Analyzing the State of Community Health Nursing
Advancing From Deficit to Strengths-Based Practice Using Appreciative Inquiry

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In this article we critically analyze the disconnect between much of the contemporary discourse and practice in Canadian community health nursing (CHN) that has contributed to the slow progress of strengths-based, health-promoting nursing practice. Appreciative inquiry philosophy and methods are introduced as a bridge to traverse this disciplinary gap. Two exemplars show how appreciative, strengths-based CHN research and action can move policies and programs toward more socially just practices congruent with CHN values. Exciting potential for nursing knowledge may arise from incorporating more strengths-based approaches into practice, education, policy, and research. Key words: activism, adolescents, appreciative inquiry, community health nursing, First Nations, health promotion, primary healthcare, social justice, strengths-based

COMMUNITY HEALTH NURSING (CHN) encompasses a wide range of nursing practices and settings, linked through common beliefs, values, and a focus on the promotion and protection of community health. Community health nurses promote health and make decisions that build on the capacity inherent in individuals and communities described by leaders in the field of health promotion as one of the most important health promotion approaches. However, a deficit orientation (eg, the individual or community is a “problem to be fixed” by an expert) visible in some CHN practices is at odds with the values, ethics, and philosophical base of CHN capacity building orientation to practice. Social justice is an important component of health promotion discourse, underlying CHN values of empowerment, social equity, the emphasis on the social determinants of health, and the concept of citizen participation as essential to PHC. Defined as one of...
the most important goals of social progress, social justice is an important principle underlying many CHN practices. Social justice often focuses on the health of populations and situates the determinants of health as societal in nature.4 The strengths-based orientation of a health-promoting process incorporating social justice is evident when it provides "a sense of control and empowerment and... a strengthening of the client's potential."5(p111)

Strengths-based, asset-oriented, and health-promoting theories and high-level policy frameworks have had limited implementation in front-line policies and programs driving much of CHN practice in Canada. A deficit orientation to problem solving is identified as the root of the disconnect between these values and principles5 and many deficit-oriented programs and policies shaping CHN practice.

In this article, we outline historical development of strengths-based health-promoting practice. Development of community health nursing as a discipline is described, and principles and standards are outlined. Community health nursing standards for practice in Canada are highlighted as an example of a contemporary framework for strengths-based, health-promoting CHN practice grounded in social justice. Appreciative inquiry is introduced as a philosophy and method to bridge the gap between the deficit orientation still embedded in some community health programs and practice, and contemporary standards and principles in CHN. Two examples of CHN research (1 with an Aboriginal community and 1 with adolescents) illustrate how appreciative, strengths-based approaches have achieved the social justice aims that are advocated in contemporary CHN discourse. The examples demonstrate how barriers and challenges in current societal contexts can be overcome, and actions can be taken to uncover and transform inequitable value structures underlying everyday CHN practices, including oppressive power relationships and language, which limit and constrain citizen action. These examples of participatory, appreciative, and multilevel CHN approaches to transforming institutional norms that may constrain health illustrate the potential for appreciative processes to redress the disconnect between values and practices in CHN practice, demonstrating CHN potential to contribute to more just health and social conditions. The article concludes with implications and recommendations for future directions in nursing knowledge development and CHN education, research, practice, and policy.

