturally acceptable, and safe programs, (d) promoting diverse participation in free universal programs, (e) building capacity and intersectoral collaboration, and (f) promoting an inclusive welcoming community. Table 4.1 provides a summary of the key strategies supporting participation and inclusion by level of social relations.

Trust and positive interactions were developed with isolated families through outreach contacts. Outreach—periodic phone or home visit contacts—was described by key informants as a foundation for reducing intrapersonal barriers, building trust, and enabling low-income and Aboriginal families to attend programs. At the intrapersonal and interpersonal levels, “Low-income and young moms . . . [have] huge trust issues.”

Trust issues resulted from internalized responses to negative encounters that involved a perceived sense of stigma or judgement that led people to feel "embarrassed or ashamed of their circumstances." At the interpersonal level, "We have a First Nations Family Support [worker] . . . she has a lot of . . . families that she contacts." "Once . . . trust was established they were more likely to participate." Another key informant suggested, "I think the Aboriginal participation is greater than it was even two years ago, and that's in part because we've got . . . that commitment to the personal relationship . . . [and] the personal phone call."

Opportunities for multiple forms of participation were created by developing welcoming programs and small groups, and by inviting participants to contribute or volunteer. The early community kitchens of the Coalition were targeted programs that focused on promoting empowerment and "social connection[s]" for low-income and isolated families. The community kitchens of the Family Centre retained this focus on creating safe social spaces and promoting social connections. Program participants were linked to other free programs and invited to volunteer. One key informant described a low-income Aboriginal volunteer: "She's feeling purposeful and I need [her] help." Similarly, low-income youth were invited to contribute to a community event: "They feel they are giving as well as receiving." Volunteering supported a sense of reciprocity, recognition, and empowerment by enabling participants to choose among valued activities and roles.

Accessible programs provided open access for families to participate. "Our programs are all free . . . and we subsidize some of our partners' programs." A school feeding program, one of the first programs implemented through intersectoral

collaboration in this community, was considered to be a "nearly" universal program. Clothing exchanges were also implemented. Key informants suggested that universal school feeding programs helped to reduce stigma, while clothing exchanges supported mutual exchange.

Culturally acceptable programs included offering traditional First Nations cultural activities as part of universal programs. Summer programs for children included traditional storytelling, beading, and a teepee raising event. A preschool program (*Under the Teepee*) and school-based programs were also supported by the initiative. These programs provided opportunities for Aboriginal families to participate in cultural activities that fit their traditions and values, and focused on creating "safe and comfortable" environments for diverse participation. A preschool program called *Stories from Around the World* also promoted respect for diversity.

Diverse participation in free universal programs was supported by inviting families from different income, ethnocultural, and age groups to participate. Later Family Centre community kitchens provided opportunities for diverse participation: "Probably our most successful program that has a real diverse group . . . financially, racially and everything is community kitchen." This participant also suggested:

> One of the reasons we aspire to get that mix . . . is because we would like to do what we can to dispel stereotypes [e.g., social division by income and race]. . . .The beauty of community kitchen is . . . it doesn't really matter [what] your income [is]. . There's a skill you can learn.

Similarly, universal preschool and parenting programs created opportunities for participants to bridge differences. As one key informant suggested, "Parenting is the . . . common denominator . . . that brings everyone together. . . . Parenting really . . . challenges people regardless . . . of your education [and] your income." Another key

informant commented on preschool programs, “They come together in these programs and there is no rich and poor. . . . They develop bonds.” At the organizational level, key informants suggested that parents, grandparents, and children were able to identify commonalities with others through their participation in mixed groups and universal programs. For example, a parenting class with a mixed group focused on a common interest in promoting healthy child development and provided opportunities for developing a shared positive identity.

Capacity building and intersectoral collaboration, as community development strategies, focused on building connections among agencies, professionals, and First Nations at the community level. One key informant explained that, “We expanded the repertoire of people around the table . . . It’s like a ripple effect.” Intersectoral collaboration enabled shared leadership, joint projects, external funding, and shared resources. The Family Centre partnerships helped to link organizational assets across sectors; partners moved from working in “silos” to working “hand . . . in glove (sic).” A series of joint planning sessions supported the development of a shared vision for the merger that created the Family Centre in 2006: “We became a ‘we’, not an ‘us’ and ‘them’ . . . once we had shared goals; that changed things.” This shared vision helped to maintain a focus on addressing SI/SE: “You have to . . . see the need for it.” The Family Centre was able to share a fully equipped preschool room at the school with partner agencies: “It’s quite a strong partnership model.” Staff support was provided for joint programs and community events. Additionally, the Family Centre board members were recruited to represent community agencies and Aboriginal professionals and community

workers as equal partners. Key informants expressed pride in their ability to work together to meet local needs: "We're effecting change."

An inclusive and welcoming community was promoted by raising community awareness and appreciation of First Nations cultures, and respect for cultural diversity. "We did realize that there could be some issues with diversity competency and understanding in the community, and particularly with regards to First Nations cultures." At the community level, newspaper articles were used to raise community awareness: "I think as a whole maybe some of the messaging . . . made people think about ethnic diversity." At a community level, cultural appreciation involved promoting understanding and respect for First Nations cultures and identity. Cultural appreciation was supported though workshops that helped community members to gain an understanding and appreciation of Blackfoot values, and ways of life, and to respect First Nations' cultural identity. "We reached out to both reserves and the in-town First Nations families. . . . [The workshop] broke down all the walls and differences . . . people could hear the message [about residential schools] without the laying on of guilt."

Strategies to Reduce Barriers and Address Exclusion

Key informants suggested that efforts to reduce barriers to participation and to address exclusion were integral to enabling participation and inclusion. Key strategies to address exclusion involved: (a) reducing financial barriers for children's participation and relieving poverty and food insecurity, (b) reducing poverty stigma by linking families to programs and resources, and (c) reducing racism and discrimination by supporting respect for diversity. See Table 4.2 for a summary of key strategies for addressing exclusion.

Efforts to *reduce financial barriers and relieve poverty* involved strategies at all levels to address both relational and structural barriers to participation. At the intrapersonal, and interpersonal levels, outreach was used to build relationships and reduce poverty stigma, and to link families to programs and resources. At the organizational level, Family Centre resources were provided to program participants (e.g., the community kitchen, the Good Food Box, and children's recreation subsidies), and made available through partner agencies (e.g., school-based skate and helmet loans). Strategies focused on community capacity development (Rothman, 2008) helped to increase the community's capacity to meet local needs by linking to national programs and mobilizing community support. For example, the Family Centre assisted low-income families to access external resources (e.g., *JumpStart*[24] recreation subsidies), and mobilized community support for the *Secret Santa* program. Key informants suggested that the *Secret Santa* program promoted a spirit of community generosity and solidarity: "the whole community . . . [was] involved."

Strategies to reduce poverty stigma began with early Coalition efforts to mobilize collective action to address poverty. One key informant commented, "We worked . . . to increase acceptance of the concept of assisting families rather than blaming them." Presentations and dialogue also helped to create awareness:

> We did a lot of work with groups and making presentations really to sort of unpack . . . child poverty from a societal perspective, from a community perspective. . . and working to reduce poverty . . . maybe it [poverty] was an individual experience but the consequences were not individual.

Early mobilization efforts helped to challenge community values of individualism and raised local awareness of poverty as a community and societal issue. Presentations to

[24] JumpStart (2015) is a national registered charity that enables low-income children to take part in sports programs.

community groups identified the impacts of child poverty on health and "the likelihood of other negative consequences for children who grow up in poverty." Church groups became a "huge asset" as volunteers and advocates. Key informants recognized the importance of early advocacy efforts: "Ground was broken by those political champions, which enables us to do what we're doing today."

Poverty stigma was reduced by gaining community acceptance and support for universal programs. Despite some early opposition from parents and community attitudes that emphasized individual (parent) responsibility for feeding hungry children, community and parent support for the school feeding program grew over time. This program was described as a "nearly" universal program; "All children who hadn't had breakfast" were invited to join in. "[For] the kids, it's all-inclusive. I'm hungry today . . . go get some breakfast. And there's no stigma . . . it took a long time to remove that." Key informants noted that the school feeding programs had expanded from kindergarten to high school and gained community acceptance.

Reducing racism and promoting respect for diversity were linked through advocacy. One key informant noted, "As an organization, we recognize[d] that there are racial divides, there are income divides . . . and they're longstanding and they do serve to exclude people." Canada's history of colonization and residential schools and the negative impacts of historic trauma on Aboriginal peoples were acknowledged in community workshops. In early 2011, a youth social inclusion project co-sponsored by the Family Centre and the school division was successful in lobbying the town council to oppose racism. This "bottom up" advocacy effort was "driven by youth". Subsequently, the Fort Macleod town council passed a resolution to join the Canadian Municipalities

Against Racism and Discrimination [CMARD] (Alberta Human Rights Commission, 2011).

Taken together, these two sets of key strategies to foster inclusion and address exclusion provide a comprehensive approach to address relational and structural change. To enable inclusion, relational changes were promoted in community attitudes (respect for culture, identity, and diversity), social relations (trust, mutual respect, and recognition), and group and community membership (claiming a shared identity as parents, grandparents, and volunteers). To enable inclusion, structural changes were promoted in the physical environment (safe social spaces), the social and cultural environment (invited safe social spaces, free universal programs, opportunities for multiple forms of participation, or empowerment), and the local policy context (media advocacy on inclusion). To address exclusion, relational changes were promoted in community attitudes (challenging individualism, poverty stigma, and racism), social relations (reducing social barriers to participation and increasing respect for diversity), and the social and cultural environment (opportunities for diverse participation and cultural contribution). To address exclusion, structural changes were promoted in access to resources (meeting basic needs, reducing financial barriers to participation), the environment (organizational capacity, town council policy resolution, and recognition of poverty and racism), and local policies (policy advocacy opposing racism).

The Influence of Context

To address the second research question about the influence of social, economic, historical, and political conditions on Family Centre strategies, four themes in program discourse are described. Themes were identified through critical hermeneutic analysis of

interview transcripts and participant observation of board meetings during 2011-2012. Themes in program discourse included a focus on local needs, universality, interactions across difference, and local leadership.

Two important changes in the Family Centre strategies occurred after registered charity was approved (Personal Communications, Family Centre Board, April 2011). These changes were made in compliance with Canada Revenue Agency [CRA] (2003) guidelines specifying the approved charitable purposes of registered charities. First, the Family Centre dropped their role in advocacy for social change to address SI/SE. Second, the Family Centre dropped all mention of potentially stigmatizing labels such as poverty or vulnerability from their public discourse and written materials. These two changes reflected a shift away from a focus on the full array of key strategies to address SI/SE. Two key strategies at the community or societal level were no longer explicitly addressed: (a) advocacy to promote an inclusive and welcoming community, and (b) advocacy to reduce racism and discrimination. While the Family Centre programs remained the same, their collaborative efforts reflected a narrower focus on promoting diverse and meaningful participation and alleviating the impact of poverty. In this section, a distinction is made between the broad array of key strategies used from 2000 to March 2011 and the more limited range of strategies identified from April 2011 to February 2012 after the Family Centre became a registered charity.

Most key informants supported the Family Centres board's pragmatic decision to become a registered charity and suggested it would have little impact on programs. These key informants believed that dropping the term social inclusion and focusing on poverty relief was just a matter of reframing language to meet CRA requirements; Family Centre

programs still implicitly supported inclusion. As one key informant commented, "The only change was that we were not allowed to lobby for change," and the advantage was increased opportunities for sustainable funding. Consistent with this view, the Family Centre core programs were sustained during the study period, although, the youth advocacy project that had been initiated and funded prior to gaining charitable status was acknowledged as an example of "something that . . . [the Family Centre] could not initiate in the future." However, as another key informant suggested,

> [O]ne of the barriers is government attitudes towards advocacy . . . I don't understand why advocacy is criminal. . . . It doesn't mean that we're going to storm the legislature. It just means suggesting improvements to help people.

For this key informant, registered charities were being limited to reducing the impacts of poverty and were barred from advocating for policy changes to address the root causes of exclusion.

Local needs. The first theme in program discourse prioritized strategies to meet the needs of Family Centre participants over efforts to promote inclusion and address exclusion at community or societal levels. During a period of fiscal restraint, the focus was on accessing funding to sustain core programs. One key informant suggested, "If we would have kept going on that path [advocacy] we would have run into a cement wall . . . and nothing would have been able to be accomplished at all." For this key informant, a shift in strategies was warranted to reduce the risk of losing staff and programs:

> [T]he whole emphasis … [on inclusion] was we were going to advocate for social change . . . but my take on it was I don't think we will make great strides in social change until we address individual needs first.

The normative claims were that sustaining funding for programs would meet local needs by reducing (a) child hunger, (b) financial barriers for children's participation in recreation, and (c) financial barriers for families and children to participate in Family Centre programs and community life. The background claim[25] was that advocacy for social change to address multidimensional SI/SE was not realistic during a period of fiscal constraint.

Universality. This discourse focused on universal language and universal programs: "Universality is a big piece of what we do." In this discourse, language and programs targeting vulnerable groups were viewed as stigmatizing, while universal programs were described as a normative ideal for strategies supporting inclusion. However, this discourse drew attention away from outreach as a strategy to enable the participation of families who were vulnerable to experiences of poverty stigma and racism. One key informant suggested that a change to non-stigmatizing language was "transformational;" words like "poverty" were removed from program handouts: "We re-worded [public documents] . . . to eliminate any reference to your income level or your vulnerability." For this key informant, inviting parents to a program for 'low-income families' could be humiliating, whereas, inviting them to a parenting class was welcoming. The normative claim was that universal programs and language would avoid stigmatizing participants. A background normative claim was that universal language provided open access to programs. Although outreach was considered a key strategy to enable the equitable participation of "the parents that we're aiming for", this strategy was not reflected in Family Centre handouts. The First Nations community worker was

[25]Background claims identified here are based on an extended period of participant observation of Family Centre board meetings, clarification of meaning during individual and group interviews, and critical hermeneutic analysis of normative-evaluative claims in sections of text.

described by key informants as a "secret weapon" for her role in outreach, yet within the universality discourse such a role became invisible.

Several key informants identified the school breakfast program as a "nearly universal" program. One participant said, "There's kids that could make breakfast at home. We don't care. . . . And the funder doesn't care." Another participant suggested that all children benefited from a nutritious breakfast. The foreground normative claim was that universal programs normalized participation, while targeted programs could be stigmatizing. A key informant described her response to her child's participation:

> I had some mixed emotions, 'cause at first I thought, 'I feed you.' . . . And then actually I just kind of let it go . . . because . . . [it's] fun. . . . I often think of the kids from the perspective of independence . . . [and] that every door should be open, right? So . . . it was no big deal.

Background normative claims suggested the following: a) children should be free to access food at school, b) parents were responsible for feeding their children, and c) the community had a shared responsibility to enable all children to meet their basic needs. While the school breakfast program overtly promoted universal access to food, background normative claims suggested a tension between parental responsibility and community responsibility for feeding hungry children. Further in the background, low-income and Aboriginal children were clearly intended to benefit from this program, but remained unnamed.

Universal parenting and preschool programs were described as inclusive because they were free and accessible, and key informants suggested that these programs reflected universal values. Equal opportunities for children's participation in preschool activities were described as strategies to create "a level playing field." The normative claim was that parenting programs were open to diverse participants because parenting involved

universal values. However, this assumption left traditional Aboriginal parenting practices and values unexamined.

