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Placing sexuality in health policies: feminist geographies and public health nursing

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Abstract Despite the increasing public profile of same-sex issues, health policies are often shaped by heteronormative assumptions. The health concerns of lesbian, gay, bisexual, transsexual/transgender, two-spirit, intersex, queer and questioning (LGBTTTIQQ) people are complex and require broadening from an often exclusively sexual health and risk focus to a more holistic approach. In this context, this paper illustrates how a critical feminist geography of health, with its focus on the mutual construction of gender relations, space and place, potentially enhances and extends current understandings of public health policy and practice. Moreover, the use of a policy lens foregrounding gender and other power relations suggests that feminist research and coalitions facilitate participatory processes that address ''the politics of discourse.'' In particular, public health nursing practice can enhance the construction of spaces of resistance that challenge heteronormative discourse through research strategies focused on sexual minority communities' health experiences and their visions for supportive care. In this respect, two strategies consistent with public health priorities to increase knowledge and participate in alliances are described. Ethnographic research with childbearing lesbians demonstrates that attention to institutional dynamics that foster safe spaces can facilitate access to public health services. Public health nurses' involvement in community coalitions can enhance dissemination of community knowledges. The implications for gender inclusive and place-sensitive public health nursing practice include the development of sensitive educators, meaningful educational curriculum and related program planning, explicit policies, community partnerships and political leadership in institutional and research venues.

Keywords Feminist geography · Public health · Lesbian · Nursing · Policy

Introduction

''Undermining one's identity, especially in the context of health damages the very foundations of one's existence'' (Taghavi, 1999, p. 26). Indeed, sexual and gender identity issues are often central in understanding health and well-being for many lesbian, gay, bisexual, transgender/transsexual, intersex,

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Two-Spirited, queer and questioning (LGBTTTIQQ) people.[1,2] Moreover, multiple factors, including race, gender, socio-economic status, age, and their various geographies, intersect to inform how sexual minorities and trans-identified people understand and experience their everyday lives (Van der Meide, 2001).

While a national health policy statement (Gay and Lesbian Medical Association, 2001) addressing LGBT health has informed American health care since it was struck as a companion document to the *Healthy People 2010* policy, no similar policy commitment to LGBT health exists in Canada where the current research is set. Despite the currency of same-sex issues in public discourses and recent legislated gains for same-sex couples related to spousal benefits and other issues, there is limited evidence that broad health policy directives or regional public health programs and services address the holistic health needs of LGBTTTIQQ people. In a Canadian public health context, issues related to sexual identity and gender identity have often been invisible or relegated to a sexual health context and read mainly in terms of ''population risk'' (Duncan et al., 2000; Ryan, Brotman, & Rowe, 2000). Such dynamics occur despite the well-documented evidence that the marginalization of LGBTTTIQQ issues in health and broader social contexts has a significant impact on individuals' capacity to achieve health and well-being (Coalition for Lesbian and Gay Rights in Ontario (CLGRO), 1997; Duncan et al., 2000).

In this context, the purpose of this paper is to use a case study approach to illustrate how Canadian public health nurses used feminist/participatory research and coalition processes as advocacy practices to develop health policies and improve access to care for sexual minority communities. First, we lay out the critical feminist policy lens underpinning this analysis and describe some relevant policy and practice dynamics framing public health environments in Ontario, Canada.[3] In this respect, two strategies consistent with public health priorities to increase knowledge and participate in alliances are described. Whilst ethnographic research with childbearing lesbians demonstrates that attention to institutional dynamics that foster safe spaces can facilitate access to public health services, nurses' participation in institutional–community alliances can enhance social change informed by community-defined knowledges. The discussion that follows demonstrates that a critical feminist geography, with its focus on the mutual construction of gender relations, space, and place (see Bowlby, Lewis, McDowell, & Foord, 1989; McDowell, 1999; Moss, 1993, 2002), facilitates analysis of nursing advocacy practices that address the intersections of sexuality and public health in a policy context. Moreover, it illustrates how public health nursing practice, using explicitly political research processes and coalitions as spaces of resistance, challenge boundaries of institutionally defined and heteronormative discourses of knowledge production. At the same time, such practices facilitate the creation of respectful and relevant services. These findings make visible both the social (discursive) and material aspects of policy processes relevant to enhancing access to care and support further development of a critical feminist geography of health.

Health geography, healthcare practice and feminist analysis

The discipline of health geography has had a long-standing concern with the distributive features of

[1] LGBTTTIQQ: We use this term to describe lesbian, gay, bisexual, transgender and transsexual, intersex, Two-Spirited, queer, and questioning people while acknowledging the shifting meanings and boundaries which limit categorization. The Public Health Alliance coalition recently chose to represent these communities using ''LGBTTTIQQ,'' although terms chosen vary over time within and across groups.

[2] Sexual identity refers to the way that an individual represents her/his sexuality to her/himself and others, (i.e., heterosexual identity, gay/lesbian, bisexual identity). It takes into account sexual orientation: the physical and emotional attraction of someone to persons of the opposite sex, same sex or both sexes (Duncan et al., 2000). Gender identity refers to one's sense of being male or female. For some transgender and/or transsexual people, two categories of male and female insufficiently represent their gender identity. Transgender is often used as an umbrella term to encompass a variety of gender expressions.