HISTORICAL DEVELOPMENT OF STRENGTHS-BASED HEALTH-PROMOTING DISCOURSE AND PRACTICE

Health promotion gained international recognition with the Ottawa Charter in 1986, over 20 years ago. The Ottawa Charter outlines 5 levels for promoting health consistent with strengths-based, social justice-focused action: (1) building public health policy, (2) creating supportive environments, (3) strengthening community action, (4) developing personal skills, and (5) reorienting the health system.6 In Canada, the Achieving Health for all Framework7 catalyzed the implementation of a proliferation of programs and policies. The framework clearly identified reducing inequities, increasing the prevention effort, and enhancing people's ability to cope as key challenges. A strengths-based health promotion approach was evident in the mechanisms identified: self-care or the decisions and actions individuals take in the interest of their own health; mutual aid or the actions people take to help each other cope; and healthy environments or the creation of conditions and surroundings conducive to health. Nurses were an integral part of championing and supporting ensuing programs such as Healthy Communities and Healthy Schools. They contributed to the development of healthy public policy such as seat belt and bicycle helmet legislation and were instrumental in initiating programs focused on enhancing self-care and mutual aide, such as Nobody's Perfect and the Canadian
Prenatal Nutrition Program. These efforts positioned Canada as an international leader in thought and action toward modification of social, physical, and policy environments to support peoples’ efforts to be healthier, rather than changing problematic features of people themselves. Health-promoting nursing theory and practice developed in discourse and theory and underpinned many undergraduate nursing curricula across the country (ie, Dalhousie University School of Nursing, McGill School of Nursing, the Collaborative Nursing Program of British Columbia).

**CHN Principles and standards**

Community health nursing is based on centuries of caring, advocacy, and public health action emerging as a nursing specialty in the 19th century with the groundbreaking work of Florence Nightingale and Lillian Wald. Community health nurses focus on health promotion and the health of individuals, families, groups, communities, and populations. Central to CHN practice, “health promotion is a mediating strategy between people and their environments—a positive, dynamic, empowering, and unifying concept that is based in the socio-environmental approach to health.” Values central to CHN include caring, empowerment, honoring different ways of knowing, social justice, equity, and respect. Primary healthcare contributed to a more ecologically oriented view of health evident in the Ottawa Charter and has been strongly endorsed by community health nurses in Canada and internationally. The principles of PHC include public participation, intersectoral cooperation, health promotion, accessibility, and use of appropriate technology. These principles have been endorsed by the Canadian Nurses Association (CNA) as essential for nursing practice to enable people to lead socially and economically productive lives.

Community health nursing practice focuses on population health promotion in a variety of settings where people live, work, play, and worship, such as public health units, schools, homes, churches, community health centers, and community agencies (ie, Street Health), and with diverse partners to meet the health needs of specific populations. These areas of CHN practice emphasize “community health promotion and community development, [where] the respect for persons is extended to respect for their experience as knowledge, and their abilities and capacities as community members to contribute to decision-making and planning at the community level.”

In Canada, standards of practice were developed to assist in defining the scope and depth of CHN practice and to lay the foundation for the development of CHN as a certifiable specialty by the CNA. Articulating standards for practice may contribute to clarifying nursing and public understandings of CHN potential contribution to societal health.

**Identifying the disconnect**

However, programs and policies that direct much of nursing practice continue to promulgate deficit-oriented values and practices that are at odds with these published professional disciplinary documents and discourse. The standards, therefore, may be difficult to emulate. A deficit orientation in CHN practice is a significant barrier to practice congruent with our stated values, ethics, and philosophy. Deficit models inhibit recognizing and working with a community’s strengths. Deficit-oriented language that is deeply embedded in nursing and healthcare discourse constrains CHN from fully exploring exciting possibilities for health-promoting practice with communities. Despite development of a body of knowledge in strengths-based, asset-oriented, capacity-building health promotion practice, use of a deficit orientation persists in many population-focused CHN roles and environments. There appears to be a lack of knowledge and education regarding design and implementation of strengths-based policy and programs that promote the health of communities. Incorporating more strengths-based
language and policy may be a catalyst for new community health-promoting partnerships at a grassroots level.

One explanation may be the legacy of deficit orientation in nursing philosophy, theory, and practice, arising from our professional socialization. Professional socialization starts with one’s education and continues in the practice environment, strongly influenced by societal and cultural norms, values, beliefs, and discourse about people. For example, understandings of populations’ health needs often arise from deficit discourses reflected in descriptors such as “vulnerable,” “at-risk,” or “high-needs.” We argue that deficit-based language highlights the perceived incapabilities of the targeted population, leading to prescriptive, expert-driven approaches to health promotion, minimizing opportunities to partner with communities to effect health-promoting change they are interested in.