> One key informant described universality as a Family Centre value.
>
> So that really is about equality, that universality. . . . It's not about those characteristics of the individual or the characteristics of the family, like your social standing, your race, your location where you live. . . . [T]hose things are all just kind of put aside with some cultural recognition incorporated, but it's really that equality.

The normative claim was that all parents and children should have equal opportunities to participate. The background claim was that supporting equality among diverse participants required treating everyone with equal respect and cultural recognition.

Interactions across difference. This theme in Family Centre program discourse reflected a shift from a focus on individual empowerment in small homogeneous groups to a focus on creating heterogeneous groups to enable positive interactions across difference.

> As an organization . . . we would like to do what we can to dispel stereotypes and get people rubbing elbows because . . . if they would just meet each other and interact . . . [they might discover that] they're more alike than they are different.

One key informant emphasized early participation: "I think if you start from [when] they're very young, [as] they grow up . . . racism isn't going to be such an [issue]." The normative claim was that by bringing diverse groups together and enabling people to develop relationships, difference could be appreciated rather than devalued.

The Family Centre cultural programs were described as universal programs. A key informant commented, "it's just . . . [got an] Aboriginal twist to it. And sometimes . . . [participants are] all Aboriginals and sometimes there'll be a good mix." Recognizing First Nations cultural identity was considered critical: "Through the programming, they

[children] get a sense of this is who I am, and . . . this community values who I am and recognizes the importance . . . [of] my culture." The normative claim here was that diverse participation should support positive interactions, appreciation of First Nations' cultures, and recognition of cultural identity.

Despite efforts to support cultural recognition, the values underlying the Family Centre programs remained largely unexamined. At a SAC meeting in late 2012 with three First Nations elders and key informants to review early study results, elders were invited to describe traditional Blackfoot values around parenting and childrearing. One Elder suggested that residential schools had greatly disrupted processes for sharing traditional First Nations values and parenting practices. The discipline used in residential schools was described as harsh, while traditional Blackfoot childrearing practices reflected a gentle approach to parenting in comparison to the dominant culture (Personal Communications, SAC, Nov. 7 2012). The normative claim here is that the unique values and parenting practices of First Nations people should be recognized, with the background claim that program values need to be examined and challenged to avoid the imposition of dominant values. Assumptions about universal values may inadvertently support the dominant values of White, English-speaking, Christian, long-term residents with this rural community.

Local leadership. This theme in program discourse addressed issues of local leadership and power relations. The board of the Family Centre was composed predominantly of community professionals, Aboriginal professionals, and community workers, with a few parents or grandparents. All board members acted as community volunteers and contributed their own time to participation on the board. The observed

board decision-making processes involved shared power in decision-making and focused on developing strategies to meet locally identified needs in relation to issues identified by staff, board members, or community members.

Key informants supported a transition to parent leadership, yet several barriers were identified. The mobility of low-income and Aboriginal parents created challenges: "We did have . . . an Aboriginal parent on the board . . . but she relocated and we lost her." Scheduling issues were also identified: "We're meeting at a time [of day] that's really good for [professionals] and we really can't do this program without them, but that's a bad time for parents." Another key informant wondered whether parents felt they might not have the knowledge or skills to be a board member:

> Moms that I know, very skilled people . . . [they] were saying, I don't really know what to do. Like what do I have to do on a board? . . . So a board has those formality things that you need to know . . . [like] voting on financials, . . . program development . . . it takes a long time to . . . even speak to them.

Finally, the board's focus was considered: "I worry that by spending so much time on the governance model at the board level—is it scaring people away?" This key informant suggested, "Once all these processes are in place, it will be easier to turn it over [to parents]." While a parent- and grandparent-led board was considered ideal, it was not considered feasible at the current stage of organizational development of the Family Centre.

Summary. Key informants described strategies to enable participation and to address SI/SE within the context of locally identified issues and community diversity. While content analysis facilitated the identification of diverse strategies to promote participation and inclusion, critical hermeneutic analysis provided important insights into the normative claims underlying a shift in program discourse and a narrowing of the

Family Centre strategies following the approval of charity status.

Discussion

This critical ethnographic study provides insights into the meaning of participation and key strategies to promote participation and address SI/SE from the perspective of key informants involved in the collaborative efforts of a rural Family Centre in Alberta. To our knowledge this is the first Canadian study to identify the strategies used by a community organization and its collaborative partners to support participation and inclusion, and to address poverty and racism as intersecting sources of exclusion. The Family Centre early strategies provided what we believe are an array of key strategies for addressing SI/SE. These strategies were used in a combined approach focused on multilevel and multiple forms of participation to enable inclusion and address social inequalities as sources of exclusion. Changes over time in patterns of participation and the diversity of participants in the Family Centre programs and activities were described by key informants in this rural Alberta community. This represented a meaningful change in social relations in comparison to the income and racial divide described in an earlier study by Dobek (2004) in this community. The current study contributes to emancipatory knowledge development by identifying a progression from non-participation to meaningful participation, and identifying strategies to enable inclusion and strategies to address unjust social relations and the social structures sustaining exclusion.

The meanings of participation and the key strategies identified in this study are consistent with three Canadian discourses on SI/SE: “the discourse on recognition”, “the discourse on equality and citizenship”, and “the capabilities discourse” (Yanicki et al.,

2015, p. 3-5). While there was a dominant focus by key informants on the discourses on recognition and equality and citizenship, key strategies also supported the development of participants' skills, knowledge and capacities consistent with the capabilities discourse. Study findings are presented to highlight each of these three SI/SE discourses.

The *discourse on recognition* (Yanicki et al., 2015) was prominent in the meanings of participation and key strategies to promote participation and inclusion in the current study. For example, positive interactions with a First Nations community outreach worker were thought by key informants to have supported a progression from nonattendance to attendance by building trust and demonstrating respect in interactions. Comfortable participation in a group reflected mutual recognition and positive interactions within a group. Meaningful participation involving contributions and reciprocity in a group supported recognition as a contributing member of the group, while community volunteering enabled recognition as a valued community member. This progression in participation highlights the importance of affirmative interactions (Yanicki, 2005) that reflect mutual recognition and respect for the dignity of all persons (Bach, 2005; Honneth, 1995). In this study meaningful participation involved making contributions to a group or to community life; this form of participation would enable participants to gain a sense of valued recognition (Bach, 2005) and social esteem (Honneth, 1995) and a valued positive identity as a contributing community member. Additionally, key strategies supported opportunities for multiple forms of participation, including valued cultural participation that recognized First Nations cultures and respected unique cultural identity. These key strategies also supported community solidarity (Honneth, 1995) and respect for difference (Young, 1990).

The *discourse on equality and citizenship* (Yanicki et al., 2015) was prominent in key strategies to reduce economic barriers and to relieve poverty, as well as strategies to reduce poverty stigma and racism. Recreation subsidies helped to reduce economic barriers and enabled children's participation in recreation and sports, while school feeding programs and clothing exchanges helped to reduce material deprivation. Early Family Centre strategies to reduce poverty stigma and racism included advocacy to promote inclusion and to oppose racism. While the Family Centre early goal of promoting full participation in community life was not fully addressed (J. Bopp, 2009), key strategies enabled social and cultural participation and addressed poverty, stigma, and racism as root causes of exclusion. Key strategies promoted equitable distribution of resources and greater equality of opportunities for participation in the social and cultural life of the community; these are notably central aspects of the discourse on equality and citizenship (Yanicki et al.). Based on the discourse on equality and citizenship, full participation in community life would also require strategies to promote economic and political inclusion and equal citizenship (Galabuzi, 2009; Labonte, 2009a) as exclusion involves the unfair distribution of resources and unequal citizenship (Galabuzi, 2009).

The *discourse on capabilities* (Yanicki et al., 2015), while less prominent in key informants' discourse, was also evident in the key strategies. Early key strategies to reduce financial barriers included educating community groups and promoting public discourse on child poverty to gain public acceptance for local action to address poverty and SI/SE. While these key strategies were not sustained by the Family Centre after obtaining registered charity status, key informants noted that early social advocacy efforts had helped to mobilize community support and built the foundations for sustainable

intersectoral partnerships. Key strategies sustained by the Family Centre included: reducing financial barriers and relieving poverty through recreation subsidies and school feeding programs , promoting divers participation in universal preschool and parenting programs to support children's optimal development and parenting skills, and creating multiple opportunities for participation. Additionally, key strategies to build trust and positive interactions through outreach and to reduce poverty stigma and racism by creating accessible and culturally acceptable programs helped to create the relational and structural conditions that enabled low-income and Aboriginal families with young children to participate.

Combined, these key strategies created opportunities for inclusion (Sen, 2000) and helped to address multidimensional exclusion (Mitchell & Shillington, 2005). These key strategies are consistent with the development of human capabilities involving: (a) choice among valued forms of participation (Sen, 2000) and freedom of expression, (b) bodily health—meeting basic needs such as being adequately nourished, (c) affiliation, and (d) play or recreation (Nussbaum, 2011). The key strategies identified in this study could be grouped to examine the development of specific capabilities (Nussbaum, 2011) or to critique opportunities for capability development (Benbow, et al., 2014). Given the importance of children's early life experiences (Hertzman, 2002), the key strategies to promote the participation of young children identified in this study have the potential to support human development (McCain et al., 2012), capability development and wellbeing (Nussbaum, 2011; Sen, 2000).

Key strategies to address SI/SE included the creation of accessible universal programs. In this study, community outreach supported participation by reducing shame.

Community kitchens supported trust, positive social relationships and a sense of belonging in a group that enabled other forms of participation. Additionally, community kitchens supported the development of cooking skills and the skills for participating in a small group. These strategies are consistent with the development of human capabilities through participation in valued activities (Sen, 2000). In conceptual literature on poverty, shame and self-exclusion can lead to capability deprivation or capability failure (Sen, 2000). For children, early community participation and social interaction is thought to be required to support the development of the basic functionings required for full participation in community life (Sen, 2000). The key strategies described in this study provide empirical support for the multilevel socioecological focus and the multiple interventions identified in the Integrated Framework for Social Justice and three discourses on SI/SE (Yanicki et al., 2015). We suggest that, consistent with the Integrated Framework, a focus on the combined SI/SE discourses is required to address both the structural and relational dimensions of SI/SE.

In this study, an important distinction is made between the early and later perspectives on meaningful participation and the focus on either empowerment or bridging difference as the catalyst for a progression in participation. Descriptions of empowerment in early community kitchens of the Coalition and descriptions of meaningful participation by key informants who had been involved from early phases of the initiative focused on a progression in participation and capacity involving developing relationships, skills, and a shift in roles (e.g., contributing to or leading activities, or influencing decision). As an ideal, meaningful participation included participation on the Family Centre board. Progression in participation in this context involved participation in

a small homogeneous group and a process of individual and small group empowerment that moved from attendance, to comfortable participation, to meaningful participation. This conceptualization of meaningful participation by key informants reflected a process of empowerment consistent with Labonte's (1993) description of personal care and small group development. As Labonte (1993) noted, a limitation of small group empowerment involving participation in a homogeneous group risks sustaining a negative identity. For example, participation in a self-help group or a group for low-income participants could sustain an identity around shared experiences of a disease or poverty. Labonte suggested that group development moves from an internal focus to a gradual process of empowerment in resistance to social inequalities in society. In contrast, the Family Centre later community kitchens described by key informants who became involved in the later phases of the Family Centre, suggested a different progression to meaningful participation. The Family Centre later community kitchens involved mixed or heterogeneous groups and diverse participation. This form of participation moved participants out of their comfort zone. As noted in previous research, bringing participants together from different income, ethnocultural, and age groups may heighten awareness of difference (Freiler, 2002) and stigma consciousness (Reutter et al., 2009) in a group setting. However, in this study, diverse participation in universal programs was thought to enable interactions across difference by providing opportunities for stigma management by building trust and reducing fear of difference and development of a positive shared identity in an interest group (e.g., as parents, grandparents or volunteers), and valued cultural participation and recognition of unique cultural identity.

Gaining a sense of belonging and a shared positive identity in a diverse group was thought to enable participants to manage stigma. In this study, stigma was described in relation to multiple forms of difference including income, single status, age, and ethnocultural differences. Diverse participation focused on shared interests, commonalities, a shared positive identity, and bridging difference by getting to know diverse participants and challenging social divides. In previous research, Reutter and colleagues (2009) described the internalization of poverty stigma and low-income participants' efforts to challenge a stigmatized social identity.

The current study adds to current knowledge by identifying forms of participation that enabled participants to claim a shared positive identity in resistance to stigma. For example, comfortable participation in valued cultural activities and diverse participation in universal programs offering cultural activities were thought to support recognition and respect. Bridging differences involved participation in heterogeneous groups that supported respect and recognition of First Nations cultures and identity. This study provide empirical support for conceptual literature in the discourses on recognition (Yanicki et al., 2015) including: the recognition of group difference (Habermas, 1998), attributing a positive meaning to difference (Young, 1990), and inclusionary othering (Canales, 2000, 2010).

In this study, bridging difference required both a focus on recognizing similarities and shared humanity, and recognizing and respecting uniqueness and difference from dominant community norms. This was sometimes referred to by key informants as creating a "level playing field" where everyone is equally valued. This study adds to Reimer Kirkham's (2003. p. 775) concept of connections through difference—a "position

of self-awareness and critical consciousness and a context . . . of support . . . [enabling] cultural safety", by providing empirical evidence in a rural community setting rather than a nursing practice and institutional setting. In the current study, the idea of a level playing field was often applied to creating welcoming preschool programs that enabled diverse parents, grandparents and children to play together. While adult participants in mixed groups at a community kitchen could become self-aware and critically conscious of difference, for young children this experience seems consistent with what Carspecken (1996) called "tacit" awareness, a holistic grasp of the meaning of interactions that would enable or constrain a child from holding hands with the child standing next to them for an activity or game. We suggest that participation in mixed groups could reduce fear of difference (Freiler, 2002) and enable this tacit understanding of and respect for difference even for young children. This finding advances current knowledge by extending applications of concepts from professionals in practice contexts to adults and children in community contexts.

Two models of CD were prominent in the key strategies identified in this study. Early Family Centre strategies reflected the use of community capacity development and social advocacy (Rothman, 2008) to support local capacity building and social change to address SI/SE. The later Family Centre focus on promoting participation and relieving the impacts of poverty provided a narrower range of strategies for supporting the inclusion of low-income and Aboriginal families in community life. The Family Centre no longer sought to stimulate public discourse, influence community attitudes, or advocate for social change to address the structural conditions that sustained exclusion. Inclusion, while still valued, was no longer an explicit organizational goal, however, key

strategies implicitly continued to promote inclusion and address exclusion. Intersectoral collaboration and CD strategies continued to focus on local capacity building, meeting local needs, promoting parenting skills and early child development, and enabling multilevel and multiple forms of participation. A focus on promoting changes in relational patterns was evident in the strategies retained at the interpersonal and organizational levels. This narrower approach to CD remained consistent with community capacity development, although no longer with social advocacy (Rothman, 2008).

While many of the Family Centre later strategies reflected a narrowed focus, strategies focused on recognition of Aboriginal identity and culture continued to expand within the scope of approved charitable purposes. Specifically, a greater emphasis was placed on two key strategies: providing safe, accessible, culturally acceptable programs and promoting diverse participation in free universal programs. These programs supported the participation of Aboriginal and non-Aboriginal families in mixed groups and social relations at interpersonal, organizational, and community levels. Invited social spaces were created that promoted what Young (1990, p. 47) called the "reproduction of and respect for group differences without oppression." These relational processes of inclusion are consistent with a process of reconciliation. Reconciliation has been defined as "an ongoing process of establishing and maintaining respectful relationships" (TRCC, 2015, p. 16).