[3] Ontario, located in central Canada, has the largest population of the 13 Canadian provinces and territories. This province has a large urban population concentrated in the largely industrial southern metropolitan area near the capital city, Toronto. While residents of most parts of Ontario are largely English-speaking, Toronto and several other urban areas are ethnically and racially diverse. In contrast to many urban, suburban areas or the rural areas of Ontario, only a handful of cities, like Toronto, have visible and well-organized LGBT communities and resources.

disease and disease services, reflected by a significant tradition of studies that focus on modeling and mapping the location, accessibility and utilization of health services often over large geographical areas. Since the mid-1990s however, a shift has occurred with an increasing concern with place, conceptualized as more than just a point, mode or container of human activity, as a complex, symbolic, power-laden and contested cultural phenomenon that affects and reflects human behavior (Kearns, 1993; Kearns & Moon, 2002; Parr, 2004). Indeed, a new generation of health geographers have argued that it is impossible to separate health and healthcare from the places where it is provided and consumed and that concurrently health and place are somewhat co-produced (Kearns, 1993). Moreover, along with a new focus on place has come an increasing interest in healthiness and well-being and a conceptual focus on the body as a central point of investigation (Andrews, Sudwell, & Sparks, 2005; Butler & Parr, 1999; Parr, 2002, 2003; Williams, 1999).

Elsewhere, in mainstream human geography, a growing volume of feminist geographies have studied how gender relations, space, and place are mutually constructed (Pratt, 2000) and have also contributed significantly to debates on sexuality and ''queer space'' (e.g., Valentine, 1993). Most recently, as Dyck (2003) argues, a 'third wave' of feminist geography looks beyond public-private divides in the gendering of place, to fluidities of identities and places including attention to the body and sexuality. At the same time, and often in association with a growing concern for ''the other,'' since the cultural turn of the mid 90s, the study of sexuality and same-sex issues in human geography has blossomed, with studies ranging from gay spaces in cities to dynamics of marginalization in heterosexual spaces (Adler & Brenner, 1992; Massey, 1994; Valentine, 1993). Central to this work is the negotiation of everyday life, a concept that is congruent with critical feminist approaches across disciplines.

As Dyck (2003) notes, unifying the above traditions, a small number of feminist geographies of health have emerged over the last 10 years, emphasizing the gendered nature of health and healthcare. In this respect, major events include a special issue of women's health published in 1995 in *GeoForum*, and a dedicated edited collection on geographies of women's health (Dyck, Lewis, & McIafferty, 2001). Meanwhile, a growing number of articles have found their way into a range of both geographical and health journals (Allison & Harpam, 2002; Chako, 2001; Chouinard, 1999; Davidson, 2001; Dyck, 1998, 1999; Hallman, 1999; Hoy, 2001; Mahon-Daly & Andrews, 2002; Moss, 1997; Moss & Dyck, 2003; Pope, 2001; Tripathi, 2001; Wainwright, 2003; Williams, 2002; Wiles, 2003). Nevertheless, notwithstanding the above contributions, feminist research in health geography is still relatively sparse (Dyck, 2003). Dyck observes, for example, that in 1989 Pearson claimed that medical geography was gender (as well as color) blind (Pearson, 1989). She notes that fourteen years later, the three keynote speakers at the 10th International Medical Geography symposium felt it important to reiterate exactly the same concern (Gatrell, 2003; Kearns, 2003; Rosenberg, 2003), whilst other papers presented at the four day meeting offered very little in the way of feminist analysis.

The exact reasons that health geography has lacked a sustained feminist analysis are not certain, though an interplay of factors is probably responsible. One could claim that, as a sub-discipline, health geography has lagged behind other varieties of human geography in terms of theoretical progress, and that the lack of feminist analysis simply reflects this. However, arguably, this observation does not alone provide an adequate explanation. Instead, one has to consider the history of the subdiscipline. In this regard, it is important to recognize that geographical analysis of health and healthcare originates somewhat outside human geography. As Andrews and Moon (2005a) suggest, it was 18th and 19th physicians, rather than geographers, who first attempted to map the spatial patterning of disease (Barrett, 2000a, 2000b; Brody, Rip, Vinten-Johansen, Pareth, & Rachman, 2000; McLeod, 2000). Even in the twentieth century, when studies of the geography of health and disease developed substantially, they remained a sub-field of medical and health services research, variously named geographic pathology, geomedicine and geographical epidemiology (Andrews & Moon, 2005a). Consequently, by the 1950s when human geographers began to develop a medical geography, they were, in effect, linking with a research tradition institutionally set within 'masculine' medicine.

By the 1970s, when feminist geographers started to impact substantially on human geography, health