Nurses have a responsibility to challenge the deficit orientation at multiple levels (from individual practice to broader social action). Needed are a shift in paradigm views; awareness and motivation for congruent competency development; and openings for more genuine partnerships with people to effect health-promoting changes in their lives and their communities. A richer, more textured understanding of people comes into view when we shift from solely a deficit orientation to understanding, valuing, and incorporating peoples’ strengths. Appreciative inquiry has strong potential for moving social justice mandates and the Canadian CHN standards of practice forward.

APPRECIATIVE INQUIRY: BRIDGING THE GAP

Appreciative inquiry (AI) has been described as a large system change philosophy, a positive mode of action research that dislodges vocabularies of deficit and liberates the potential of communities, a new alternative for social action, an innovative process of capacity building, and a tool of organizational and community development that focuses on learning from success. Watkins and Cooperrider state AI is a worldview, a belief that organizations are affirmative systems, a theory, and a mindset. Underlying AI are 7 principles (constructionist, simultaneity, poetic, anticipatory, positive, heliotropic, and generative principles), which inform its theory of change. Consequently, AI may facilitate ethical CHN practice through promoting action consistent with strengths-based community values.

The appreciative philosophy underpinning the potential of strengths-based approaches to CHN practice offers a language and a way of engaging in practice that can transcend deeply rooted, sometimes unjust societal institutions that limit the health-promoting potential of CHN practice. Appreciative inquiry provides a language and has articulated how and why to use a strengths-based approach at individual, organizational, and systems levels. Appreciative inquiry is a philosophy and method of change popular in the organizational development literature but its entrance into the nursing and healthcare literature so far has consisted mainly of applications on an organizational level in acute care contexts. Appreciative inquiry is not visible in the published CHN, health promotion practice, or research literature. However, AI is complementary to CHN practice and is a new community development method that focuses on community strengths.

Strengths-focused work may be a building block to creating further strengths. Problems may be handled in a way that is strengths building rather than problem fixing and through this process empowerment may occur. Appreciative inquiry is therefore a different way to approach a felt need or problem in nursing. Seeking constructive ways to operate together in harmony so that the strengths of everyone are used to the benefit of all is a superior model of health promotion. Providing positive, strengths-building environments in which change may occur is one way of using AI as a health-promoting
route to achieve the CHN goal of building community capacity and realizing social justice. For example, conversation with a community that wishes to address a health issue can start with an exploration of the community’s preexisting assets or strengths. Transferable strengths can be identified and used as building blocks to create further dialogue, create a version of the preferable future, and mobilize energy for change.

Theoretical fit between health promotion and appreciative inquiry

In AI, all people have the opportunity to tell their stories, feel they are listened to, and their ideas are valued. This is both a health-promoting and empowering strategy, as AI’s goal is egalitarian participation of members throughout an organization to ensure ownership of ensuing plans. Everyone’s participatory voice is established at the beginning of the process, engendering a model of sharing and listening in a deeply focused way and quickly generating a deep sense of connection among participants. In AI there is an underpinning philosophy that if people become inspired and excited talking about something, they will gain energy toward action. Questions in AI are deliberately focused to draw out the essential goodness of the system. The act of questioning becomes an intervention that may precipitate change.31

As one of the principles underlying AI, social constructionism suggests that social and psychological realities are products open to continuous reconstruction through conversation between a nurse and the community. In an AI process, the obvious is questioned to deepen understanding and avoid superficial explanations.32 Therefore, even when problems have been identified, there is a role for identifying and building upon positive practices.26 For example, through a philosophical shift and altered language, AI has been used to change the inner dialogue of a school from problem-oriented, deficit discourse to strength-oriented, affirmative discourse.33

CLOSING THE GAP BETWEEN DISCOURSE AND PRACTICE

Two areas of significant public health investment are maternal child health nursing and school health. Our examples in each of these areas demonstrate the transformative potential of appreciative strengths-based approaches to CHN research and action. The first example of a First Nations nursing organization in rural British Columbia, Canada, illustrates how use of a strengths-based approach transformed systems-level policy, programs, and documentation systems in maternal child CHN. In the second example, CHN research using AI to partner with adolescents and staff in an urban high school in Alberta, Canada, challenged a deficit orientation about adolescent capabilities and resulted in a policy review by the Board of Education.