Study findings support emancipatory knowledge development by identifying: (a) a progression from non-participation to meaningful participation; (b) forms of participation that supported a shared positive identity, a sense of group belonging and

management of stigma; (c) key strategies thought to support bridging of difference, recognition of unique cultural identity, and interactions of mutual respect in heterogeneous groups; and (d) CD processes embedded within key strategies thought to support social change to address SI/SE at a community level.

Several constraints and challenges were identified for rural community-level efforts to address SI/SE. The Family Centre faced political constraints, conflicts between the dominant discourse on universality and the Family Centre value of inclusion and unexamined program values. Key informants described conflicting forces within the political and socioeconomic environment that constrained the Family Centre collaborative efforts to address SI/SE. For example, the use of key strategies to reduce racism and discrimination as processes of exclusion were both constrained and supported by the federal government policies and initiatives. The federal government neoliberal social policies (Labonte, 2009b) restricting policy advocacy by registered charities (CRA, 2003) effectively suppressed the Family Centre local advocacy efforts opposing racism. Yet the report and hearings of the Truth and Reconciliation Commission of Canada had raised local awareness of the intergenerational harm caused by residential schools and called for action to address racism (TRCC, 2015). Within this policy environment, the Family Centre was unable to engage in social advocacy to address racism and exclusion; however, key strategies for inclusion thought to promote respect and recognition of First Nations cultures and identity were strengthened.

Conflicts between the dominant discourse on universality and the Family Centre values were evident. The dominant discourse on universality emphasized inclusive language; this foregrounding of acceptable language and the use of politically correct

terms to define program goals and strategies was required to align with funders. However, these language restrictions resulted in backgrounding the previous focus of the Family Centre on SI/SE. While key informants suggested that social inclusion remained a core value of the Family Centre, inclusion was removed from program goals and public discourse after registered charitable status was achieved. The Family Centre narrowed focus on community capacity development and inclusive language and their withdrawal from public discourse on racism resulted in a decreased focus on the structural inequalities leading to exclusion and the loss of key strategies that overtly targeted poverty and racism as structural causes of exclusion (i.e., social advocacy at community or societal levels).

Although the discourse on universality focused attention on equality in access to programs and resources, it was clear that the Family Centre also retained a focus on targeted strategies to promote equity in outcomes. For example, there was continued use of universal strategies along with targeted outreach to engage isolated families. This approach is consistent with what Powell (2009) described as "targeted universalism." In this approach, goals focus on the whole population, evidence is applied to develop strategies, and the "obstacles faced by specific groups" are addressed through tailored strategies (National Collaborating Centre for Determinants of Health [NCCDH], 2013, p. 3). Targeted universalism has been proposed as a promising strategy to promote health equity (NCCDH, 2013).

Finally, the dominant discourse on universality is considered in relation to unexamined program values. Universal parenting programs in this study were assumed to reflect universal values, and thus First Nations values and parenting practices were left

unexamined. As noted by a First Nations elder in a SAC meeting, traditional cultural values and parenting practices were disrupted by residential schools. The literature supports this claim; residential schools caused intergenerational trauma by disrupting the transmission of cultural values and traditions (Allan & Smylie, 2015). Respectful interactions with First Nations people and respect for First Nations values, beliefs, and practices are important first steps toward healing and reconciliation from historic trauma (TRCC, 2015). We suggest, in agreement with Powell (2009), that unless the underlying values of universal programs are critically examined, universality may unintentionally impose dominant values and norms (Powell, 2009). Recognition and respect for First Nations traditional practices and values are needed to support equity (TRCC, 2015). This study contributes to emancipatory knowledge development by highlighting the tension between the dominant discourse on universality and the discourse on recognition, which pose challenges to enabling just social relations.

The current study has acknowledged limitations and strengths. A limitation of the sampling strategy is that the perspectives of key informants may not represent the views of the individuals and families taking part in Family Centre programs or of community members. The strategies identified within the study period reflected only a snapshot of a complex process that unfolded over an extended period to address SI/SE. The rural context and population demographics are specific to the current study and should not be considered generalizable to other rural settings. Strengths of this study include the voices of key informants, in-depth field work, triangulation in data collection, and the multilevel analysis as part of the study design (Carspecken, 1996). Strategies to address SI/SE were identified as cross-cutting themes across interviews (cases), multiple settings (programs),

and multiple sources of social exclusion (outcomes of interest). The identification of cross-cutting themes across a heterogeneous sample (i.e., key informants) may reflect broader social patterns (Patton. 2002).

Several implications for practice and research to address SI/SE arise from study findings. The key strategies identified in this study provide a comprehensive set of strategies to address SI/SE at multiple levels of social relations. We recommend that a comprehensive set of key strategies to address SI/SE be considered in other rural settings. Second, we suggest that a focus on both the structural and relational dimensions of SI/SE is required to effect meaningful change. However, the strategies to address SI/SE identified in this study warrant further exploration in collaboration with low-income and Aboriginal families. To address study limitations, additional research is recommended to clarify the forms of participation and the relational processes and conditions supporting a progression from non-attendance to meaningful participation. Second, research is recommended to explore the key strategies to address SI/SE in other rural communities seeking to address poverty, stigma, and racism in collaboration with Aboriginal peoples. Third, research is also recommended to identify the processes for adapting key strategies to local contexts. Finally, further critical research is needed to uncover the processes for promoting social change to support just social relations and just social structures in both rural and urban contexts.

Conclusion

Study results and the ensuing discussion highlight the promise and the challenges of intersectoral collaborative efforts to address SI/SE. The strategies described reflect the perspective of key informants and the power of critical research to uncover the relational

processes and structural conditions influencing these collaborative efforts in one rural Alberta community. Local approaches to addressing SI/SE present both opportunities for intersectoral collaboration and challenges in supporting social change. This study contributes to emancipatory knowledge development by identifying different meanings of participation, multilevel and multiple forms of participation, and key strategies to promote inclusion and address exclusion that could be tailored to support community-based efforts to address SI/SE in other rural communities.

Table 4.1 Summary of Key Strategies to Promote Inclusion

Key Strategies	Intra- & Interpersonal Levels	Organizational Level	Community & Societal Level
Build trust, positive interactions	Outreach (intra-) Build trust with families Reduce intrapersonal barriers Outreach (inter-) - Contacts with Low-income & Aboriginal families - Mutual respect - Positive interactions - Culturally sensitive - support	Build trust with isolated families - Culturally sensitive support Link families to resources	
Create opportunities for multiple forms of participation	Outreach (intra-) Invite participation Outreach (inter-) Invite contributions & reciprocity	Create small groups Create welcoming programs Provide opportunities for meaningful participation - Invite contributions - Invite volunteers, leaders, decision-makers	Invite partner representation on the board - Partners, Aboriginal professionals and outreach workers Host free community events
Provide accessible, culturally acceptable, and safe programs	Outreach (inter-) Invite cultural participation, contribution, & leadership	Create safe social spaces Create culturally acceptable programs - Mixed groups Offer First Nations cultural programs - Invite cultural contributions & leadership Link programs across agencies	Access external funding Promote diverse participation Intersectoral collaboration
Promote diverse participation in free universal programs	Outreach (inter-) Invite participation - Bridge difference in small groups	Promote diverse participation in free universal programs - Community kitchens - Parenting classes - Preschool programs - Mixed groups	Promote diverse participation in community events Access funding

Table 4.1 Summary of Key Strategies to Promote Inclusion (cont.)

Key Strategies	Intra- & Interpersonal Levels	Organizational Level	Community & Societal Level
Building capacity and intersectoral collaboration		Build trust across organizations Build partnerships - Joint planning - Shared vision - Link community organizations	Partnerships Organizations Community members - First Nations communities - Professionals
Promote an inclusive and welcoming community	Outreach (inter-) Invite diverse participation	Intersectoral Collaboration Promote respect for diversity	*Media advocacy *Advocacy on inclusion

*Starred items were stopped after the Family Centre became a registered charity.

Table 4.2 Summary of Key Strategies to Address Exclusion

Key Strategies	Intra- & Interpersonal Level	Organizational Level	Community & Societal Level
Reduce financial barriers for children's participation and relieve poverty and food insecurity	Outreach (intra-) Reduce financial barriers Outreach (inter-) by First Nations Community Support Worker (FNCSW) Reduce financial barriers Link low-income families to resources	Create programs with intersectoral partners Promote diverse participation - School feeding programs - Free accessible programs - Recreation subsidies	Intersectoral Partnerships Access external funding *Public discourse on poverty and SI/SE and the socioeconomic and political context
Reduce poverty stigma, and link families to programs and resources	Outreach (intra-) Reduce stigma Outreach (inter-) - Direct invitations - Link low-income parents to programs and resources	Promote diverse participation in programs - Community kitchens - Mixed groups Provide access to resources	Gain community acceptance and support Intersectoral collaboration - Enable collective contributions Clothing exchange - Church & community volunteers
Reduce racism and discrimination and promote diverse participation in cultural activities	Outreach (intra-) Reduce racism Outreach (inter-) Link Aboriginal families to programs - Cultural congruence Direct invitations - Respect, - Culturally sensitive support	Promote diverse Participation Promote respect for diversity - *Invite youth leadership to address racism and discrimination	Intersectoral collaboration, - Cultural events Promote respect for First Nations Cultures *Youth-led advocacy to oppose racism *Public discourse on racism, SI/SE and the historic context

*Starred items were stopped after the Family Centre became a registered charity.

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V. Discussion

This study was implemented to explore social inclusion/exclusion (SI/SE) within a rural Alberta community. To my knowledge, this is one of the first Canadian studies to explore SI/SE in a rural community context. This study took place in Fort Macleod, Alberta and included 13-months of field work including interviews, participant observation, and document review during 2011 and early 2012. In this chapter, I begin by presenting a summary of key study findings and study contributions to knowledge development and to research methods and design. I highlight the implications for nursing, and collaborative community development (CD) practice, and recommendations for future research. Finally, I include a brief epilogue to describe my plans for dissemination strategies, actions to address social justice, and future research.

I begin by reflecting on my research focus. First, I was interested in exploring experiences of SI/SE from the perspective of parents and grandparents participating in the programs and activities of a Family Centre in rural Alberta. Additionally, I was interested in identifying the process and conditions that enabled or constrained the participation of and experiences of SI/SE of low-income and Aboriginal parents, grandparents, and children participating in a rural community life. Seventeen parents and grandparents participated in two individual interviews or group interviews. Participants included low-income, middle- and high-income parents and grandparents (self-reported) and Aboriginal and non-Aboriginal parents and grandparents. All participants reflected on their own and their children and grandchildren's participation in the programs and activities of the Family Centre and their experiences of SI/SE.

Second, I wanted to explore the strategies used to enable the participation and inclusion of low-income and Aboriginal parents, grandparents, and young children in the programs and activities of the rural Family Centre from the perspective of key informants, and the strategies used to address exclusion. Key informants included leaders, employees, and volunteers who had participated in the Family Centre collaborative efforts with intersectoral partners to address SI/SE over a period of many years. Twelve key informants took part in an individual interview and nine in a group interview. Key informant experiences with the collaborative efforts to address SI/SE ranged from those who began in 2000 with the implementation of the first school feeding program to those who began their participation after the development of the Family Centre in 2006. Key informants described strategies to address both inclusion and exclusion and described the strategies used by the Family Centre to enable the meaningful participation of all families and children in community life.

Third, I wanted to explore how social, economic and political conditions influenced the Family Centre strategies to encourage participation and to address SI/SE during the study period, and retrospectively, from the beginning of the initiative in 2000. Participant observation, document review, and a group interview were used to explore this focus.

Overall study findings suggest that long-term community intersectoral collaborative efforts may support participants' transitions toward a greater sense of inclusion at a community level. Different strategies may be salient for supporting participant transitions in each of the three relational patterns identified in this study. A wide array of key strategies were identified to enable participation and inclusion and to

address poverty, stigma, and racism as sources of exclusion, however, after the Family Centre became a registered charity, a narrower range of strategies was used to alleviate the impacts of poverty and to address SI/SE.

Key Findings and Contributions to Knowledge Development

In preparation for this study, I was interested in exploring interdisciplinary understandings of SI/SE as a dialectical concept of interest for nursing research. As a dialectical concept, SI/SE required an exploration of contradictory ideas (Labonte, 2012). These ideas were identified in nursing, public health, political economy, and development literature. The discourses identified were rooted in older debates on moral and political philosophy and social theory (Yanicki et al., 2015). As a concept of interest for nursing research, the SI/SE dialectic involved person-environment interactions and impacts on population health, consistent with Fawcett's (2005) metaparadigm of nursing. I concluded that as a concept SI/SE fell within the disciplinary boundaries of nursing and that research on SI/SE could contribute to the development of substantive disciplinary knowledge.

In the first paper, key findings included the identification of three Canadian discourses on SI/SE, development of the Integrated Framework for Social Justice, and application of the Integrated Framework to critique Canadian nursing discourse on social justice (Yanicki et al., 2015). Canadian discourses on SI/SE included: discourses on recognition, capabilities, and equality and citizenship (Yanicki et al.). Social justice was identified as the unifying concept within these three discourses. These discourses were then used to inform the development of an Integrated Framework for Social Justice (Yanicki et al.). The SI/SE dialectic was conceptualized within an ecological model and

potential points of intervention were identified at each level of social relations from the intrapersonal level to the global level. The resulting Integrated Framework provides a heuristic device for conceptualizing multilevel interventions to promote inclusion and to reduce exclusion. Two foundational nursing documents were reviewed to identify current conceptualizations of social justice in nursing and alternative conceptualizations of social justice in nursing literature.

The broad conceptualization of social justice presented in the Integrated Framework (Yanicki et al., 2015) contribute to nursing knowledge development by bringing into focus a range of opportunities for nursing action that go beyond the dominant discourse on ethical nursing care at the individual level in the Code of Ethics (Canadian Nurses Association [CNA], 2008). In the Integrated Framework, opportunities for action were identified at intrapersonal, interpersonal, organizational, community, societal, and global levels to address both the relational and structural dimensions of SI/SE and social (in)justice.

Integrative and emancipatory knowledge were developed in relation to the key findings identified in this paper. *Integrative knowledge* refers to the integration of interdisciplinary knowledge within nursing knowledge to support a more holistic understanding of phenomena of interest to nursing (Chinn & Kramer, 2011) and critical nursing scholarship (Mill et al., 2001). Integrative knowledge and emancipatory knowledge are important for nursing knowledge development as they guide action to promote social change (Chinn & Kramer, 2011). The identification of three Canadian discourses on SI/SE supports exploration of different understandings of the root causes of SI/SE and strategies to address the social inequities that underlie social exclusion. The

Integrated Framework proposes interventions to promote social justice and to address social injustice at multiple levels of social relations. The Integrated Framework has been proposed as a broader conceptualization for social justice in nursing, however, I suggest that this framework could also be used to support collaborative CD efforts and interdisciplinary research.