geographers were still in the process of 'convincing' medicine and health services research that they, as social scientists, had something unique to add (notably this is reflected by the inclusion of a consultant physician on the early IBG/RGS medical geography study group). This pre-existing location of medical geography within medicine itself, and struggle for recognition, in part explains why medical geography did not keep pace theoretically with other fields of human geography. Moreover, it is not hard to imagine why 'radical' geographers in the 1960s and 1970s, such as feminists, did not find medical geography to be a particularly welcoming or attractive academic environment. Indeed, the tension between being 'contemporary' in a geographical disciplinary sense, and 'relevant' in a medical sense, has existed for some time (Parr, 2004). Even when medical geography eventually underwent its own cultural turn in the mid 1990s (and was repackaged as health geography), there existed much controversy and debate on relevancy and empirical, theoretical and methodological directions (Dorn & Laws, 1994; Kearns, 1993, 1994a, 1994b; Mayer, 1996; Mayer & Meade, 1994; Parr, 1998; Paul, 1994) that to some extent continues to this day (Parr, 2004). Depending on one's theoretical position and background, in this debate, qualitative geographical research on health and place might be regarded as being the most 'progressive' strand of research moving the sub-discipline further away from the shadow of bio-medicine and increasing its critical capacity. Alternatively, however, it might be regarded as an internally-focused and largely self-referential intellectual discourse lacking the ability to inform health policy and practice. Meanwhile, quantitative research on disease and disease services might be regarded as being somewhat subservient to bio-medicine or as a useful informative ally (Andrews, 2006; Kearns & Moon, 2002).

Perhaps surprisingly, a potential solution to these debates has come from an unlikely source. As Andrews (2006) explains, during the last 3 years a number of nurse researchers have started to use geographical theory and perspectives and develop explicit geographies of nursing (Liaskenko, 1994, 1996, 1997, 2001; Malone, 2003; Sandelowski, 2002). As both Andrews (2006) and Andrews and Moon (2005b) suggest, this research is based on an increasing realization that in contemporary health care, new relationship dynamics exist between nurses and patients, which are very much affected by the changing character of places for healthcare (Andrews, Wiles, & Miller, 2004). Moreover, new settings for healthcare (Liaschenko, 1994), the constant transition of traditional settings (Liaschenko, 1996), and interrelated physical, emotional and moral distancing from patients (Liaschenko, 1994; Malone, 2003) all emphasize the contemporary relevance of place. Insofar as the sub-discipline of health geography is concerned, the collective disciplinary message of these nursing studies is that the emergence of postmodern perspectives and qualitative methods does not necessarily have to imply a disengagement with research on disease and medicine, but a revisioned engagement with health care (Andrews, 2006). Indeed, nursing research has been notable for its critical perspective on medicine and, at times, an explicit counter-medical stance. The potential contribution of geographical studies of nursing is therefore to research place, professional and practice issues and patients, and hence to become a professionally focused and practice-based geography of health (Andrews, 2003, 2006).

Nevertheless, despite the novelty and contribution of these nurse geographies, because of their relative infancy, a number of notable gaps remain in this literature. First, the community-focused studies that have been published to date address home care and miss public health practice (Andrews, 2006). One study with its focus on mental health and immigration (Gastaldo, Andrews, & Khanlou, 2004) has implications for a critical public health practice although public health nursing practice is not explicit. Second, notwithstanding a few notable exceptions (Halford & Leonard, 2003; Peter, 2002), for the most part, nurse geographies have lacked feminist analysis. Here then the current study on public health nursing practice contributes, engaging with sexuality and policy issues through a feminist geographical perspective. With these disciplinary issues in mind, we now move on to specifically consider our issue, sexuality and public health nursing in Canada.

Contexualizing lesbian health advocacy in a Canadian public health nursing context

Like the British National Health Service (NHS), Canada's health care system is publicly funded and

administered. Also like the NHS, widespread political and economic reform is occurring, involving cost-cutting measures and rationalization of resources with a focus on efficiency. However, in both countries the scope of potential structural change is limited due to widespread public support for a universal health care scheme based on equitable and accessible care for all and despite an acknowledgement of the considerable challenges this implies (Frey, 2002).

In a public health context, influential public policies based on the World Health Organization (WHO) vision of health have shaped current health directions over the last two decades. In particular, two influential policy documents, *The Ottawa Charter for Health Promotion* (WHO, 1986) and *Health For All* (Epp, 1986) embodied a commitment to creating conditions that address prevention rather than treatment. This entailed a shift from a primary focus on biomedicine, to one that recognized that the social determinants of health such as income and social status, social capital and health services were key considerations (Hamilton & Bhatti, 1996). In order to promote accessible and high quality care for all populations, Canadian health policy analysts—whose practice is informed by this WHO vision of Primary Health Care (PHC)—named health promotion activities, including advocacy, as central to health professional practice in their policy documents. Specifically, they positioned strategies that facilitated public participation, strengthened community health services and contributed to coordination of healthy public policy as integral to reducing the social inequities that hinder the achievement of good health and well-being for both individuals and communities (Epp, 1986).

In today's neoliberal political environment, health promotion and population initiatives are often focused on changing individual lifestyles and behaviors. These activities may be palatable to funders, administrators and practitioners alike, since they may offer short-term measurable outcomes and place the onus on individuals to change (Raphael & Bryant, 2002). Nevertheless, Primary Health Care also moves beyond this focus to include health practice that builds community capacity: ''foster[ing] community competence to identify and meet health needs'' (McMurray, 2003, p. 144). In this view, in addition to working with individuals, practitioners collaboratively work with local communities to define their issues and actions that enhance the possibility of enhancing sustainable social change at the structural level to improve the everyday lives of vulnerable groups. While the PHC philosophy affirms political actions that facilitate community self-determination, in reality, organizational and community constraints (among other factors), shape institutional–community collaborations in which institutions or communities hold significant power and/or ownership of knowledge and decision-making (MacDonnell, 2005). In particular, in 1996, The Canadian Public Health Association (CPHA, 1996), in its *Action Statement for Health Promotion in Canada*, reaffirmed the need to advocate for healthy public policy, strengthen communities and reform health care systems, naming two primary activities: enhancing knowledge base and building stronger alliances.