Example 1: Transforming nursing care in First Nations communities

The nursing department of the Nuu-Chah-Nulth Tribal Council is part of a health and community service organization governed by a tribal council with transferred authority for health and development of its 14-member First Nations. Drawn from participatory case study research that has been described elsewhere,34 we briefly outline here the transformation process of this small nursing organization from a deficit-oriented approach to a strengths-based approach to partnering with First Nations communities to work on individual, family, and community priorities. Quotes are from research participants.

The transformative process started with a growing awareness that current conditions and practices were unsatisfactory. Nurses noticed that “things didn’t feel right” in their community practice and began to look deeper at their own practices and resulting community responses. As one nurse described it:

I can remember saying to myself, “I don’t know if I’d want somebody coming here and not really even figuring out what I know . . . somebody coming and having a group and I would only be there
because I’d have been told to be here.” I asked myself first, “would I like this?”. And the other [prompts] were the nonverbals, like people not really participating.

Once nurses developed a critical consciousness of the need, or a desire to change, they took steps to understand and appreciate lived experience, historical context, and root causes of health issues in the community. To support their learning and change, they reached out to resources in the community such as Elders or spokespeople.

So, the idea was ... here we are working within a world that is so dominated with cultural priorities defined by the people and the leadership in the community, so we have to be watchful not to come and impose something from the outside. On the other hand, there is a real tension and dynamic between the regulations you have to uphold as a professional.

As their understanding deepened, nurses described feeling an incredible amount of conflict and tension between their accountability to the community, their employer, and their professional standards of practice. During this uncomfortable time of reflecting on and questioning their practice, nurses were fortunate to be supported by a dynamic nursing leader who encouraged them to reach out to each other and their communities with their questions and concerns about the fit of the programs with communities’ priorities, needs, and capacities. They received organizational and peer support for their willingness to change and their efforts to learn new competencies commensurate with CHN values. Nurses and community members alike felt comfortable reaching out for help with their questions and struggles in an environment of respect for persons and their inner strengths, and respect for cultural knowledge and the role of Elders.

The transformation process took several years, but once a new approach had been developed, the group was motivated to undertake a systematic process of organizational change to transform CHN practice to fit with the community values. New, focused priorities unfolded and over the years a mutual process of colearning and cocreation transformed CHN practices and relationships with communities. The process itself required that nurses and community members develop the competencies for mutual understanding, respect, and partnership. For example, providers developed a deeper awareness and understanding of traditional practices and community members’ wishes to integrate traditional culture into healthcare. Community members developed a deeper appreciation of nurses’ potential contribution to their goals and dreams and understanding how the partnership could be implemented within their governance and administrative structures and systems.

A new CHN framework was collaboratively constructed using a variety of approaches, starting with the formation of a working group comprised of nurses, representatives from every community in the tribal council, health advisory committee of the tribal council, communities, and Elders. The multi-stakeholder group’s open-ended discussions provided opportunities for people to talk about what health meant to them, the role of health workers, discussion about different programs, and the needs of different populations (ie, seniors or youth). Discussion facilitation was provided by outside facilitators, local Elders, and organizational leaders. The meetings were widely attended by, and input was gathered from staff, community members, and leaders of the tribal council. This input was gathered into themes, which were taken to cultural meetings. The cultural meetings included representatives from all 14 First Nation communities and were held to ensure that the content and values that were developed were congruent and in keeping with local and traditional knowledge, values, and beliefs. The results were then brought to meetings in each of the 3 regions governed by the tribal council. Input from the community forums and cultural and regional meetings was then synthesized by a smaller working committee, with nursing theory and practice. Finally, the nursing practice consultant of the
professional association became involved and helped to integrate the provincial nursing standards into the culturally based framework. The end result of the process was a written framework and philosophy guiding CHN practice with the Nu-Chah-Nuulth communities. The framework was symbolically illustrated with a logo that described nursing practice based on the language and images grounded in local values, beliefs, and customs.