In the second paper, experiences of SI/SE were explored from the perspective of parents and grandparents in relation to their experiences of participating in the programs of the Family Centre and their collaborative activities with intersectoral partners. Key study findings include the identification of three relational patterns of SI/SE and factors supporting transitions to greater inclusion for participants. The experiences of SI/SE described by participants largely reflected the discourse on recognition (Yanicki et al., 2015). The wide array of key strategies implemented by the Family Centre and their partners enabled low-income and Aboriginal families to participate in social and cultural activities; nevertheless experiences of exclusion due to poverty, food insecurity, stigma, racism and discrimination were still evident from interviews. Participants' experiences reflected relational and cultural inclusion, and relational, cultural, material, and moral exclusion as domains of SI/SE.

Three relational patterns—permanent strangers, newcomers and boundary crossers—reflected different patterns of participation, belonging, and inclusion. Low-income and Aboriginal participants were represented in all three of the relational patterns identified, while middle and high income participants were only represented in newcomer or boundary crosser patterns. Permanent strangers reported limited participation and a provisional sense of belonging. Newcomers regularly took part in group activities and

reported a sense of group belonging, but had difficulty making friends and described themselves as outsiders in the community. Boundary crossers reported having a sense of belonging and group inclusion and most felt included in the community.

Different forms of participation supported a sense of belonging within each relational pattern. Permanent strangers described a community kitchen as a source of belonging although for a few participants group belonging remained provisional. Newcomers described gaining a sense of group belonging and social connections through participation in children's programs or church-based activities. Boundary crossers gained a sense of belonging and inclusion by participating in a range of formal programs with diverse participants and groups within the community as well as school-based activities.

Transitions experiences first involved changes in social relations and the environment that triggered an internal shift in awareness, attitudes, interests, self-perceptions or identity which in turn influenced relational patterns. The factors supporting transitions in participation and belonging described by some participants in this study varied by the participant's relational pattern (ie., permanent strangers, newcomers or boundary crossers). Participants described changes in social relationships (e.g., developing trusting relationships) combined with changes in the environment (e.g., free or subsidized programs and programs that supported diversity) as having enabled a shift toward greater participation and for some a change in their relational pattern. A few permanent strangers described a shift from non-participation to periodic participation and a provisional sense of belonging.

For some low-income Aboriginal participants, the combination of relational inclusion and cultural inclusion supported a transition from permanent stranger to

boundary crosser. These relational processes combined experiences of affirming interactions, valued recognition, and a sense of group belonging with experiences of recognition and respect for Aboriginal cultural and identity. The transitions toward greater participation and the changes in relational patterns described by parents and grandparents were linked to valued forms of participation in the programs and activities of the Family Centre and partner agencies. This is an important study finding. The transitions identified in this study contribute to current knowledge by linking experiences of participation to process and structures of SI/SE across three relational patterns.

Relational and cultural inclusion were supported by affirming encounters, building trusting relations, feeling valued and recognized, and having a sense of belonging. For permanent strangers, outreach contacts were often required to build trusting relationships and reduced internalized barriers to participation. For low-income and Aboriginal participants, being invited to participate and to contribute to program and community activities as a volunteer provided a sense of being recognized and valued. Cultural participation supported recognition of cultural identity. This finding was supported by both parent and grandparent interviews and key informant interviews. Leading a cultural activity supported recognition as a volunteer or community member. This experience supported a sense of community belonging as volunteers felt valued for their contributions and cultural knowledge. Some boundary crossers resisted stigma and claimed a positive identity as parents, grandparents, or community members through participation in mixed groups in universal programs These study findings reflect a sense of valued recognition (Bach, 2005) that enabled participants to overcome internalized powerlessness (Labonte, 1993). Consistent with previous research, affirming encounters

(Browne & Fiske, 2001; Yanicki, 2005), trusting relationships, and respect for Aboriginal culture reduced social distance (Browne & Fiske, 2001) and reduced fear of difference (Freiler & Zarnke, 2002).

However, study findings also identified that relational, cultural, and moral exclusion continued to constrain the participation of permanent strangers. While permanent strangers chose not to participate (self-exclusion) to avoid shame, judgement, and negative encounters, boundary crossers were more likely to transcend experiences of stigma and awareness of difference or to take action to address bullying.

In the third paper, key informants described many strategies thought to have supported the participation of low-income and Aboriginal parents, grandparents, and children over time. Key findings included: different meanings of participation and progression in participation, an array of key strategies to address SI/SE, and conflicting forces within the socioeconomic and political environment which constrained the Family Centre efforts to address SI/SE.

Multiple meanings of participation were described by key informants reflecting a progression in forms of participation moving toward meaningful participation. The forms of participation included: nonattendance, attendance, comfortable participation, diverse participation, and meaningful participation. Overall, key informants suggested that meaningful participation involved contributing to (e.g., participating in food preparation at a community kitchen), leading activities (e.g., parent or grandparent leadership of cultural activities or youth leadership of an advocacy initiative), influencing decisions (e.g., attending a board meeting), or volunteering (e.g., helping with the school breakfast program, a community event or a fundraiser).

Key strategies involved an array of strategies to promote participation and to address SI/SE. Key strategies for enabling participation and inclusion included: (a) building trust and positive interactions, (b) creating opportunities for multiple forms of participation, (b) providing accessible, culturally acceptable, and safe programs, (c) promoting diverse participation in free universal programs, (d) building capacity and intersectoral collaboration, and (d) promoting an inclusive and welcoming community. The key strategies for addressing barriers to participation and exclusion included: (a) reducing financial barriers for children's participation and relieving poverty and food insecurity, (b) reducing poverty stigma by linking families to programs and resources, and (c) reducing racism and discrimination by supporting respect for diversity. This array of linked strategies was thought to have supported meaningful changes in patterns of participation and social relations and an increase in the diversity of participants in Family Centre programs over time.

Early key strategies (2000-2005) for building capacity and intersectoral collaboration, reducing financial barriers for children's participation, and relieving poverty and food security were consistent with the discourse on citizenship and equality (Yanicki et al., 2015). The CD processes of building trusting relationships, and creating organizational partnerships and intersectoral collaboration were consistent with Rothman's (2008) community capacity development, and Labonte's (1993) collective empowerment at the community organization and coalition building levels.

In contrast, later strategies were most consistent with the discourse on recognition and the discourse on capabilities (Yanicki et al., 2015). The key strategy of promoting diverse participation by bridging difference supported recognition of difference and

unique identity (Young, 1990). A focus on bridging difference enabled some low-income Aboriginal boundary crossers to claim a shared positive identity. The creation of mixed groups provided opportunities for diverse participants to explore shared interests in universal programs. Similarities were explored while respecting differences (e.g., cultural diversity), and recognizing unique cultural identity (Young, 1990).

The discourse on capabilities (Yanicki et al., 2015) was evident in key strategies to reduce financial and relational barriers to participation, to relieve poverty, and to create opportunities for multiple forms of the participation including universal preschool and parenting programs. The use of outreach, the removal of financial barriers, and the development of First Nations cultural programs were thought to have created relational and structural conditions that supported a meaningful change in the patterns of participation of low-income and Aboriginal parents, grandparents and children. Taken together, these strategies supported opportunities for human development (Nussbaum, 2011) and capabilities (Sen, 2000).

I found limited key informant and Family Centre board discourse on capability development during the study period somewhat surprising given the preschool and parenting programs provided. This may have been related to the transition to registered charity status and funding constraints that were prominent topics of discussion. A broader focus on capability development for mothers seems warranted given the challenges described by several mothers and grandmothers who experienced early childbearing, and had returned to school for upgrading to complete high school or postsecondary education. It is not surprising that this pattern was most commonly described by permanent strangers. As SmithBattle (2012) has suggested, greater attention to upstream

strategies is needed to address the social policies, social inequalities and exclusion of young low-income mothers. A capabilities approach (Sen, 2000) would move beyond a focus on parenting education to identify policies and strategies to support the educational attainment of young mothers and the optimal development of their children.

These study findings extend previous literature by describing: (a) key strategies to promote participation and address SI/SE within a rural context, (b) forms of participation thought to have supported shared identity, belonging, and transitions in participation and relational patterns, (c) CD processes for addressing poverty, stigma, and racism as sources of exclusion, (d) strategies to bridge difference, and to promote recognition of Aboriginal cultures and identity.

The formal shift away from Family Centre use of empowerment strategies was a somewhat surprising study finding given the early focus on empowerment by key informants and the strong emphasis on empowerment within CD and participation literature (Labonte, 1993, 2005; Wallerstein, 2006). However, recent literature on participation suggests that CD strategies have not always enabled empowering forms of participation due to the inequalities in power relations within communities (Cooke & Kothari, 2004; Hickey & Mohan, 2007). The Family Centre program discourse, identified through observation and critical hermeneutic analysis, revealed several constraints and challenges for community-level efforts to address SI/SE. These constraints and challenges included: socioeconomic and political constraints, and conflicts between the dominant discourse on universality and Family Centre values, and unexamined program values.

Gaining registered charity status resulted in a narrowing of the Family Centre key strategies and foregrounding of language acceptable to the federal government's policies for registered charities (Canada Revenue Agency, 2003, 2006). Within this neoliberal social policy environment, the Family Centre chose not to engage in policy advocacy to address racism or promote inclusion. The discourse on universality, dominant among funding agencies, foregrounded language consistent with the funder's goals. This resulted in the backgrounding of the Family Centre value of social inclusion. The discourse on universality framed both targeted language and targeted services for poor or vulnerable families as potentially stigmatizing.

The funder's dominant focus on universality emphasized programs for all families and the value of equality emphasized treating everyone the same. This conflicted with the Family Centre value of social inclusion and key strategies supporting equity such as: building trust and positive interactions, reducing racism by promoting cultural respect, and promoting diverse participation in cultural activities. These strategies required targeting, recognition of difference and respect for unique cultural identity. Family Centre resistance to this dominant discourse was evident in the continued strategies to address SI/SE, including targeted outreach to isolated families—a promising practice described as targeted universalism in the literature (National Collaborating Centre for Determinants of Health, 2013; Powell, 2009). Finally, the dominant discourse on universality also contained unexamined assumptions that universal parenting programs reflected universal values. I support Powell's (2009) assertion that unless the underlying values of universal programs are examined, universality may inadvertently sustain the values of the dominant groups in society. In this study, the values of the dominant White,

middle- & high-income Christian long-term residents could inadvertently be imposed on low-income and Aboriginal parents through universal programs unless programs are adapted to reflect respect for unique groups and populations.

Finally, I reflect on the Family Centre program discourse on local leadership. While key informants valued parent and grandparent leadership, there was limited evidence of parent engagement in Family Centre board roles during the period of this study[26]; however a few grandparents participated on the board during the study period. This could be related to socioeconomic and political conditions facing community organizations in Canada at the time of the study (Imagine Canada, 2010), and the stage of organizational development of the Family Centre in their transition to registered charity status. The mobility of many of the low-income and Aboriginal families residing in the community also created barriers for engaging parents and grandparents in volunteer roles on an ongoing basis. For example, by the conclusion of my two interviews with 14 families, most of these families could no longer be contacted by phone or by home visit to invite them to a group interview.

Taken together, the findings from interviews with mothers, grandmothers, and key informants provide support for key strategies to address SI/SE and for the use of multiple levels of intervention as identified in the Integrated Framework for Social Justice (Yanicki et al., 2015). Both SI/SE and social (in)justice involve multiple levels of social relations and structural factors that sustain inequalities in society (Yanicki et al.). Interviews with parents, grandparents, and key informants identified multiple supports for

[26] The board included two grandmothers during the study period, but only periodic participation from parents. It is important to note however, that since the time of this study, several parents have been recruited to the board of the Family Centre. It is recognized that any study only captures practices during a limited period of time and that as noted in study findings CD efforts are dynamic and evolve to address current needs

participation and similarly identified both poverty and racism as underlying sources of multidimensional exclusion. Both relational and structural factors were identified that supported or constrained participation. Overall, parents and grandparent participants expressed a sense of appreciation for the Family Centre programs and activities with partner agencies that enabled the participation of families with young children. As noted by boundary crossers and key informants, participation in mixed groups provided opportunities for parents, grandparents, and children to engage in social interactions across income, ethnocultural, and age differences. These are positive findings that support the claims by several key informants that the collaborative efforts of the Family Centre have made a difference over time. The increased diversity among program participants is a positive sign that a longstanding income and racial divide in the community may continue to be reduced over time. However, it was also clear to me, based on both content analysis and critical hermeneutic analysis, that the shift to a more limited range of key strategies associated with registered charity status may constrain Family Centre efforts to address the structural dimensions of SI/SE.

One thing that struck me during this study was that gender inequalities were not specifically raised as a focus by study participants, and therefore, I chose not to focus on gender issues in my analysis. I recognize, however, that it is not simply a matter of coincidence that all of the parents and grandparents who agreed to participate in interviews in this study were women. This is a limitation of the study, as the relational patterns and transitions identified, and the strategies to promote participation and to address SI/SE may be different for men and women. Women are over represented among those living in poverty and Aboriginal women are at greater risk of experiencing

intersecting sources of inequality due to income, race/ethnicity, and gender in Canadian society (Raphael, 2011). Similarly, women (Reid, 2004), Aboriginal peoples (Frohlich et al., 2006), and racialized groups are at higher risk of experiencing exclusion (Galabuzi, 2009). A limitation of this study may be that the relational patterns described reflect a gendered pattern of interaction among women who experience SI/SE.

Another issue that struck me was that the board members were all community volunteers. The nurses, teachers, and community workers and the Aboriginal staff from partner agencies were all participating as volunteers, and meetings were held after regular work hours. This is a testament to the commitment of the key informants in this study. In my previous role as a public health manager from 2000-2003, I supported public health nursing participation in activities to address local community issues through intersectoral collaboration and forming partnerships with other community agencies. The meetings of the Kids In Need Coalition would have, in part, included paid work for nurses working in public health or population health roles. Over time, a shift has occurred from paid work to the work of community volunteers. This shift has paralleled a decline in government funding for community organizations and grants that support community partnerships to promote health and social wellbeing. Government cutbacks and limited grant opportunities have negatively affected the health, education and not-for profit sectors (Imagine Canada, 2010), yet this was not raised as an issue by most key informants. Only one key informant raised this as a social policy issue of concern in relation to Family Centre registered charity status. The shift from paid to unpaid work took place before the study and perhaps it was no longer viewed as an issue among participants, or was simply considered a given in the current policy context. Yet, without the dedication of key

informants, the array of key interventions developed by the Family Centre would not have been possible. Again, the majority of board members were women. I am left to wonder how CD work is to be supported in future without the level of initial investment and support by a group of community professionals who can facilitate the initial processes of CD in this community as part of their paid work roles.

Methodological Contributions

This study also raises some questions about the strengths and limitations of critical ethnography as a process for emancipatory knowledge development. During the course of this study, I found that one of the strengths of critical ethnography was that it enabled a comparison of observed behaviour patterns and routine discourse in multiple social settings (Carspecken, 1996). Participant observation enabled me to observe social interactions in mixed groups as the Family Centre programs and activities evolved over a period of time. I was also able to observe the Family Centre board during a period of key decision-making regarding charitable status. These observation experiences provided a valuable context for interviews with parents and grandparents and with key informants. These experiences also brought me face-to-face with the everyday struggles of low-income parents and grandparents attending programs in the winter with young children and no transportation.

Dialogic interviews supported validation of shared meanings and the exploration of contradictions. Group interviews were particularly helpful in exploring contradictory ideas within and across cases. I was also able to explore shared meanings and culturally unique understandings about parenting and parenting values with the support of the Study Advisory Committee (SAC) which included three First Nations elders. Support from the

SAC was extremely valuable to me in preparing for the study and reflecting on early study findings.