In spite of social activist voices in health care policy making, and ethical, professional, organizational and legal policy mandates for equitable health services, heteronormative social policies continue to operate in Canada (CLGRO, 1997; Duncan et al., 2000). Onken (1998), for example, identifies dominant discourses of alienation, repression, omission, and stigmatization that influence how and whether sexual minority issues are taken up. Although health agencies may consider that they address LGBTTTIQQ concerns, feedback from communities often paints a sharply different picture (CLGRO 1997; MacDonnell, 2001b). Particular conceptualizations of deservedness create exclusionary visions of care that direct health policies and practices across federal, provincial and local levels (Brodie, 1996; Duncan et al., 2000; Raphael and Bryant 2002).

Even though the list of social determinants of health has expanded over time to include gender and race, explicit attention to sexual identity and gender identity issues has been limited. For the most part, they are implicitly included under the rubric of ''social exclusion'' (Toronto Charter for a Healthy Canada, 2003). Moreover, although large cities like Toronto, Montreal and Vancouver, may offer organized support for diversely positioned members of LGBTTTIQQ communities, such invisibility in policy domains contributes to systematic discrimination reflected by insensitive health or educational environments, gaps in service provision and limited material resources (CLGRO, 1997; Duncan et al.,

2000; MacDonnell, 2005; Ryan et al., 2000; Taghavi, 1999).

In terms of healthcare practice, in general, professional nursing mandates call for the provision of culturally competent care. However, this is often implicitly focused on visible difference related to race/ethnicity with limited attention to deeply embedded institutionalized racialized dynamics (Gustafson, 2002). In prevailing conservative environments, discourses of tolerance and acceptance may frame existing policy processes that also overlook the complexities of institutionalized heterosexism.

Professional imperatives support public health nurses' engagement with politics and policy in order to address the needs of vulnerable populations and to foster the development of healthy communities (Canadian Nurses Association, 2000; Stevens & Hall, 1992). Moreover, nurses' personal critical reflection on professional practice may lead to an understanding of the impact of dominant heterosexist discourses and prompt political action. Nursing research, as it contributes to knowledge production, can also be a political strategy. Although such nursing actions may challenge dominant modes of policy and can influence the development of more inclusive policies, complex power relations also inform nurses' political practice, potential policy clout and strategies used to disseminate knowledges. Indeed, gender dynamics shape the very legitimacy of nurses' political practice that occurs on the ground at the everyday local level rather than in the traditional legislative and electoral spheres (MacDonnell, 2005; Vickers, 1997). As McKeever (1996) notes, ''nurses hold privileged positions in relation to families, but they remain subordinate to those who determine policies, most of whom have backgrounds in business, law, medicine, or public policy'' (p. 5).

At the same time, as members of a female-dominated caring profession, nurses who advocate for sexual minorities challenge nursing norms in which gender-conforming appearance and behaviors are informed by dominant notions of North American, White, middle-class, heterosexual femininity. Indeed, silencing and invisibility mark lesbian health as marginal to everyday nursing practice. For example, disclosure of same-sex status by nurses themselves is discouraged, and implicit workplace policies shape how or whether lesbian issues are visible at any point in a public health nurse's practice setting. This advocacy practice is contested, given the heteronormativity within the profession. While nurses encounter institutional barriers and tensions as they participate as activists in this highly politicized focus, a number also find openings to advocate publicly or more subtly using strategies that include research and collective action (MacDonnell, 2001a, 2005).

Methodology

Feminist ethnographic research

A research study by one of the authors of this policy analysis (MacDonnell, 2001b) provides a good example of critical feminist ethnographic research using a participatory model to critique existing health systems and inform policy. A case study approach was used to examine the educational needs and support of childbearing lesbians in order to enhance access to relevant programs and services in a public health context. Feminist ethnographic research (Reinharz, 1992) and a critical analysis of qualitative data emerging from participant interviews focused on gender and other relations of power that shape actions to enhance lesbians' everyday lives.

Feminist ethics informs the ethnographic study, as well as this policy analysis. We recognize that making explicit our social locations as researchers and analysts is integral to this discussion and shapes the way we name, analyze, and represent the issues. Judith MacDonnell has over two decades of public health nursing experience and became involved with LGBT activism through research, education and policy during the course of this study. She is working from the position of a heterosexually identified nurse ally with high social privilege. This paper discusses a study that was designed and carried out by Judith and its contributions to an analysis of policy-making in a public health context The second author, Gavin Andrews, also has significant privilege as a middle-class writer and advisor.

This research addressing the educational needs of childbearing lesbians emerged through Judith's critical reflection on her own heterosexist practice as a White, middle-class, heterosexually identified public

health nurse and prenatal educator and factors contributing to heterosexism in the professions. Although the academic literature reflected two decades of articles addressing childbearing lesbians, these issues remained virtually invisible in professional education and public health programming (MacDonnell, 2001b; Stevens, 1992).