The new framework resolved conflicts nurses had previously experienced trying to honor and respect the different “codes” directing their practice. The framework brought some sense and commonality to the different layers and pressures, assisted in the process of making practice more uniform across communities and individual nurses, and helped nurses see their work in the context of broader community economic and social development. Nurses now had a way of talking about their work as integral to that of the broader community and organization. Fundamentally, the framework solved the problem of how to integrate the gaps and tensions between different worldviews, values, and knowledge systems. This improved bilateral communication and resulted in more effective delivery of nursing services that were readily accepted and used by the populace.

As one nurse described, the framework formalized the transformation of the philosophy and practice of nursing:

the framework [illustrates] our philosophy of nursing. Like how we want to work as nurses in the community by bringing in the strengths of the community and what’s important for the community.

Once the framework was developed, nurses realized that they needed to change the charting and other organizational infrastructure to reinforce the practice.

So we have the visual framework … that was really nice but then we had this medical model charting. So like we’re trying to do this traditional holistic nursing that really values the culture and yet all of our charting was medical model that totally didn’t fit. … You know so you couldn’t really practice your nursing as you wanted to. … So we had to develop new charting systems.

The new charting approach, the “Mothers Story,” involves the whole family. It directs the nurse to explore, reinforce, and affirm the family’s primary role in the baby’s well-being. It also reinforces parent-infant attachment and emphasizes the importance of the baby’s and families’ cultural identity. Pivotal to the Mother’s Story, the hopes and dreams question sets up the provider to listen, empower, and facilitate while making space for and respecting clients’ self-determined process. The Mother’s Story supports nurses to recognize and organize their care around clients’ assets and to acknowledge and build on their strengths. The interactions focus on building realistic, incremental achievable goal setting skills.

The impact of the new approach has been favorable and strongly endorsed by both nurses and community members. The views of the nurses are reflected in this comment:

[Previously] people were probably … you know, at a later stage of pregnancy, so they came because so and so said they should come … and so it was an obligation, more or less, the nurse was there so you should see the nurse. So over the years, that’s grown to, “I want to get pregnant. How can we have a healthy pregnancy?” And so that’s what I’ve seen in ten years and I think it’s phenomenal.

Discussion

The work of the nursing program illustrates a systematic approach to transforming relationships between health services (organizations and providers) and Aboriginal communities (people). Nurses questioned and deconstructed the values, beliefs, and assumptions underlying health services organizations and relationships. It was a dynamic, relational, creative, generative process. Critical attributes of the process were as follows.

1. Respect—a critically reflexive, historically and contextually situated understanding of who people are, how they choose to define themselves, but based in a broader deeper critically reflexive understanding of power
relations in society: ideological, values, structures, and how they shape attitudes and behavior. This understanding is necessary for a real, genuine, heart-felt, connected respect for persons and their lived experience. Respect for peoples entailed respect for their traditional values, beliefs, knowledge, and practices and its place in their lives, situated within an appreciation of the “why.”

2. A partnership model of development, which supports, recognizes, and facilitates co-learning and self-determined processes for all involved.

3. A transformative agenda that balances capacity building with health services delivery. A solely health service delivery agenda implicitly accepts the status quo. A transformative, appreciative health-promoting agenda puts capacity building on its list of priorities for resource allocation and action and sustains hope for the future. Lags between phases or pieces of development such as performance measurement may create some discomfort as performance on old priorities suffers because energy and resources are being directed to capacity building. However in the longer term, with increasing community capacity and re-alignment of performance measurement systems to fit with priorities and outcomes identified by the partnership, the rate of performance gains will accelerate.