One of the unique methodological approaches that I used in this study was the combination of both critical hermeneutic analysis and content analysis. I found that both forms of analysis were essential to answer the research questions posed in this study. However, this combined focus led to an interesting tension between critique of underlying processes of injustice and content analysis of the strategies used to address SI/SE. The latter was more comfortable for me, as I was drawn to coding and classifying the strategies used to address SI/SE. In the end, the identification of key strategies required combining multiple levels of coding and reflection on program discourse. Mentorship from and debriefing with my supervisor was certainly required to work through these tensions as Carspecken (1996) wisely advises and to move further into the critical hermeneutic analysis.

One of the challenges of critical ethnographic methodology was that of honouring participants' voices, especially the voices of those parents and grandparents who expressed ideas that differed from the views expressed by other participants. I sought to include these views in the findings. As I came to understand the insider perspective of participants through the process of validation, critical reflection was required about the power issues that sustained current relationships between those developing the key strategies and the participants experiencing those strategies as programs and activities. Some of the insights that emerged created a sense of resistance in me as I sought to explore contradictions in the claims of individual participants and to understand diverse perspectives. At times I felt torn between a sense of duty to reflect individual mother's

and grandmother's voices and the need to protect the confidentiality as participants. I also felt a sense of duty to adequately reflect the discourse of key informants and the history of the strategies that came to make up the key strategies identified in the study. Some time and distance from field work were required for me to be able to adequately convey the different meanings of participation described by key informants and to synthesize study findings. Critical ethnography takes time and reflection. However, as time has passed since the completion of my data collection for this study, changes have occurred in the activities and programs of the Family Centre which have addressed some of my early recommendations.

Implications for Nursing and Intersectoral Collaboration

This study is relevant for nursing in a number of ways. First, SI/SE is an urgent matter of social (in)justice and a matter of concern to nursing. Nurses have both a moral and ethical responsibility to promote health equity (Canadian Nurses Association, 2010) by promoting just interactions and addressing the underlying structures of social inequality (Falk-Rafael, 2005). Second, multiple opportunities to promote social justice and to address SI/SE can be identified within the context of routine nurse-person interactions; nurses are uniquely positioned to address both the relational and structural dimensions of SI/SE (Yanicki et al., 2015). Third, I hope that the Integrated Framework and study findings will support and stimulate dialogue. I suggest that despite limited action to address SI/SE in Canada (Labonte, 2009) and the challenges faced by nurses in their individual and collaborative efforts, many nurses continue to act for social justice (Falk-Rafael & Betker, 2012).

Nurses who participated as key informants in this study engaged in collaborative intersectoral partnerships and were key advocates for CD as a process to promote social change (Community Health Nurses of Canada, 2011). I suggest that individual nurses and professionals nursing associations have a key role to play in promoting health equity (Reutter & Kushner, 2010; Cohen & Reutter, 2007). Social justice is a foundation for ethical nursing interactions (Reutter & Kushner, 2010) promoting respect, recognition, capability development, and equal citizenship (Yanicki et al., 2015). Relational change requires critical caring to transform social relationships at interpersonal and organizational levels (Falk-Rafael, & Betker, 2012). Leadership is also required at community, provincial and national levels to support policy advocacy and social change to address the structural inequalities that sustain SI/SE and health inequities in Canadian society (Cohen et al., 2013). A greater emphasis should be placed on embedding social justice in undergraduate nursing curricula and developing organization capacity to promote health equity action (Cohen et al.) to address SI/SE and social (in)justice (Yanicki et al.).

Intersectoral collaboration and sustained partnerships are needed to support social change to reduce social exclusion at a community level. It is recommended that study findings be considered as a range of options that could inform CD efforts to address SI/SE in other communities. First, the Integrated Framework for Social Justice (Yanicki et al., 2015) provides a theoretical framework that could guide intersectoral collaborations to develop multilevel interventions to address SI/SE. Second, the key strategies identified in this study provide a practice-based set of linked strategies that could be adapted to local contexts in other rural settings to develop intersectoral

interventions that promote participation and inclusion and that address poverty, stigma, and racism as sources of exclusion. Study findings suggest that long-term community collaborations and CD efforts may be required to support transitions towards greater participation and inclusion. The longstanding intersectoral collaboration described in this study may support cohort effects over time through joined up efforts at a community level. For example some parents and grandparents reported that their children's and grandchildren's experiences of participation at an early age were more positive than their own experiences as a child growing up in this community. It is possible that over time, intersectoral efforts could contribute to a positive shift in the experiences of a whole cohort of children that would support greater shifts toward inclusion. This approach warrants further exploration in other rural settings.

Recommendations for Future Research

Limited nursing research has addressed SI/SE as a determinant of health or explored poverty and racism as underlying sources of exclusion. Greater emphasis should be placed on critical scholarship and emancipatory nursing knowledge development to challenge social inequalities and to uncover the relational processes and social structures that sustain SI/SE.

Research is recommended to explore the key findings of this study in other contexts: (a) the relational patterns of men's and women's experiences of SI/SE, (b) supports for transitions to greater inclusion for other population groups such as newcomers to rural or urban communities, (c) the application of key strategies to address SI/SE in other rural communities and (d) community-level and societal interventions to address poverty and racism explored through community coalitions such as Vibrant

Communities initiative, or the Canadian Municipalities Against Racism and Discrimination (CMARD) in rural or urban settings. These studies could contribute to a program of research addressing SI/SE through a variety of study designs such as participatory action research, critical ethnography, or a school-based intervention studies.

To begin to address some of these research needs, I plan to develop a participatory action research study to explore strategies to address SI/SE in two communities with interdisciplinary collaborative groups with an active early child development coalition. The purpose of this study would be to identify local priorities for action to address poverty and/or racism as sources of exclusion and to explore the development of a range of key strategies adapted to meet local needs to address SI/SE at a urban and rural community levels.

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VI. Conclusion

Epilogue

Consistent with the emancipatory intent of this study I briefly outline my own work to support social change and social justice. I have made presentations on aspects of my doctoral research, including at conferences, agency board meetings, and an undergraduate nursing course: Campus Alberta Student Conference on Health, Banff (Sept. 2015); Canadian Public Health Association Conference, Vancouver (May 2015); Canadian Municipalities Against Racism & Discrimination Conference (CMARD), Lethbridge (Mar. 2014); Family & Community Support Services, board meeting, Fort Macleod (May, 2014); Parents as Teachers, board meeting, Lethbridge (Nov. 2013); Kids First Family Centre, board meeting (Nov. 2013; Jan 2013); and Nursing students NURS 4570 class, University of Lethbridge, (Jan. 2013). Future plans for research dissemination include the presentation of paper three at local (i.e., CMARD, Kids First Family Centre, Alberta Health Services and School Division levels), and national conferences (The Canadian Public Health Association Conference, and the Community Health Nurses of Canada Conference).

In my current role as an academic, I coordinate the Public Health and the new Aboriginal Health degrees at the University of Lethbridge. I have developed and taught a course on community development and social justice, and I continue to teach a course on health and society which is co-listed as a health sciences and a sociology course. I have incorporated service learning into my advanced public health course to engage students in learning through volunteer work with community agencies. I have supported public

health students as a faculty advisor in practicum placements focused on community development and policy analysis in Alberta, Saskatchewan, and British Columbia.

I participate in community efforts to address poverty and to promote health equity. I continue to support the Kids First Family Centre in Fort Macleod and I attend board meetings. I am currently a member of Vibrant Lethbridge and I participate on the Living Wage Subcommittee. I am a longstanding member of the Canadian Public Health Association, the Alberta Public Health Association, the Community Health Nurses of Canada, and the Community Health Nurses of Alberta. I hope that the emancipatory intent of this study may also support the Family Centre and other communities seeking to address the challenging dynamics of SI/SE within the context of their own communities.

Final Reflections

My final reflections on this study were to ponder a statement by a key informant who asked me whether it was more important to affect local change that would facilitate change in one person's life that could ripple through the community or to lobby for social change to address SI/SE. After much reflection, I would suggest that findings from this dissertation provide a strong assertion that it is in fact most effective to work towards both forms of change. There is an urgent need for action that promotes inclusion *and* addresses exclusion. We should not be limited by simple dichotomies that suggest we need to choose one or the other (e.g., to address poverty or promote social inclusion, or to promote inclusion or address exclusion). From the perspective of social justice, we all have a moral obligation to address inequalities and to promote just social relations and just social structures within our communities and our society. I hope the findings form

this dissertation shine a light on the path ahead for collaborative community work and research to address SI/SE.

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VIII. Appendices

Appendix A. Biographical Statement[27]

I have had a longstanding interest in poverty reduction and promoting social justice. This interest stems from my own experiences growing up in a low-income household. I experienced supportive relationships through opportunities to participate in organized community activities as a child (e.g., brownies, girl guides and rangers), and during my young adult years I had the opportunity to make a contribution to my community as a brownie leader.

My educational background includes a Bachelor of Science in Nursing from the University of Saskatchewan and a Master of Science in Health Promotion from the University of Alberta. I was a participant in the first SEARCH (Swift and Efficient Application of Research in Community Health) program offered by the Alberta Heritage Foundation for Medical Research (AHFMR) in collaboration with Regional Health Authorities. I have participated in several collaborative research teams and published articles based on this research.

As an experienced public health nurse, I have many years of experience working in rural settings with Aboriginal populations. As a rural public health nurse, I have lived and worked in isolated poor rural communities. I have worked with First Nations communities and Metis colonies providing primary health care and public health nursing services. As a public health nurse, I gained experience in interviewing and assessment. This experience should assist me to remain sensitive to the responses of community members in all aspects of the study, and to adapt study data collection approaches as required to explore emerging themes.

[27] This biographical statement was submitted with the research proposal.

During my graduate studies and as a researcher, I completed a graduate level course on transcultural nursing (in my master's program). I have recently participated in a cultural training session on the Blackfoot worldview at the 2009 and the Aboriginal Science Conference at the University of Lethbridge. My thesis research focused on Social Support and Family Assets in Low-Income Lone Mother Families participating in a Home Visitation Program. This qualitative exploratory descriptive study utilized mixed methods of data collection. In my thesis research I examined low-income at individual & family levels of analysis. As part of my doctoral studies I completed a research internship in 2006 at the University of Ottawa with Dr. Nancy Edwards and audited a course on multiple interventions in community health.

As a nurse manager, nurse/health promotion consultant, and executive director of an nongovernmental organization, I have also had the opportunity to work on social action, policy advocacy and community development in several leadership roles. My experiences in policy advocacy have been at the organizational level (e.g., the Alberta Public Health Association [APHA]), as founding member of several coalitions (e.g., the South West Alberta Poverty Coalition [SWACP], the Chinook Tobacco Reduction Network, and the Alberta Social Health and Advocacy Network [ASHEN]—now defunct) and in supervising staff leading community development initiatives in three cities (e.g., arts-based community development with youth through APHA/ASHEN). I completed a two-year commitment on the APHA board as the chair of the communications committee for the Alberta Public Health Association in 2009.

I also have had a longstanding collegial relationship with health professionals in the town of Fort Macleod. As a Program Director of Wellness Services in the former

Chinook Health Region (1995-2003), I managed public health nursing programs regionally including staff in the Fort Macleod office. In this role, I participated in the original community consultations on child poverty in Fort Macleod in 1999. I have worked with the health promotion specialist/population health facilitator from this community on many regional and provincial projects [e.g., including the South West Alberta Poverty Coalition (SWAPC), APHA, and ASHEN].

As a clinical instructor in the Faculty of Health Sciences, I have also supervised nursing students in the community of Fort Macleod and worked with two public health nurses as preceptors (2006-2007). In my role as a coordinator for the Public Health degree, University of Lethbridge, I continue to participate in the SWACP. However, to avoid a conflict of interest with my work, and the engagement of nursing students in community projects, I have not participated in two youth arts-based community development and social inclusion projects sponsored by the SWACP and the Kids First Family Centre (KFFC) in the town of Fort Macleod.

Appendix B. Historical Background on the Kids First Family Centre

Community consultations were undertaken by staff of the Chinook Health Region (CHR) in Fort Macleod during the fall of 1999 to discuss high rates of child poverty (Donahue & Furman, 2001). The rate of child poverty (family income below the Statistics Canada Low-Income Cut-offs or LICO, by community size) in 2001 was 20.9% in Fort Macleod, and 18% within the CHR (Donahue & Furman, 2001). The Kids In Need (KIN) community action coalition was formed in the spring of 2000. The KIN project team identified food security and social inclusion as issues for local action. Schools, community service organizations, local community groups and community volunteers were involved in KIN to develop Fort Macleod's first universal snack program at the elementary and middle schools in November 2001 (Dobek, 2004; Donahue & Furman, 2001). The universal snack program was designed to provide snacks to students regardless of socio-economic background. A universal program was proposed by KIN (and CHR staff) to reduce stigmatization and social exclusion for children experiencing food insecurity (Dobek, 2004). Members of the KIN project also participated in a regional coalitions and a provincial network for social action on poverty. The KIN project evolved into an incorporated society or community-based organization called the Fort Macleod Society for Kids First (Kids First) in 2004. In order to maintain financial viability and avoid duplication of services for children and families, further restructuring has occurred.

The Kids First Family Centre (KFFC), a collaborative community-based organization, was developed in 2006, through the integration of the Fort Macleod Society for Kids First (Kids First) and the Fort Macleod Family Centre (Family Centre). A

community capacity building and asset mapping process was undertaken in May of 2007 to develop a shared vision for action (Roberts, 2007). This capacity building process engaged community members, board members, as well as representatives from partner organizations and groups in mapping community assets (Roberts, 2007). In 2009, KFFC completed a participatory evaluation and planning process (J. Bopp, 2009). This built upon a preview participatory review of the Kids First project in 2004 (M. Bopp, 2004). Program participants were included in both of these participatory review processes.

As part of an environmental scan during a recent strategic planning session for the KFFC program, five trends were thought to "affect the degree to which…[local children and families] can meet their basic needs and experience social inclusion" (J. Bopp, 2009, p. 13). Trends included the worsening economic climate, the intergenerational disadvantage (poverty and social exclusion) experienced by some families, government policies and the erosion of the social safety net, jurisdictional divisions affecting First Nations people, and a "social and economic 'divide' between the First Nations and dominant society populations" (J. Bopp, 2009, p. 13). I attended and observed this session. Community professionals, Kids First and Family Centre board members and a few parents involved in leadership roles participated in this session facilitated by Dr. Judy Bopp.

A consensus emerged at the strategic planning session in 2009 that KFFC's recent focus on developing integrated services would not address all of the determinants of "child and family poverty and exclusion" or "wellbeing" in the Fort Macleod area (p. 12-14). It was agreed that "attitudes and behaviour" needed to change within the community and community members need to be engaged in "capability building" and "policy

change/system/redesign" (p. 11-12). The KFFC committed to maintaining a focus on engaging community members in community development as well as the delivery of programs and services. Participants at this session identified social inclusion as a priority issue for KFFC and the community of Fort Macleod.

KFFC has incorporated a focus both on delivering program services and on community development [e.g., community capacity development or capacity building] (J. Bopp, 2009). Community partners and two programs with historically differing approaches were successfully integrated over a two-year period and they were able to identify shared priorities and core approaches. This merger has provide greater funding stability for KFFC. Services and program activities will be focused on food security and child/parent capability development, and collaborative efforts will be used to engage community members in capacity building.