Judith's research was a descriptive, exploratory study that used purposive convenience sampling and a case study approach to examine one lesbian couple's perceived educational needs for effective prenatal support in order to improve access to meaningful care. As Reinharz (1992) indicates, feminist ethnographic methodology has three goals ''(1) to document the lives and activities of women; (2) to understand the experience of women from their own point of view; and (3) to conceptualize women's behavior as an expression of social contexts'' (p. 51). As an outsider to the lesbian communities, Judith was aware of the need to be accountable to the participants and their communities and how she represented their voices and issues. We have cited several excerpts from the narratives in the findings section, using pseudonyms that the participants chose.

In order to understand how lesbians themselves defined education and support for their childbearing, prenatal and postnatal interviews were completed with one expectant lesbian couple, each coparent and biological mother within their partnership. These professionals in their thirties, residing within a large city in Southern Ontario and with a toddler and another child on the way, were also key informants to the medical and midwifery reproductive health systems. Study questions investigated issues surrounding supportive care, participant understandings of safety, and issues relevant to their everyday lives. In addition, an important component of this study was a joint participant–researcher reflection, in which the researcher and participants, each taking into account their respective social locations and privilege, imagined possibilities for change that would enhance supportive care for diversely situated childbearing lesbians.

Analytic framework: gender as policy lens

During data collection and analysis, an invitational framework (Purkey & Novak, 1996) was helpful to facilitate a comprehensive understanding of issues, since it systematically addresses five indicators of educational environments: the 5 P's of people, places, programs, processes, and policies. With its focus on the dynamics of interactions between individuals and their environments, it was possible to consider the factors contributing to supportive or non-supportive interactions between childbearing lesbians and their providers, as well as those related to larger institutions. According to this model, people, places, programs, processes, and policies mark indicators of inviting or disinviting care. For care to be intentionally inviting, it must be predictable and consistent across the institution. Purkey & Novak (1996) have described consistently and/or consciously nonrespectful settings as ''lethal'' and the Ontario Human Rights Code uses the term ''poisoned environment'' (CLGRO, 1997, p. 123).

A critical feminist lens, with its focus on gender and other social relations of power, informs and is informed by concepts relevant to feminist geographies. Since gender can be considered as both a ''conceptual category and analytical lens'' (Bensimon & Marshall, 1997, p. 2), the use of gender as a policy lens can offer insight into the knowledges constructed in policy contexts and the processes whereby knowledge production occurs. As such, this gender analysis addresses the spaces and places framing policy research, as a form of institutional knowledge production, and the political actors involved in these processes.

In contrast to a more limited view of policy-making, in which policy is constructed by 'experts' with 'expertise' in the legislative and electoral spheres and formalized in document form, we conceptualize the ''policy process [as] the politics of discourse'' (Taylor, Rizvi, Lingard, Henry, 1997, p. 43; Vickers, 1997). Considering policy as both product and process, value-laden and contested (Marshall, 1997), facilitates examination of the formal and informal mechanisms that legitimate certain discourses and knowledge claims over others in the policy sphere. Thus, although analysis of participant narratives addressed themes emerging from the data, it also focused on discourses informed by relations of power that shaped these women's lives.

In the research, a critical feminist geographic approach to nursing practice foregrounds the gendered

and sexualized power dynamics contributing to social inequities that are experienced at the everyday level. Feminist geographers across a spectrum of standpoints offer analytic explanations of inequality through geographic foci of place and locality. Indeed, androcentric assumptions are embedded in institutional spaces and places and mark the ways in which women's activities are legitimated in public or private spheres (Rose, 1993). However, as Blunt and Rose (1994) stress, ''the politics of diversity among women'' (p. 7), the complex and intersecting locations of race, ethnicity, sexuality, class and other relations of power including institutional discourses that inform their lives, shape how diversely situated women understand and experience their health.

Such dynamics are also relevant to how women across social locations produce knowledge in particular historical and geographic contexts (Blunt & Rose, 1994). Critical feminist and/or participatory research, focusing on issues historically invisible in institutional spaces, is an advocacy practice that also constructs evidence for policy-making and program development. Important parameters of how power dynamics are considered in research for policy change on behalf of vulnerable populations are how participant and researcher voices are visible and represented throughout the research process. Priorities include knowledge production processes that affirm identities, build on diversely situated lesbians' activism, and enhance community self-determination (Stevens & Hall, 1992). This focus on geographies of difference foregrounds the construction of gendered identities and considers the micro-geographies of the body, social spaces in places, imagination and the mind (Dyck, 2003).

Findings

Eleven themes emerged from the narrative analysis. These included: coparent and biological childbearing experiences, isolation, determination, strategies used to locate support, the diversity of lesbian communities, public or private availability of support, and childbearing as a turning point in their lives. Other themes addressed how this couple defined support and barriers to support in terms of inviting or disinviting interactions that were categorized in terms of people, places, programs, policies, and processes and a 6th P, politics, which emerged. A final theme addressed future inviting possibilities.

Although this couple described attributes of lesbian-positive health environments and interactions with health care providers, they framed these relationships in a context of the larger structural dynamics of heterosexism across all social institutions. For example, they spoke of everyday heterosexist language and resources that privilege heterosexuals and create barriers for disclosure of same-sex status, especially outside of large urban centers with well-organized and visible sexual minority communities. They also addressed reproductive policies and programs such as insemination procedures and infertility clinics that implicitly or explicitly exclude lesbians.