Suggestions for CHN practice include developing the competencies for integrating into practice experiential and embodied knowledge. This means that as frontline nurses, administrators, leaders, and researchers we need to be prepared to delve into our lived experiences and examine how our values and assumptions have been shaped by taken-for-granted ideologies. Nurses must engage in personal reflection and growth, which can be difficult and has not always been part of nursing professional’s education and socialization. However, to develop genuine relationships with communities and clients and expect them to do their own personal work, nurses must develop an understanding of how their own lived experiences have been shaped by taken-for-granted societal values and ideologies. The complex and personal nature of this kind of practice is not well understood within mainstream health service organizations. Therefore, outside support, recognition, and acknowledgment of the challenging work and accomplishments may be scanty at times. Nurses need to be supported by their employing organization and encouraged to use outside resources to support them in sustaining hope and in doing emotionally charged work, such as counseling and alternative healing therapies.

Example 2: School-based health promotion using AI

A school-based participatory action research (PAR) project explored the possibilities for nursing partnerships with marginalized adolescents for mental health promotion. In this project, adolescents were coresearchers working in an egalitarian partnership with teachers and nurses to collect and analyze positive stories of students who had made a difference in their school. Appreciative inquiry was used both as a philosophical strengths-based approach guiding this research and as a method to collect interview data. An in-depth description of the research is the subject of another article.

As PAR is already considered to be an empowering means of working with marginalized populations to address problems, what did AI contribute to PAR? Appreciative inquiry created a deliberate focus on the strengths of this population, unlike the norm in a North American conceptualization of adolescents. A normalized conceptualization of adolescents as problems to be fixed results in perpetuating a culture of hegemony and disempowerment for adolescents. Adolescents may not be viewed as potential partners in health promotion if mainstream culture negates their capabilities; they risk becoming subjects of
Appreciative inquiry was used in this research as a means to address the issue of oppression through its focus on strengths and positive possibilities. It was proposed as 1 way to “rupture the status quo” (professional control of the community’s health) that Drevdahl38 suggested nursing must seek to improve its interventions with communities, and provided a context for hope to evolve.

Hope has been described as an essential ingredient for health and well-being in the field of mental health.39 If AI promotes vocabularies of hope, new alternatives for elevating the human spirit will occur40 and contribute to adolescent mental health promotion. Positive energy arises from unleashing the power of people’s dreams33 where hope resides. “The liberation of power creates a self-perpetuating momentum for positive change.”33(p235) Energy to continue to create positive change arises from hope and positive experiences in AI.

In this PAR project, it had been 1 student’s goal to make the interview process a positive one for his interviewee and him; thus, the interview could be a mental health-promoting process by itself. In later discussions about the impact the research process had on them, students emphasized the mental health promotion aspect to the research.

I felt like we’re getting something done that makes people feel good, and it made me feel good too... As long as you have a group of people who actually care about a subject... if you give them the opportunity to partake in it like we had here with the whole equality, ... a kid could talk intelligently about a subject as long as they know that they’ll be heard and it’s something that they’re actually passionate about.

Appreciative inquiry is uniquely suited for social innovation in action research,41 and it created openings for action possibilities to emerge in our project. Identifying and working with student strengths throughout the research process facilitated student action at the end of the project. For example, the coresearchers chose to deliver an oral presentation of the project findings to the local board of education. This presentation spurred the board trustees to consider policy options to give high school students more voice in educational decision making.

Discussion

The valuable outcome of the school research project was the enthusiastic adolescent interest in health promotion approaches to social change and understanding their involvement was meaningful. People’s interest in topics is engendered by the ways in which professionals invite them into conversations about topics of interest and actively engage them in problem solving or searching for opportunities for change. Respect, relationship building, and trust development are key ingredients for mutually beneficial partnerships with communities. For example, when adolescents have experiences where their voices are listened to and acted upon, they experience greater interest in involvement regarding future changes. Energy arises from successful action resulting in change, either internal (ie, in confidence or perceptions of capability) or external change (ie, changing school policies for greater student voice). What is important is that new horizons are opened that create future possibilities for health-promoting change. Appreciative inquiry provided this energy and subsequent hope for health-promoting change.