The proposed critical ethnography can be expected to address differing questions than has been addressed in previous participatory program evaluations. While the participants at the program planning sessions identified the impact of broad social trends on their community, the processes and power relations that may be influencing the participation and inclusion of low-income parents remain largely unexamined. Critical research therefore can make an important contribution to providing information to support both KFFC program development and collective social action.

Appendix C. Research Notice[28]

Notice of a Research Study in Fort Macleod

Social Inclusion/Exclusion: Low-income Parents Participating in Community Development in Rural Alberta

My name is Sharon Yanicki. I am a doctoral student in the Faculty of Nursing at the University of Alberta.

I will be doing a study in the town of ***Fort Macleod***. I will be observing and taking part in the activities of the ***Kids First Family Centre***. I'll be talking to many people in the community.

Study Purpose

The purpose of this study is to learn about the ways in which low-income parents with young children come to feel included in the community.

I want to talk with parents about feeling part of the community. Talking part is not always easy on a low income. Sometimes parents and children may feel left out or kept out. Sometimes they may feel welcomed and feel they belong.

How do I take part?

Are you interested in more information?

Call Sharon Yanicki for more information *at 403-332-5233.*

Flesch Kinkaid Grade level: 7.5

[28] This research notice, adapted from Edgecombe (2006), was posted in public places in Fort Macleod and printed in the local newspaper to make community members aware of the study.

Appendix D. Letter of Introduction

Invitation to Kids First Family Centre Participants
Title of Research Study: Social Inclusion/Exclusion: Low-income Parents Participating in Community Development in Rural Alberta

My name is Sharon Yanicki and I am a doctoral student at the Faculty of Nursing, University of Alberta. I invite you to be part of a study taking place in the town of Fort Macleod with the Kids First Family Centre.

What is the purpose of the study?
The purpose of this study is to learn about the ways in which low-income parents with young children come to feel included in the community. Taking part is not always easy on a low income. Sometimes parents and children may feel left out, or kept out. Sometimes they may feel welcomed and feel they belong.

Who can participate?
Low-income parents with young children (0-9 years) who attend Kids First Family Centre activities are invited to take part in this study.

What will happen?
I will meet people in Fort Macleod. I will talk to people in a variety of locations. I will observe and participate in the Kids First Family Centre program with your permission. You will also be invited to take part in two interviews. A few group interviews will be held to clarify ideas and discuss the study findings.
.
Why are we doing this study?
What you tell me may be helpful to professionals supporting parents with young children. What you tell me may be helpful to the Kids First Family Centre to better support parents and young children.

It's your choice.
It is your choice to be part of this study or not. You are free to talk to me about the study. Your decision to take part in this study will not affect the support you receive from Kids First Family Centre. A final report on the study will be shared with the Kids First Family Centre.

How do I take part?
If you are interested in finding out more about the study or to participate in the study, please call me, Sharon Yanicki, at 403-332-5233.
You may also call the Kids First Family Centre and ask that your contact information (phone number) be given to me. I will then contact you to talk to you about the study.
If you have any concerns about this study, you may call the principal researcher (or collect):Dr. Kaysi Kushner, University of Alberta, at 1-780-492-5667

Flesch-Kincaid Grade Level: 7.6

Appendix E. Interview Guide – Formal Interviews – Key Informants

Title of Research Study: Social Inclusion/Exclusion: Low-income Parents Participating in Community Development in Rural Alberta

Domain: a) recruitment and participation/non-participation (enablers/barriers to the participation of low-income parents and children).
I'm interested in understanding how low-income parents and children are encouraged to participate in the activities, services and events of the KFFC program in Fort Macleod.

1. Based on your experience with the KFFC program, can you describe some of the ways the participation of low-income parents and children has been promoted?
    a. Are there any approaches that have been more successful than others? If so, please describe.
    b. Are there any barriers for parents and children's participation in the program?
    c. If yes, can you describe the barriers? How were these addressed?

Domain: b) cultural diversity among participating low-income parents and children

I'm also interested in understanding how parents and children from different social, economic and cultural groups are encouraged to participate in KFFC programs in Fort Macleod.

2. Can you describe the cultural diversity of Fort Macleod residents and the participation of diverse groups of parents and children in KFFC programs?
    a. What strategies have been used to promote the participation of these cultural groups?
    b. What types of barriers has the program addressed in promoting the participation of certain groups?
    c. Do you think the diversity of KFFC participants has changed over time? If so, what may have contributed to this?

Domain: c) participation of parents in governance and decision-making

3. Describe the ways in which KFFC program participants have been engaged in program planning, decision-making and evaluation.
    a. How have parents been engaged in the KFFC Board? Has this changed over time or remained the same?
    b. What has been most helpful in engaging low-income parents?
    c. What has been most helpful in engaging culturally diverse parents?
    d. Describe some of the challenges you have faced in sustaining participation.

Appendix F. Interview Guide[29] – Formal Interviews – Parent Participants

Title of Research Study: Social Inclusion/Exclusion: Low-income Parents Participating in Community Development in Rural Alberta

Interview #1 – Social Inclusion/Exclusion: Low-income Parents Participating in Community Development in Rural Alberta

Introduction: The purpose of this study is to learn about the ways in which low-income parents with young children come to feel included in their community. Sometimes parents may face challenges in taking part in community activities. They may feel left out, or kept out. At other times it may be easier to participate.

To start off, I'd like you to reflect on some of your experiences with the Kids First Family Centre.

Domain: a) Lived experiences of parent participation/non-participation

1. Tell me about how you and your children first came to participate in the KFFC program.

2. I'm interested in understanding what it is like for you to participate in the KFFC program.

   Tell me about a typical day at the . . . (name a group session such as a community kitchen)?[30]
   a. What happens in a typical session/activity?
   b. Tell me about how you feel when you take part in this session/activity.
   c. Are there times when you have felt welcome or unwelcome in the group? Describe what happened to make you feel that way.

Domain: (b) lived experiences of parent inclusion/exclusion (participation, development, social relations and opportunities)

3. Thinking back over your participation in KFFC (over the last 1-3 years), were there times when you were excited about being part of the program? Can you tell me about one of those experiences?
   a. What was that like for you?
   b. Did you have the opportunity to learn something new? (If applicable)
   c. Did you meet new people or make new friends?

4. Similarly, thinking of your participation in KFFC (over the last 1-3 years), were there times when you felt uncomfortable with a program activity or didn't feel welcome in a group?

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[29] Format adapted from Carspecken (1996).

[30] Spradley (1979, cited in Carspecken, 1996) recommends opening with a grand tour question describing a typical day to encourage description

a. Tell me about that experience.
b. What happened?
c. How did you feel about that experience?

5. Some communities have a wide variety of activities for parents and children while other communities have fewer opportunities. What is it like for you and your family living in Fort Macleod?
    a. How easy or hard is it for you take part in activities that interest you?
    b. What made it easier for you to take part in a program or activity that you were interested in? Can you give me some examples?

6. Were there times when you couldn't participate in KFFC activities that you were interested in?
    a. Can you tell me about one of those experiences?
    b. What things get in the way of you being able to participate?

Domain: (c) Parents perceptions of their child(ren)'s participation and experiences.
I'm interested in understanding some of your child(ren)'s experiences in KFFC or other community activities.

7. Think about a recent activity (or an activity in the past three years) that your child(ren) attended. Can you tell me about that?
    a. How easy was it for your child to take part?
    b. How did your child feel about that?
    a. What made it easier for your child(ren) to take part?
    c. Did anything make this a positive experience?
    d. Did anything make this a negative experience?

8. Have you ever felt concerned that your children were being left out?
    a. Is there anything that made it more difficult for your child(ren) :
        i. Take part?
        ii. Fit in?

Program Participation: I'd like to understand what KFFC programs you and your family members/children have participated in. Could you look at this list and check off all of the activities you and your family have participated in during the last three years (√). Complete one checklist for each member of your family (See the List of Program Activities – Appendix E).

Participant Demographic Form: I also have a form for you to complete that will help me to understand more about your family. You can fill this in yourself, or if you like, I can read it to you. You are free to answer any question or decline to answer any question.

Interview # 2 – The Conditions influencing Social Inclusion and Exclusion

Title of Research Study: Social Inclusion/Exclusion: Low-income Parents Participating in Community Development in Rural Alberta

Thank you for agreeing to participate in a second interview. The purpose of this interview is first to clarify a few issues from our first interview (your experiences in participating in the KFFC program) and second, we will talk about your experiences of feeling included and part of the community of Fort Macleod.

I'd like to begin by reflecting on our first interview.

9. Did you have any comments to add from the first interview?
    a. Did anything come to mind for you after we talked, that you would like to add?

I had a few questions that I wanted to clarify.

10. In this situation you described…
    a. Can you tell me more about that?
    b. I understood you to mean…Is that correct?
    c. When you used this term, I understood….
    d. The issue (theme, cultural typifications, process of SI/SE) that stood out for me from the experience you described… was…, would you agree? Have I understood that correctly?

In this interview, I'm interested in reflecting on your participation in the community of Fort Macleod. Sometimes parents with young child(ren) may face challenges in taking part in community activities. They may feel left out, or kept out. At other times it may be easier to participate.

In this interview, I'd to understand more about how welcome you or your child(ren) feel to take part in the community.

Domain: (c) values and norms influencing participation (inclusion as a normative ideal, a welcoming community, opportunities to contribute and be recognized).

11. Tell me about a group(s) (or a community) that you take part in to where you feel most welcome.
    a. Can you tell me about a time recently when you felt welcome or unwelcome?
    b. Tell me what that was like for you?

12. Can you describe a situation where you were able to help out with a community event or volunteer (e.g., for KFFC)?
    a. How was that experience for you?
    b. How easy or hard is it for you to contribute?

c. Would anything make this easier for you?

13. Did anything make it easier or harder for you to take part?
    a) Did KFFC programs make this easier or harder?
    b) Did anything about the community of Fort Macleod make this harder or easier?
        Tell me about that. What has changed, what is the same?

Domain: (d) processes and structures supporting equity/inequities and justice/injustice (in access to power, resource,)

12. Are there resources that should be available for you and your children that are not available in this community?
    a. Who should provide these resources for families and children?
    b. How could this be improved for low-income families?

Domain: (e) processes and structures sustaining difference (low-income and cultural identity).
Living on a low-income can make it very challenging to take part in activities and feel part of the community.

13. Can you think of a time when you would have liked to have taken part in a community or social activity but you couldn't? Describe that experience for me.
    a. What stopped you from taking part?
    b. Do you feel accepted in this community? If so, in what ways?
    c. Is there another community or group that you feel accepted and welcomed in? Tell me about that.

14. Are there other factors that have influenced your ability to participate and feel part of the community?
    a. Would you say was your . . . (income, gender, culture/race/ethnic identity, community's history)

Domain: (f) Social inclusion as a normative ideal:

15. If you could have three wishes to make the community of Fort Macleod into a more welcoming community for all families and children, what would you wish for?

Appendix G. KFFC Program Activities Checklist

Kids First Family Centre, Fort Macleod Site

Adult Participation (Mom/Dad/Other) _____Child Participation _____
Complete one checklist per person._____

Check all that Apply	Program Activity/Event	Timing	Location
	School Breakfast Program	Week Days	W. A Day School, G. R. Davis School
	School Lunch Program	Week Days	W. A Day School, G. R. Davis School F. P Walshe School, Central Outreach School
	Fort Macleod Preschool (FM Preschool & KFFC)	Weekly/ Periodic	(W. A. Day School, Family Centre Room) (Tues. and Thurs. am & pm)
	Stay & Play, (Parents As Teachers[PAT] & KFFC)	Weekly/ Periodic	W. A. Day School , Family Centre Room (Monday am)
	Parent Participation Preschool Program (Lethbridge College, Local Parents and KFFC)	Weekly/ Periodic	Family Centre Room, W. A. Day School (Friday am & pm)
	*Community Kitchen	Monthly	Community Hall **(2nd Friday of the month at 11:00 am)
	*Teen Kitchen	Monthly	*F. P. Walshe School **(3rd Friday of the month at 1:30 pm)
	Community Good Food Box	Monthly	Fort Macleod / Granum/Brocket (Order last Thurs of month, pick-up 2nd Thurs of next month)
	Community Clothing Exchange	Seasonal	G. R. Davis School, October W. A. Day School, Nov.
	Community Halloween Party	Seasonal	Fort Macleod
	**Community Easter Egg Hunt	Seasonal	Fort Macleod
	**Canada Day Celebrations – Children's Games (Project READ, The Fort & KFFC)	Seasonal	The Fort
	Secret Santa Program (School & Agency referrals)	Seasonal	KFFC coordinating Community Donations (Nov. / Dec.)
	*Community Resource Fair	Annual	September
	*Youth Digital Storytelling training (2009)	One-time Project	Fort Macleod

Adult Participation (Mom/Dad/Other) _____ Child Participation _____
Complete one checklist per person._____

Check all that Apply	**Program Activity/Event**	**Timing**	**Location**
	*Youth Social Inclusion Project (2009-2010) (KFFC, South West Alberta Poverty Coalition & WomanSpace)	Project	Fort Macleod
	Volunteer Recognition Event (FCSS & KFFC)	Annual	Fort Macleod
	*Circle of Courage, Community Development Seminar (2010) (Dr. Martin Brokenleg)	One-time Project	Fort Macleod
	*Youth Art/Talent Shows	Periodic	Fort Macleod
	**Triple P Parenting Program (Seminars and one-on-one Guidance)	On-Going	Fort Macleod Health Centre, KFFC Office
	**Make Your Own Pow Wow Outfit	Weekly	W. A. Day School (Lunch Hour – from October to May)
	**I am Special Group (Girls 9-12 years)	Weekly	G. R. Davis School (After School – from October through May)
	**Baby is Here…Now What? (Partnership with Alberta Health Services – Public Health)	Weekly	W. A. Day School (Wed. afternoons)
	**Stories from Around the World (Toddlers & Parents)	Weekly	W. A. Day School (Wed. mornings)
	**Cow Bus Children's Festival	Annual	Fort Macleod / Brocket
	First Nations Family Support **Aboriginal Story Telling (6-10 years)	Summer Program	Monday Afternoons, Library
	First Nations Family Support **Traditional Beading (8-12 years)	Summer Program	Wednesday Afternoons, Library
	First Nations Family Support **Under the Tipi (Parent Engagement & children 0-6 years)	Summer Program	Tuesday Mornings FM Health Centre

Adult Participation (Mom/Dad/Other) _____Child Participation_____
Complete one checklist per person._____

Check all that apply	Program Services	Timing	Location
	KFFC Recreation/Arts Program Subsidies $100.00 per child per year	Year Round	KFFC Office
	**Canadian Tire Jumpstart Program $300 per child per season (Canadian Tire & KFFC)	Year Round	KFFC Office
	Skate & Helmet Lending	Seasonal	KFFC Office (weekdays)
	School Supplies Assistance	Each Semester	Requested by and delivered to each local school as required.
	**Ages & Stages Developmental Check-ups (3-5 years) (Alberta Health Services, Elementary Schools & Parent Link Centres)	Annually	W. A. Day School, Granum Elementary
	Referrals to available resources	Year Round	KFFC Office
Other (List other types of participation, such as volunteer work, attending meetings, evaluations and consultations)			
			Fort Macleod

* Revisions Sept. 15, 2009
**Revisions July 22, 2010

Appendix H. Participant Demographic Form

Title of the Project: Inclusion/Exclusion: Low-income Parents Participating in Community Development in Rural Alberta