They identified challenges encountered by lesbians across locations of race/ethnicity, socio-economic status and geography since factors such as geographical accessibility, convenience, and cost are also important for women attempting to locate support. Ellen[4] wondered: ''Imagine being a lesbian in [a small town in Northern Ontario]....and you want a child. We're in a city of over 400,000 people.'' The prohibitive costs of purchasing sperm and expensive fertility medications that are not covered by health insurance also limit access to women for whom the financial aspect of conceiving is a factor. They emphasize that childbearing women who are marginalized in other ways in addition to their same-sex orientation are likely at increased risk of receiving disinviting messages. As Ellen stresses, ''Well, God forbid that you're a *single* lesbian having a baby, or that you're a *Black* lesbian having a baby! I mean, *you don't even want to go there!*''

Under strategies for change, the couple considered mandated policies for provider education on broad issues of diversity important to facilitate the development of more sensitive health practitioners. The participants also identified the need for both inclusive professional educational curriculum, services targeted specifically to lesbians, as well as the need for all health department programs to be lesbian-positive. They suggested that policies that explicitly address sexual orientation should be visible throughout

[4] Pseudonyms used for participants.

institutions, calling for the inclusion of diversely positioned community members with respect to race/ethnicity, sexual orientation and geography in the development of organizational policies. They emphasized the need for professionals and communities to collaborate on developing services that build on existing resources created by lesbians. The couple viewed public health organizations, with their well-established information networks, as potentially helpful in promoting the dissemination of community-led resources for lesbians. Policy processes that enhance lesbian community development and that are sensitive to diversity within lesbian communities are integral to creating access to spaces and places that provide supportive services.

In fact, the research findings suggested support for the 6th P, politics,[5] in which power relations frame understandings of institutional heterosexism and other dynamics of oppression like racism (i.e., power over others). Despite the participants' high-situated privilege, as White, middle-class, able-bodied, professionals, they could not consistently anticipate inviting care in public institutions. Instead, they turned to private networks to locate support from lesbian-positive care providers and institutions for their childbearing needs. They sought advocates such as midwives, who could minimize the potential homophobic reaction and heterosexist assumptions that posed an ongoing threat to relevant and respectful care. Although they viewed on-line resources as a social support, they felt that time and energy limited their ability to tap into that option. Ellen maintained that word of mouth was the only was to access reliable information locally on lesbian childbearing. As women who were well-connected to mainstream and lesbian communities in large cities, they had a range of networks for potential childbearing supports. Ellen contacted a colleague, a lesbian physician, ''who was practising in Toronto, and asked her what she was doing to assist lesbians who want to have children. She said that she didn't have a clue.'' However, she followed up with a search on their behalf and recommended the physician who provided preconceptual care for both pregnancies.

At the same time as the two participants described barriers created by oppressive dynamics such as heterosexism, they indicated how they strategized to locate support, thereby illustrating resistance to structural constraints. By also conceptualizing politics and power in its positive form, as it is produced through action, the study offered insight into how institutions facilitate individual and community empowerment. A joint participant–researcher reflection focused on envisioning possibilities for change at both practitioner and systems levels and provided a space to consider individual and institutional roles in privileging dominant heterosexist knowledge claims over others, along with comprehensive strategies for change.

Defining safe spaces

The findings identify political dynamics as a significant factor in access to care and offer a systematic approach to facilitating safe environments using the invitational framework (MacDonnell, 2001a, 2001b; Purkey & Novak, 1996). Given the historical context in which lesbians have been pathologized and excluded from mainstream institutional care, safety cannot be equated with optimal physical care (Stevens, 1992). These participants suggest that safety can be read however, as intentionally inviting care. Using the principles of the invitational model, inviting interactions are those that convey respect, optimism, trust, whereas disinviting interactions convey suspicion, pessimism, or contempt (Purkey & Novak, 1996). For environments to be considered intentionally inviting, communities must be able to consistently locate inviting support within them. Although supportive individual providers of care are important, predictable support requires attention to larger institutional environments. A comprehensive approach moves beyond isolated strategies such as education of nurses, requiring simultaneous attention to how the issues are taken up in relation to people, places, programs, processes, policies, and politics. Clients accessing service interpret individual providers' care in light of the larger institutional messages that validate or exacerbate silencing of lesbian health. In fact, the 6 Ps are highly interrelated. Moreover, place, as a

[5] In 1992, Dean Fink offered the addition of a 6th P, ''Politics,'' to the invitational framework. Whereas he addressed how political savvy is useful in facilitating respectful and meaningful school environments, this study extends this concept of ''politics'' to address how complex relations of power are implicated in enhancing access to institutional care.

category that explicitly takes into account dynamics of power in particular settings, crosscuts them all. In fact, as this study demonstrates, by foregrounding the microspatial relationships between people and institutions, place and space continually intersect.

For example, for these study participants, an inviting aspect of midwifery is the advocacy role that the participants interpret in terms of how this facilitates safety within a health care system that has historically been disinviting to lesbians. One of the participants, Sharon, who is a birth mother, coparent, and physician, notes that many lesbians choose alternative care providers because of their perception of an unsafe traditional medical system. She stresses that even if she or her partner had been assessed as high risk, necessitating a referral to an obstetrician, ''We would still have had a midwife there with us to help us advocate .... I would be afraid to go into the health care system with a physician.''