A key concept for nursing practice arose from a discussion about the horizon changes adults experienced from partnering with adolescents in this strengths-based project. Conversations in PAR are vital to produce collaboration and self-awareness of capabilities and through this process, adults “… learn to relinquish some of their own power and control.”38(p18) Adolescent voices were understood as vital to the group, so they were listened to closely, with openness to search for understanding what they said. A conceptualization of adolescents as citizens with rights may facilitate this horizon change. Potential future directions for CHN practice and research might occur as one student suggested,
by “getting kids involved more in the process of what’s going on in the school, and listening to their ideas and giving them some ability and a voice.” A reciprocal teaching and learning relationship was present, resulting in mutual consciousness raising, facilitated by AI. Nurses need opportunities to create new stories about adolescent capabilities if they are to improve their practices with adolescents. Opportunities may be facilitated through educational or research support and guidance for nurses and a more visible presence in their schools.

IMPLICATIONS AND RECOMMENDATIONS FOR FUTURE DIRECTIONS

Relevance for nursing practice

A heightened awareness of incongruent, oppressive policies or exclusionary practices would help nurses address policy changes for working with communities that are consistent with the standards of practice, such as promoting health, building individual and community capacity, building relationships, facilitating access and equity, professional responsibility and accountability; and the PHC principle of public participation.1,43

There is also a place for activism in nursing practice, following the declared importance of nursing involvement in government policy formulation and the design and delivery of healthcare services43 and the Community Health Nurses Association of Canada statement that nurses are situated within broader social, political, and economic contexts that require nurses “... to question and move beyond the status quo and structures of domination in society that affect the health of persons and communities.”44(p5) To be concerned with health is to be concerned with the social context, and through this process, nursing is a political act.44 Respect for people may translate in these examples to advocating for greater voice for adolescents or aboriginal peoples, requiring nurses to become political activists.44 Lobbying key decision makers to effect policy changes to address the oppression of groups of people is one possible route for health-promoting changes that involve individuals more fully as citizens in society. Acting on a political level has been described as a natural extension of nursing caring.44

Although political activism may represent a valuable nursing activity that promotes health and encourages positive societal change, nurses do not often consider themselves politically competent and do not pursue political activism.45 Nurses would benefit from educational efforts to instill political confidence and thereby strengthen the profession’s collective power and influence.45 For example, nurses may be uniquely positioned to involve adolescents and school personnel in the development of effective public health policy through their expertise in working with these populations and abilities to solicit their contributions through existing partnerships.46 Action, in one conceptualization of public health, draws on the values of participation, enablement, empowerment, equity, and social justice that draw citizens into action.46 The essence of community or public health promotion is giving voice or listening to people47 and appreciating their strengths. When nurses have positive relationships with people, they are in a position to work in partnership with communities to support action that is empowering and results in social change.47

Table 1 contrasts deficit versus strengths-based approaches to problem solving in community health. A simplified example to illustrate Table 1 could show a nurse partnering with members of a school community to address a problem. Using an appreciative approach, the nurse might ask the members to share stories or give examples of when the school was functioning at its best. For example (depending on the situation or problem), stories could include instances when students or staff made a difference in the lives of others, or developed new health programs or strategies that were well received by students. Strengths could be extrapolated from the stories and used for subsequent partnering with the school community to envision the potential that could be tapped into, to assist with their new challenge. Planning
Table 1. Comparison of traditional and strengths-based problem-solving approaches

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<tr>
<th>Traditional problem-solving steps</th>
<th>Strengths-based appreciative approach</th>
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<tr>
<td>1. “Felt need” Identification of problem(^{31(23)})</td>
<td>1. Appreciating and valuing the best of what exists in the present(^{31})</td>
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<td>2. Analysis of causes(^{31(23)})</td>
<td>2. Envisioning the potential based on existing strengths</td>
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<td>3. Analysis of possible solutions(^{31(23)})</td>
<td>3. Dialoguing what could be done</td>
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<td>4. Action planning (treatment)(^{31(24)})</td>
<td>Underlying assumptions:</td>
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<td>Underlying assumptions:</td>
<td>The community can address its problems</td>
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<td>The community is a problem to be fixed</td>
<td>Community knows best</td>
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Conversations could mobilize the positive energy created in the first 2 steps, leading to an alternative problem-solving approach using the community’s strengths. Appreciative inquiry philosophy and methods are, therefore, introduced as practical and effective ways of crossing the philosophy-practice gap in CHN. As a philosophical guide to action, AI shows strong potential for advancing social justice mandates and the CHN standards of practice. Greater use of appreciative, strengths-based approaches in community health programs and policies requires congruent language and methods applied to CHN action toward social justice and more effective health service delivery.