Case Code number _____

1. Do you have any difficulty reading English? Yes _____ No _____
2. What is your current age? Years _____
3. What is your gender? Female_____ Male_____
4. What is the highest level of education you have completed?
    a. Junior high or less_____
    b. High school_____
    c. Some community college, technical school or university _____
    d. Completed community college or technical school_____
    e. Completed university degree_____

5. Are you currently:
    a. Single never married
    b. Married
    c. Divorced
    d. Separated
    e. Common law
    f. Widow/Widower

4. Are you currently a resident of:
    a. Fort Macleod_____
    b. The rural area surrounding Fort Macleod _____
    c. Other (specific)_____

5. How long have you and your family lived in Fort Macleod or the surrounding rural area?
    a. 6 months –1 year
    b. 13 months - 2 years
    c. 25 months – 3 years
    d. more than 3 years

6. I have participated in the Kids First Family Centre activities, events and services for:
    a. 6 months
    b. 7 months – 1 year
    c. 13 months – 2 years
    d. 25 months – 3 years
    e. more than 3 years

7. I have most commonly participated in Kids First Family Centre (pick one):
    Group-based activities: Yes _____No _____
    Volunteer activities: Yes _____ No _____
    Board Meetings: Yes _____ No _____
    Other _____

8. Describe your children's participation in the Kids First Family Centre during the last three years:

	Age	Gender	Participant	How long has each child participated?
Child 1:	_____		Yes _____ No____	Months _____ Years _____
Child 2:	_____		Yes_____ No____	Months _____ Years _____
Child 3:	_____		Yes_____ No____	Months _____ Years _____
Child 4:	_____		Yes_____ No____	Months _____ Years _____
Child 5:	_____		Yes_____ No____	Months _____ Years _____

9. What languages do you speak?
   First language: _____ Second language: _____

10. Do you identify yourself as a member of an ethnic or cultural group?

    Yes_____ No _____ If yes, specify: _____

Flesh-Kincaid Readability: Grade 5.2

Appendix I. Study Tracking Form

Title of the Project: Inclusion/Exclusion: Low-income Parents Participating in Community Development in Rural Alberta

Case Code number _____
Name of Family Contact (First/Last): _____ _____
Age:____ Gender _____

Contact Information:
Phone: Yes _____ No _____
Mailing Address: _____
Street Address: _____
Driving directions: _____

Any safety issues in visiting the home? Yes _____ Dog_____ Other ____

Recruitment: How did the client hear about the study?

b. The information letter from the KFFC program _____
c. The research notice _____
d. Snowball sampling – received information from a study participant _____
e. Group participant during observation sessions _____

Eligibility Requirements:

1. Family Income <= to LICO: Yes _____ No _____
   Annual Family Income: _____LICO for Fort Macleod/area _____
   Number of people living in the household: Adults _____Children _____

2. Child(ren) (birth to 9 years): Yes _____# _____

3. Adult is a KFFC participant: Current: Yes ___Past: Yes ___

4. Current participant in KFFC for > 6 months: Yes _____ No _____

5. Fluent in English: Yes _____

Consent: Family willing to speak to the researcher: Yes _____ No _____
Consented for a formal interview: Yes _____ No _____
Consented to follow-up contacts: Yes _____ No _____
Consent form attached: Yes _____ No _____

Contact Dates: Interview #1: _____ Interview #2_____ Group Inv. _____
Gift certificate given: Interview #1: _____Interview #2_____ Group Inv._____
Research summary: Sent by mail:_____

Appendix J. Letter of Support

FORT MACLEOD
KIDS FIRST FAMILY CENTRE

Supporting Healthy Growth and Development of Children & Families

Wednesday, December 09, 2009

To Whom It May Concern:

Re: Approval for Sharon Yanicki Doctoral Project

In early September 14, 2009, Sharon presented to the Fort Macleod Kids First Family Centre Society about the scope and sequence of her proposed research study. It is a study which will support programming for our community due to the importance of the research topic and the previous commitment of the researcher to our group.

At the December 8th, 2009 Fort Macleod Kids First Family Centre Society Board meeting the following motion was approved:

Vera Crow Shoe moved the Fort Macleod Kids First Family Centre supports, in principle, the work, "Social Inclusion/Exclusion Study" of Sharon Yanicki, subject to approval by the Research and Ethics Committees through the University of Alberta. Sue Lichtenberger seconded the motion. Motion passed.

We are very excited to be part of this work and look forward to assisting her in any way. If you have any questions or concerns do not hesitate to contact me at 403-553-3362.

Sincerely,

Ian Stewardson
Co Chair
Fort Macleod Kids First Family Centre

Appendix K. Consent Information Sheet – Observation & Informal Interviews - Key Informant, Parent & Grandparent Participants

Title of the Project: Social Inclusion/Exclusion: Low-income Parents Participating in Community Development in Rural Alberta

Principal Investigator: Dr. Kaysi Eastlick Kushner, Faculty of Nursing, University of Alberta
Co-Investigator: Sharon Yanicki, doctoral student, Faculty of Nursing, University of Alberta, Coordinator Public Health Degree & Lecturer, Faculty of Health Sciences, University of Lethbridge,

Why is this study being done? The purpose of this study is to learn about the ways in which low-income parents with young children come to feel included in the community. Taking part is not always easy on a low income. Sometimes parents and children may feel left out, or kept out. Sometimes they may feel welcomed and feel they belong.

What will happen? I will attend Kids First Family Centre activities and events to observe and participate. You are free to agree to allow me to observe and participate in the Kids First Family Centre activities or you may refuse. I will observe group sessions and take notes. I may ask you questions during or after the session.

What are the benefits of the study? What you tell me may be helpful to professionals supporting parents with young children. What you tell me may be helpful to the Kids First Family Centre in finding ways to support and assist parents and children to take part in the community.

Are there any risks? The only risk to you is being uncomfortable or upset about what you tell me. If there are things that are upsetting you during the interview, I will find someone for you to talk to. You will be provided with some suggested places to ask for help, where you can speak to a counselor, nurse or doctor.

How will my privacy be kept? I will keep your name and what you say or do private. A code will be used on all study materials. I will take notes during the sessions I observe and only the research team and I will see these notes. You will not be named in any reports or talks about this study. The study data will be kept for at least five years after the study is done. The study data may be used again in another study. The researchers will first get approval from an ethics board to make sure that data are used properly. All information will be held private except when professional codes of ethics or the law requires reporting.

It's your choice: It is your choice to be part of this study. Choosing not to participate will not affect the support you receive from the Kids First Family Centre. You may choose not to answer a question. You may stop being in the study at any time. You may ask questions at any time.

Reimbursement of expenses: You will be given a $10 gift card for each interview, to respect your time in the study.

If you have any questions: Phone: Sharon Yanicki at 403-332-5233 at the Faculty of Health Science, University of Lethbridge.

Additional contact: If you have concerns about the study you may call the principal investigator (call collect): Dr. Kushner at 0- 780-492-5667 at the Faculty of Nursing, University of Alberta
If you have general questions about the study, you may call the Office of Research Services, University of Lethbridge, [Phone: (403) 329-2747]

Study findings: Do you want a summary of results of the study? If yes, please provide your mailing address to Sharon Yanicki at 403-332-5233 at the Faculty of Health Science, University of Lethbridge.

A final report on the study will be sent to the Kids First Family Centre and filed with the University of Alberta.

Verbal Consent

Activity/Event/Service Observed: _____

Name of Participant_____
or
Name of KFFC staff member_____

Sharon Yanicki_____ _____
Initials Researcher Date
Flesch-Kincaid Grade Level: Grade 7.3

Appendix L. Consent Information Sheet –Formal Interviews – Key Informants

Title of the Project: Social Inclusion/Exclusion: Low-income Parents Participating in Community Development in Rural Alberta

Principal Investigator: Dr. Kaysi Eastlick Kushner, Faculty of Nursing, University of Alberta
Co-Investigator: Sharon Yanicki, doctoral student, Faculty of Nursing, University of Alberta, Coordinator Public Health Degree & Lecturer, Faculty of Health Sciences, University of Lethbridge,

This study has been approved by the University of Alberta, and is being supported by the Kids First Family Centre, and the University of Lethbridge. This study has also been approved by Alberta Health Services.

Purpose: The purpose of this study is to learn about the ways in which low-income parents with young children come to feel included in the community. Taking part is not always easy on a low income. Sometimes parents and children may feel left out, or kept out. Sometimes they may feel welcomed and feel they belong.

Who is a Key Informant? Kids First Family Centre board members, staff, community professionals and community members who have been involved in planning and directing program activities, services and events over the last three years are invited to participate in this study.

What will happen? I will talk with you about [specify focus of interview] for about one hour. I will record the interview so that it can be typed out for review.

What are the benefits of the study? What you tell me may be helpful to professionals supporting parents with young children. What you tell me may be helpful to the Kids First Family Centre in finding ways to support and assist parents and children to take part in the community.

Are there any risks? The only risk to you is being uncomfortable or upset about what you tell me. If there are things that are upsetting you during the interview, I will find someone for you to talk to. You will be provided with some suggested places to ask for help, where you can speak to a counselor, nurse or doctor.

Will my privacy be kept? I will keep your name and what you say or do private. A code will be used on all study materials. I will take notes during the interviews. Our interviews will be recorded. Only the research team, the transcriber and I will know what you said. The transcriber will sign an oath to keep what you said private. You will not be named in any reports or talks about this study. The study data will be kept for at least five years after the study is done. The study data may be used again in another study. The researchers will first get approval from an ethics board to make sure that data are used

properly. All information will be held private except when professional codes of ethics or the law requires reporting.

It's your choice: It is your choice to be part of this study. You may choose not to answer a question. You may stop being in the study at any time. You may ask questions at any time.
Choosing not to participate in this study will not affect your role with the Kids First Family Centre.

Contact: If you have any questions: Phone: Sharon Yanicki at 403-332-5233 at the Faculty of Health Science, University of Lethbridge.

Additional contact: If you have concerns about the study you may call the principal investigator (call collect): Dr. Kushner at 0- 780-492-5667 at the Faculty of Nursing, University of Alberta
If you have general questions about the study, you may call the Office of Research Services, University of Lethbridge, [Phone: (403) 329-2747]

Study findings: Do you want a summary of results of the study? If yes, please provide your
mailing address to Sharon Yanicki at 403-332-5233 at the Faculty of Health Science, University of Lethbridge.

A final report on the study will be sent to the Kids First Family Centre and filed with the University of Alberta.

Flesch-Kincaid Grade Level: Grade: 7.6

Appendix M. Research Consent Form –Formal Interviews – Key Informants

Title of the Project: Social Inclusion/Exclusion: Low-income Parents Participating in Community Development in Rural Alberta

Principal Investigator: Dr. Kaysi Eastlick Kushner, Faculty of Nursing, University of Alberta
Co-Investigator: Sharon Yanicki, doctoral student, Faculty of Nursing, University of Alberta, Coordinator Public Health Degree & Lecturer, Faculty of Health Sciences, University of Lethbridge,

Part II:	Yes	No
Do you understand that you have been asked to be in a research study?	□	□
Have you read and received a copy of the attached information sheet?	□	□
Do you understand the benefits and risks involved in taking part in this research study?	□	□
Have you had an opportunity to ask questions and discuss this study?	□	□
Do you understand that you are free to withdraw from the study at any time without having to give a reason and without affecting your future participation in Kids First Family Center?	□	□
Has the issue of confidentiality been explained to you?	□	□
Do you understand who will have access to your records, including personally identifiable information?	□	□
This study has explained to me by Sharon Yanicki.	□	□

Part III: Signatures
I agree to take part in this study.

Date:_____

Signature of Research Participant_____

Printed Name:_____

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Researcher:_____

Printed Name: _____

*A copy of this consent for must be given to the subject.

Flesch-Kincaid Grade Level: Grade 7.3

Appendix N. Consent Information Sheet – Formal Interviews – Parent & Grandparent Participants

Title of the Project: Social Inclusion/Exclusion: Low-income Parents Participating in Community Development in Rural Alberta

Principal Investigator: Dr. Kaysi Eastlick Kushner, Faculty of Nursing, University of Alberta
Co-Investigator: Sharon Yanicki, doctoral student, Faculty of Nursing, University of Alberta, Coordinator Public Health Degree & Lecturer, Faculty of Health Sciences, University of Lethbridge,

Why is this study being done? The purpose of this study is to learn about the ways in which low-income parents with young children come to feel included in the community. Taking part is not always easy on a low income. Sometimes parents and children may feel left out, or kept out. Sometimes they may feel welcomed and feel they belong.

What will happen? I will come to talk to you two times. Talks will take place in your home or in another place in the community. The talks will be tape recorded. Each talk will last about one hour. I will ask questions about your experiences and the situations in which you have felt included or left out. I will ask you to fill in a form about yourself at the end of the first talk. You will also be invited to talk together with a group of some other parents with children later in this study. In the group, I will ask you to share your views with other parents.

What are the benefits of the study? What you tell me may be helpful to professionals supporting parents with young children. What you tell me may be helpful to the Kids First Family Centre in finding ways to support and assist parents and children to take part in the community.

Are there any risks? The only risk to you is being uncomfortable or upset about what you tell me. If there are things that are upsetting you during the interview, I will find someone for you to talk to. You will be provided with some suggested places to ask for help, where you can speak to a counselor, nurse or doctor.

Will my privacy be kept? I will keep your name and what you say or do private. A code will be used on all study materials. I will take notes during the interviews. Our interviews will be recorded. Only the research team, the transcriber and I will know what you said. The transcriber will sign an oath to keep what you said private. You will not be named in any reports or talks about this study. The study data will be kept for at least five years after the study is done. The study data may be used again in another study. The researchers will first get approval from an ethics board to make sure that data are used properly. All information will be held private except when professional codes of ethics or the law requires reporting.

It's your choice: It is your choice to be part of this study. Choosing not to participate will not affect the support you receive from the Kids First Family Centre. You may choose not to answer a question. You may stop being in the study at any time. You may ask questions at any time.

Reimbursement of expenses: You will be given a $10 gift card for each interview, to respect your time in the study.

If you have any questions: Phone: Sharon Yanicki at 403-332-5233 at the Faculty of Health Science, University of Lethbridge.

Additional contact: If you have concerns about the study you may call the principal investigator (call collect): Dr. Kushner at 0- 780-492-5667 at the Faculty of Nursing, University of Alberta
If you have general questions about the study, you may call the Office of Research Services, University of Lethbridge, [Phone: (403) 329-2747]

Study findings: Do you want a summary of results of the study? If yes, please provide your mailing address to Sharon Yanicki at 403-332-5233 at the Faculty of Health Science, University of Lethbridge.

A final report on the study will be sent to the Kids First Family Centre and filed with the University of Alberta.

Flesch-Kincaid Grade Level: Grade 6.5

Appendix O. Research Consent Form – Formal Interviews – Parent & Grandparent Participants

Title of the Project: Social Inclusion/Exclusion: Low-Income Parents and Participating in Community Development in Rural Alberta

Principal Investigator: Dr. Kaysi Eastlick Kushner, Faculty of Nursing, University of Alberta
Co-Investigator: Sharon Yanicki, doctoral student, Faculty of Nursing, University of Alberta, Coordinator Public Health Degree & Lecturer, Faculty of Health Sciences, University of Lethbridge,

Part II:	Yes	No
Do you understand that you have been asked to be in a research study?	□	□
Have you read and received a copy of the attached information sheet?	□	□
Do you understand the benefits and risks involved in taking part in this research study?	□	□
Have you had an opportunity to ask questions and discuss this study?	□	□
Do you understand that you are free to withdraw from the study at any time without having to give a reason and without affecting your future participation in Kids First Family Center?	□	□
Has the issue of confidentiality been explained to you?	□	□
Do you understand who will have access to your records, including personally identifiable information?	□	□
This study has explained to me by Sharon Yanicki.	□	□

Part III: Signatures
I agree to take part in this study.