The couple was unable to locate any local programs that incorporated the range of preconceptual, prenatal, postpartum and parenting support relevant for their childbearing. Neither the local lesbian community nor mainstream parenting resources available to childbearing women provided resources that met their broad needs for information. They perceived prenatal classes provided by public health nurses as disinviting places, as Ellen explained:

> It is our understanding from colleagues, friends, and other health care professionals that prenatal classes [are] so unilaterally assumptive and focused on marriage, and male and female relationships, not to mention middle class, [that] even friends of ours who had been to prenatal either left for that reason, [or] highly recommended that we don't go.

However, as the couple reflected on ways the system might change, they identified that even with their solid expertise in reproductive health, they would have attended prenatal classes geared to the unique issues that lesbians face. Safety is equated with sensitivity and relevance.

Although this study focused on expectant couples, the couple identified that safety and other issues relevant to enhancing supportive care for childbearing lesbians required public health attention to time frames well beyond the immediate childbirth and beyond the health care sector. They spoke of an increased awareness of potential safety concerns for their sons as they consider the very real dangers of life as sons of lesbian moms. These experiences have alerted them to the difficulties that lie ahead as the children grow older. As Sharon notes, this requires ongoing education across all social institutions and programs, stating, ''We have to make sure that we have mechanisms in place to counteract [negativity]. We have to talk to all our teachers beforehand.''

Through this research (MacDonnell, 2001b), these participants named other indicators of safe environments that are often noted in the literature (CLGRO, 1997; Duncan et al. 2000; O'Hanlan, 1998; Stevens, 1992). These research findings collectively suggest that inviting care opens the door for disclosure of identity, in which professionals affirm all aspects of clients' identities. Supportive care explicitly addresses the holistic nature of lesbians' lives, maintains confidentiality or anonymity as desired, and validates diverse expressions of sexuality and family. At the same time, intentionally inviting environments offer high quality physical and emotional care and enhance the possibility of finding safe spaces through lesbian community and connections with allies. Institutional silencing has as its impact what O'Hanlan (1998) calls ''homophobic fallout,'' in which diversely situated lesbians avoid health care institutions rather than risk irrelevant and disrespectful care (Stevens, 1992).

Dynamics of power and privilege were central to the way the findings emerged in this study. The ethnographic research process focuses on meaning-making for participants and researcher alike. In the process of co-constructing strategies to enhance supportive care co-construct, they acknowledge their situated privilege as participants and researcher. These women were White, middle-class, English-speaking and financially privileged, living in a city in Southern Ontario and were conscious of their high situated privilege. They took into account how diversely located childbearing women with respect to race/ethnicity, geographic location, immigrant and economic status might encounter particular barriers to care and envisioned how individual client and provider interactions and institutional systems might change accordingly.

Reflexivity: research and activism

Through the joint reflection on imagining possibilities for change, Judith used her privilege as researcher to

also question the invisibility of lesbian health with participants, especially childbearing issues in public health contexts: how organizational profiles, research and educational settings support or challenge heteronormativity. Together, Judith and the participants considered the political aspects of high quality educational environments for childbearing lesbians. Implications for public health nursing practice include the development of sensitive educators, meaningful curriculum, program planning, explicit policies, community partnerships and political leadership in institutional and research venues. Inviting care moves beyond individual health provider and patient/client interactions in a particular agency location. Action on the part of institutions requires attention to both the content and visibility of the holistic needs of childbearing lesbians, as well as the processes through which knowledge is produced and legitimated in institutional contexts. Health care institutions with their discretionary power to authorize funding and programming for communities have a role in advocating for and creating policies and research agendas that challenge heteronormativity across sectors. Both collaboration of childbearing lesbians and public health nurses and simultaneous attention to the multiple dimensions of place as depicted through the invitational framework of the 6 Ps that inform high quality support, can foster more inviting health care.

During this research process, Judith reflected on her own social privilege as a White, middle-class, heterosexually identified mother and nurse, a member of a profession that has historically silenced lesbians. She recognized that this professional location and heterosexual privilege can both enhance and hinder potential relationships with sexual minority communities. While clients, as consumers of health services, seek places and spaces that are inviting, as a researcher undertaking explicitly political and reflexive research addressing inviting spaces and places to facilitate health and well-being, she also imagines how her own practice is implicated in these systems of domination.

In fact, prompted by this research process, Judith began to participate in activist processes within and outside of research that are congruent with shifting practitioner practice on both individual and collective levels in order to work towards the imagined landscapes of safe communities for childbearing lesbians and other minority communities. She became active in a province-wide coalition comprised of LGBTTTIQQ-identified public health practitioners and allies, the Public Health Alliance for LGBTTTIQQ Equity, that nurses and other professionals had created to challenge the invisibility of sexual minority issues in their field. As a workgroup of the Ontario Public Health Association (OPHA), a body that has advocates on local, provincial and national levels for action on health-related issues, the PHA works across difference to identify and implement practices and policies that are sensitive to sexual minority health.

In fact, this workgroup incorporated these study findings (MacDonnell, 2001b) on childbearing lesbians into a position paper that they co-wrote on enhancing access to public health services for lesbians and gay men. They named sexual identity as a determinant of health and created implementation strategies for enhancing access to relevant care for lesbians and gay men in a public health context (Duncan et al., 2000). The PHA called for public health institutions to take political leadership to explicitly address the holistic needs of sexual minorities and advocated for research to inform practice. Public health nurses, with their institutional affiliations, can be well-positioned to both participate in collaborative processes that generate community knowledge and institutional processes that reflect on dynamics of institutionalized heterosexism, as well as enhance the dissemination of these knowledges to effect policy change.