Implications for nursing education

It is time to question nursing student socialization if we wish to “walk the talk” of PHC. Overall, an examination of the philosophical approaches we use in teaching would be helpful—are we unconsciously transmitting only a deficit outlook of “find the problem and fix it” that, while life saving in the emergency department, is out of step in CHN? Can we teach student nurses to look for strengths to build upon, whether in individuals, families, communities, organizations, or systems for healthcare delivery? What is the tone of nursing lectures—are communities or individuals positioned as problems to be solved, or as people with strengths with whom we can partner for health promotion and heighten a community’s efforts to effect changes?

For example, in one of the authors’ CHN theory course, AI was brought into a classroom lecture as an example of a method of engaging in the principles of PHC and standards of practice to promote health. Students were challenged to focus on wellness nursing diagnoses based on a community’s strengths, and through this exercise were invigorated with a new appreciation of the communities they work with. How can such strengths-based approaches to nursing practice be normalized in the curriculum?

Policy implications

Walking the talk of PHC also extends to examining organizational level policies and practices. Policies that direct CHN practice must be examined for their congruence with the standards of practice and principles of PHC. What are the implicit assumptions about individuals, families, or communities underlying practice directions and mandates? Do policies arise from a deficit model? How does this impact nursing practice? How could deficit-based policies and practices evolve into strengths-based policies and practices? Answering these questions will not be an easy task as societal factors, such as generalized beliefs about groups of people, affect policies formulations that drive organizational and individual nursing actions.
Policy manuals could be read with a critical eye looking for assumptions behind the language used to describe populations. To further understandings of potential oppression or marginalization of groups of people, one could ask whether the language of the policy would still be acceptable if it was used to refer to another group of people. Using the example of the school population, more specific policy questions could be asked such as the following: What proportion of adolescent versus adult representation is recommended for school or health committees? What involvement do students have in determining the health needs of their school population?

Are policies reflective of nurses working to full scope of practice? For example, the CNA states that nurses must provide leadership for health promotion in school health. However, many articles on school health do not mention nurses at all or only briefly, as research subjects. There is a gap between where nursing wishes to be positioned and the general perception of nursing’s positioning in health promotion. Nursing’s voice in the literature on school health research is noticeably absent. If nurses wish to be leaders in health promotion, full scope of practice would mean much more visible involvement and voice in health promotion including the areas of research, political advocacy and action, and policy formation.

Implications for research

Further research using strengths-based approaches to partnering with communities will assist in further developing the disciplinary health promotion knowledge so crucial to CHN practice. Further research on the utility of AI is warranted, especially to assess its ability to contribute to moving CHN discourse and practice away from a deficit orientation toward a strengths-based orientation. Coupled with methods to explicate barriers and constraints to nurses’ practice to take action on socially unjust environments and policies, AI could be used to identify and develop more widely promising CHN practices.

Working from within a social justice framework, researchers are encouraged to reconsider who can and should help determine research agendas, namely people most affected by issues within their communities. In addition, researchers must ask themselves: what research designs best suit capacity-building partnerships for nursing? What issues must be addressed to engage in effective partnerships with communities to promote health? What supports do communities need to become involved in health promotion program planning with nurses?

CONCLUSIONS

The focus of this article has been on analyzing the disconnect between the health promotion discourse and a deficit-based practice in CHN. We suggest that there is an incongruency between practice and the values, ethics, and philosophical base of CHN. Appreciative inquiry holds promise for traversing this gap in nursing to provide more socially just health promotion practice with individuals, families, groups, communities, and systems. We believe that exciting potential for nursing knowledge development in health promotion will arise from incorporating more strengths-based approaches, such as AI, in our CHN practice, education, policy, and research.

REFERENCES