Date:_____

Signature of Research Participant_____

Printed Name:_____

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Researcher:_____

Printed Name: _____
*A copy of this consent for must be given to the subject.

Flesch-Kincaid Grade Level: Grade 7.3

Appendix P. Consent Information Sheet – Group Interviews – Parent & Grandparent Participants

Title of the Project: Social Inclusion/Exclusion: Low-income Parents Participating in Community Development in Rural Alberta

Principal Investigator: Dr. Kaysi Eastlick Kushner, Faculty of Nursing, University of Alberta
Co-Investigator: Sharon Yanicki, doctoral student, Faculty of Nursing, University of Alberta, Coordinator Public Health Degree & Lecturer, Faculty of Health Sciences, University of Lethbridge,

Why is this study being done? The purpose of this study is to learn about the ways in which low-income parents with young children come to feel included in the community. Taking part is not always easy on a low income. Sometimes parents and children may feel left out, or kept out. Sometimes they may feel welcomed and feel they belong

What will happen? I will talk with you in a group of other parents with children. Each group talk will take place in a community building in the town of Fort Macleod. Group talks will last about one 60 to 90 minutes. The talks will be tape recorded. I will report some of the things I found when talking with parents and program staff, and I will ask you to share your views in the group.

What are the benefits of the study? What you tell me may be helpful to professionals supporting parents with young children. What you tell me may be helpful to the Kids First Family Centre in finding ways to support and assist parents and children to take part in the community.

Are there any risks? The only risk to you is being uncomfortable or upset about what you tell me. If there are things that are upsetting you during the interview, I will find someone for you to talk to. You will be provided with some suggested places to ask for help, where you can speak to a counselor, nurse or doctor.

Will my privacy be kept? Each participant will be asked not to talk outside of the group about what others say or do. I will keep your name and what you say or do private. A code will be used on all study materials. I will take notes during the interview. Our interview will be recorded. Only the research team, the transcriber and I will know what was said. The transcriber will sign an oath to keep what you said private. You will not be named in any reports or talks about this study. The study data will be kept for at least five years after the study is done. The study data may be used again in another study. The researchers will first get approval from an ethics board to make sure that data are used properly. All information will be held private except when professional codes of ethics or the law requires reporting.

It's your choice: It is your choice to be part of this study. Choosing not to participate will not affect the support you receive from the Kids First Family Centre. You may

choose not to answer a question. You may stop being in the study at any time. You may ask questions at any time.

Reimbursement of expenses: You will be given a $10 gift card for a group interview, to respect your time in the study.

If you have any questions: You can phone: Sharon Yanicki at 403-332-5233 at the Faculty of Health Science, University of Lethbridge.

Additional contact: If you have concerns about the study you may call the principal investigator (call collect): Dr. Kushner at 0- 780-492-5667 at the Faculty of Nursing, University of Alberta
If you have general questions about the study, you may call the Office of Research Services, University of Lethbridge, [Phone: (403) 329-2747]

Study findings: Do you want a summary of results of the study? If yes, please provide your mailing address to Sharon Yanicki at 403-332-5233 at the Faculty of Health Science, University of Lethbridge.

A final report on the study will be sent to the Kids First Family Centre and filed with the University of Alberta.

Flesch-Kincaid Grade Level: Grade 6.7

Appendix Q. Research Consent Form – Group Interviews –Parent & Grandparent Participants

Title of the Project: Social Inclusion/Exclusion: Low-income Parents Participating in Community Development in Rural Alberta

Principal Investigator: Dr. Kaysi Eastlick Kushner, Faculty of Nursing, University of Alberta

Co-Investigator: Sharon Yanicki, doctoral student, Faculty of Nursing, University of Alberta, Coordinator Public Health Degree & Lecturer, Faculty of Health Sciences, University of Lethbridge,

Part II:	Yes	No
Do you understand that you have been asked to be in a research study?	□	□
Have you read and received a copy of the attached information sheet?	□	□
Do you understand the benefits and risks involved in taking part in this research study?	□	□
Have you had an opportunity to ask questions and discuss this study?	□	□
Do you understand that you are free to withdraw from the study at any time without having to give a reason and without affecting your future participation in Kids First Family Center?	□	□
Has the issue of confidentiality been explained to you?	□	□
Do you understand who will have access to your records, including personally identifiable information?	□	□
This study has explained to me by Sharon Yanicki.	□	□

Part III: Signatures
I agree to take part in this study.

Date: _____

Signature of Research Participant_____

Printed Name: _____

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.
Researcher: _____
Printed Name
*A copy of this consent for must be given to the subject.

Flesch-Kincaid Grade Level: Grade 7.3

Appendix R. Consent Information Sheet - Group Interview – Key Informants

Title of the Project: Social Inclusion/Exclusion: Low-income Parents Participating in Community Development in Rural Alberta

Principal Investigator: Dr. Kaysi Eastlick Kushner, Faculty of Nursing, University of Alberta
Co-Investigator: Sharon Yanicki, Doctoral Student, Faculty of Nursing, University of Alberta, Coordinator Public Health Degree & Lecturer, Faculty of Health Sciences, University of Lethbridge,

Who is invited to participate? Board Members and Staff of the Kids First Family Center are invited to participate in a focus group as part of a research study on social inclusion/exclusion. A focus group will be arranged at a convenient time and location.

Why is this study being done? The purpose of this study is to learn about the ways in which parents with young children, especially those on a low income, come to feel included in the community. Sometimes parents and children may feel left out, or kept out. Sometimes parents may feel welcomed and feel they belong.

What will happen? I will talk with you in a group with other Kids First Family Center Board members and staff. This focus group will take place in a community building in the town of Fort Macleod. The focus group will last about 60 to 90 minutes. The session will be recorded. I will report some early study findings, and I will ask you to share your views in the group.

What are the benefits of the study? What you tell me may be helpful to professionals supporting parents with young children. What you tell me may be helpful to the Kids First Family Centre in findings ways to support parents and children to take part in the community.

Are there any risks? The only risk to you is being uncomfortable or upset about what you tell me. If there are things that are upsetting you during the interview, I will find someone for you to talk to. You will be provided with some suggested places to ask for help, where you can speak to a counselor, nurse or doctor.

Will my privacy be kept? I will keep your name and what you say or do private. A code will be used on all study materials. I will take notes during the interviews. Our talks will be recorded. Only the research team, the transcriber and I will know what you said. The transcriber will sign an oath to keep what you said private. You will not be named in any reports or talks about this study. The study data will be kept for at least five years after the study is done. The study data may be used again in another study. The researchers will first get approval from an ethics board to make sure that data are used properly. All information will be held private except when professional codes of ethics or the law requires reporting.

It's your choice: It is your choice to be part of this study. You may choose not to answer a question. You may stop being in the study at any time. You may ask questions at any time.
Choosing not to participate in this study will not affect your role with the Kids First Family Centre.

If you have any questions about the study call Sharon Yanicki at 403-332-5233.
Alternate Contacts: If you have concerns about the study, you can call Dr. Kaysi Kushner collect at 0-780-492-5667 at the University of Alberta.
If you have questions about your rights as a participant in this research, you can call: the University of Alberta Research Ethics Office at 492-2615 or the Office of Research Services, University of Lethbridge at 403-329-2747 or Email: research.services@uleth.ca.

Study findings: Would you like a summary of the findings of the study? Contact Sharon Yanicki at 403-332-5233 to receive a copy. A final study report will be sent to the Kids First Family Center. The study report will also be filed with the University of Alberta.

Flesch-Kincaid Grade Level: Grade 7.8

Appendix S. Research Consent Form – Group Interviews – Key Informants

Title of the Project: Social Inclusion/Exclusion: Low-income Parents Participating in Community Development in Rural Alberta

Principal Investigator: Dr. Kaysi Eastlick Kushner, Faculty of Nursing, University of Alberta
Co-Investigator: Sharon Yanicki, doctoral student, Faculty of Nursing, University of Alberta, Coordinator Public Health Degree & Lecturer, Faculty of Health Sciences, University of Lethbridge,

Part II:	Yes	No
Do you understand that you have been asked to be in a research study?	□	□
Have you read and received a copy of the attached information sheet?	□	□
Do you understand the benefits and risks involved in taking part in this research study?	□	□
Have you had an opportunity to ask questions and discuss this study?	□	□
Do you understand that you are free to withdraw from the study at any time without having to give a reason and without affecting your future participation in Kids First Family Center?	□	□
Has the issue of confidentiality been explained to you?	□	□
Do you understand who will have access to your records, including personally identifiable information?	□	□
This study has explained to me by Sharon Yanicki.	□	□

Part III: Signatures
I agree to take part in this study.

Date: _____

Signature of Research Participant_____

Printed Name: _____

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Researcher: _____

Printed Name: _____
*A copy of this consent for must be given to the subject.

Flesch-Kincaid Grade Level: Grade 7.3

Appendix T. Parent & Grandparent Group Interview Guide

Title of Project: Social Inclusion/Exclusion: Low-income Parents Participating in Community Development in Rural Alberta

Thank you for agreeing to take part in a group discussion as part of a research study. I am conducting this study in conjunction with the Kids First Family Center.

Sometimes parents with young children may face challenges in taking part in community activities. They may feel left out, or kept out. At other times it may be easier to participate. Some communities have a wide variety of activities for parents and children while other communities have fewer opportunities.

1. What has made it easier or harder for you take part in:
   a. the programs offered by the Kids First Family Center
   b. other programs that interest you in Fort Macleod?

Many parents or grandparents said that they there were programs and activities for adults and children to take part in in Fort Macleod. Yet, sometimes there were still some barriers. I'm going to describe some of the themes that parents and grandparent identified.

2. Please comment and share your ideas about these themes.
   a. How does this fit with your experiences?
   b. Can you give some examples?

Themes: Theme 1: Relational factors (How people act and relate to you.)
Supports (for participation): Being invited, knowing people, and participants were friendly and welcoming
Barriers (to participation): Being new, having a negative experience while growing up, or having a negative experience for your child/grandchild

Theme 2: Organizational factors (Programs offered and how they are organized):
Supports: Hearing about it by word of mouth, a regular schedule, a good time, free programs and childcare, and staff invited me to take part or to help out
Barriers: The time or location of programs

Theme 3: Internal factors (How you feel about taking part):
Supports: Feeling comfortable taking part in a group or a community event, and feeling welcome
Barriers: Feeling shy, different, or worried about being judged

Theme 4: Structural factors (Resources and supports that help you take part):
Supports: Someone to go with, getting a ride, events and activities available that you or your children want to attend
Barriers: No transportation

Some parents suggested that they enjoyed taking their children to programs that matched their cultural values about parenting and raising children.

3. How well do the programs offered in Fort Macleod match with your values and your culture?
   c. Can you describe some of your experiences where there was a good fit?
   d. Can you describe an experience where there wasn't a good fit?

Some preschool programs required parents to take a turn volunteering. For some people this was a positive experience while others found it hard to juggle the time commitment with their young children.

4. How important do you think it is for parents to be involved through volunteering in a program?

Some parents and grandparents described planning to volunteer to help the KFFC with different activities. Some parents described feeling valued when they were invited to contribute in a program activity or lead an activity.

5. How important is it for parents to be invited to contribute to program activities or make decisions about the program?

6. What would you like to see? Do you think parents should be more involved in planning for the activities rather than just coming and cooking?

Some parents described the importance of programs that provide subsidies that made activities more affordable for their children to take part. A few parents described experiences where they felt uncomfortable with how their children were being treated by other children (bullying) or adults (being mean).

7. Would you say that these factors have influenced your ability or your children's ability to participate and feel part of the community?

While parents/grandparents generally felt that they and their children could take part in activities, their feelings of being included in the community varied. Some parents /grandparent took part in only a few activities and still felt uncomfortable attending community events (Permanent Strangers). Some parents were exploring meeting new people and joining groups. Some parents feel like they belonged in the community and feeling took part.

8. How do you feel about participating in the community?

9. What helps you to feel you belong in a group or to a community?

Appendix U. Key Informants Group Interview Guide

Title of Project: Social Inclusion/Exclusion: Low-income Parents Participating in Community Development in Rural Alberta

You will be invited to provide feedback on early study findings and themes. Many parents and grandparents reported that they were able to take part in program and activities in Fort Macleod. Both supports for participation and barriers were identified. A few additional questions were circulated to you by email for group discussion.

Please comment and share your ideas after I read each theme.

1. How important are each of these factors in the participation of low-income and Aboriginal parents, grandparents, and children/grandchildren?

2. How does this fit with your experience [with the Family Centre's programs and the activities offered with partner agencies]?

Theme 1: Relational Factors (How people act and relate to each other)
Supports (for participation): Being invited, knowing people; friendly & welcoming behaviour (participants)
Barriers (to participation): Being new, negative past experiences while growing up, or a negative experience as a child

Theme 2: Organizational Factors (The programs offered and how they are organized)
Supports: Hearing about programs through word of mouth, a regular schedule, a good time (of day), free programs and childcare, and being invited to participate or to help out
Barriers: The time or location of programs

Theme 3: Internal Factors (How people feel about taking part)
Supports: feeling comfortable taking part in a group or a community event, and feeling welcome
Barriers: feeling shy, worrying about being judged, feeling different or left out, or feeling uncomfortable in a larger group.

Theme 4: Structural Factors (The resources and community factors influencing participation)
Supports: Someone to go with, getting a ride, events and activities available in the community that parents/grandparent and children want to attend
Barriers: No transportation

[Culture, Values & Parenting]

- Some parents suggested that they enjoyed taking their children to programs that matched their culture and values about parenting and childrearing.

- Traditional parenting practices and First Nations values were explored with the Study Advisory Committee (SAC). Three elders on the SAC described traditional parenting practices and values and the negative impact of residential school on parenting practices.

3. What are the values that guide the Family Centre programs and activities?

[Registered Charity Status, Volunteering & Community Development Strategies]

- Some preschool programs require parents to take a turn volunteering.
- Some parents and grandparents described volunteering or planning to volunteer.
- Several participants described thinking about how they might contribute to Family Centre programs or the community.
- Some participants described sharing program resources with their low-income neighbours. For example: one low-income parent described making soup and sharing it with a few low-income neighbors. She also described sharing recipes from the Community Kitchen with her neighbours.
- Community development strategies may include supporting participants in taking leadership roles, designing programs or volunteering.

4. Has gaining registered charity status had any impact on Family Centre programs and the strategies used?

5. Are community development and empowerment strategies still important?

[Social Advocacy & Media Coverage]

Local media coverage was tracked during the Family Centre during the study period.

- Family Centre articles on social inclusion regularly appeared in the paper in the year prior to the start of the study, but declined during the study period.
- A Family Centre sponsored Youth Social Inclusion Initiative successfully lobbied town council to address racism. A few articles on this youth-led initiative appeared in the paper.

6. Please describe the focus of Family Centre media coverage. What do you speak to the media about now that you are a registered charity?