Discussion and implications

Judith's study offers insight into a particular context of one highly privileged childbearing couple's lives as they seek support for their childbearing. However, her findings resonate with an increasing body of literature on institutionalized heterosexism with respect to education and health policy and practice (CLGRO, 1997; Duncan et al., 2000; O'Hanlan, 1998; Stevens, 1992 and many others). They have implications for understanding the gendered and sexualized nature of place and space with evidence that childbearing lesbians, as a group of childbearing women who occupy sexual minority locations, have often been rendered invisible in health care provider education, professional

programs and services. Dominant conceptualizations of lesbian health are equated with sexual health, and sexuality is often equated with the private sphere. As populations or bodies, whose lives are inscribed by sexuality as it interacts with gender, race and other social relations, lesbians have historically been excluded and/or marginalized in health contexts.

This ethnographic research focused on lesbian childbearing in a public health context identifies community knowledges that can inform nursing practice and policies. As these findings indicate, in order to create gender-inclusive and place-sensitive care, public institutions must consider the holistic needs of lesbians and a comprehensive approach to care to enhance access to responsive health services. Lesbian mothers themselves transgress dominant heterosexual discourses of motherhood through their childbearing, and their families become sites of resistance, a challenge to heteronormativity. As these women imagine inviting health care landscapes, they address both official health care agencies and the larger social context of communities as relevant to enhancing their health and well-being. Given the barriers to health care identified by this couple with their high social privilege, there are implications for increasing how multiple sites of support, both traditional health services in the public domain and informal community and social supports are implicated in health care service provision across regions. This couple indicates that affirmation of their identities as lesbians and as a lesbian family are crucial to finding places that provide inviting care—their capacity to locate meaningful and relevant information and support as defined by lesbian communities themselves. As Liaschenko (as cited in Peter, 2002) has noted,

> Places are symbolic constructions reminding us of our connections to others...they give meaning to our lives....Place is important in shaping our identities and in fostering (or depleting) our sense of self and agency. (p. 65)

As participants define components of safety that characterize inviting health institutions within their communities, they address the social relations between individuals and institutions or microsocial spatial relationships between health care providers and their clients or communities. At the same time, public health nurses find safety through their links with coalitions that support and advance advocacy initiatives that challenge the dominant heteronormativity in their practice settings (MacDonnell, 2005). It is evident that this research is both informed by and informs feminist geographic approaches since both space and place and relations of power are implicated in enhancing concrete health care services, the relationships that shape them, and the policy actors involved. In particular, a gender lens enhances an understanding of the factors related to space and place that enhance and constrain political practice as nurses engage with research processes that might influence gender-sensitive policy for sexual minority communities.

As this analysis of nurses' advocacy practices of research and coalition work illustrates, concepts of gender, space, and place are integral to understanding how nurses conceptualize their practice as political. As individual and collective activists, their identities are inscribed by complex, shifting dynamics of power that inform and emerge in relation to their politics. They are both complicit with institutional processes as health professionals, yet challenge their organizations and professions to address the heteronormative discourses framing the possibilities that diversely located LGBTTTIQQ people can achieve health and well-being. These policy actors influence the ''politics of discourse'' (Taylor et al., 1997).

Consistent with Andrew et al.'s (2004) call for a greater understanding between place and professional practice, these findings frame the interrelationships between nurses' political activism practice, space and place. These political actors who are part of the PHA coalition, whether they are nurses advocating on behalf of groups marginalized in health care, or members of these communities themselves, participate in processes of alliance building and mobilization that enhance their impact on social and political reform (Allen, 2003). However, this nursing practice, with its explicit commitment to ethical practice is informed by the need to foster more equitable processes in the process of developing evidence, along with conscious attention to the politics of location (Blunt & Rose, 1994; Public Health Alliance, 2002). Notably, it is congruent with Peter's (2002) view of place in which nurses practice caring in explicitly critical and political ways as they work at the everyday level to enhance social justice (MacDonnell, 2005).

In contrast to traditional discourses of policy-making by disinterested policy actors removed from the field, these nurses employ explicitly political and collaborative research processes and coalitions to construct spaces of resistance to dominant discourses of knowledge production that challenge boundaries of institutionally defined health discourses, knowledge production, and policy actors (MacDonnell, 2005). As communities and professionals collaborate to envision change to health systems and communities, they use critical and participatory research processes for their emancipatory potential (Blunt & Rose, 1994). As such, they challenge dominant discourses of policy processes created by health experts, affirming and legitimizing the subjugated knowledge claims emerging from marginalized communities defined by intersecting dynamics of gender, sexuality, and community and institutional locations.

There has been a lack of a feminist perspective on health in geographic research. This study, however, showcases the potential contributions of these analyses to health policy and public health. The use of a gender lens demonstrates how public health nurses, using explicitly political research to create spaces of resistance, enhance the possibility of action to shift heteronormative discourses across institutions and communities. By facilitating participatory policy processes, they enable the production and institutional authorization of diverse situated knowledges. These practices not only promote the health and well-being of sexual minorities by validating the sexual identities that are central to their lives, but also enhance community self-determination through the development of safe and accessible services and resources, places that are meaningful to these communities.

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