Empowering Ontario Public Health Nurses to Address the Causes of Poverty: A Qualitative

Descriptive Study

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Abstract

Research has demonstrated repeatedly that income and income distribution are powerful determinants of health. While Ontario public health units are mandated to promote health and reduce health inequities, they have done little to help eliminate poverty, instead focusing on individual behaviours such as smoking, diet, and physical activity – an approach likely to worsen health inequities, rather than mend them. Public health nurses (PHNs) across Canada recognize poverty as a powerful determinant of health, yet have expressed challenges in their ability to take meaningful action to address it (Cohen, 2006b; Reutter & Ford, 1996). The study sought insight into how Ontario public health units can strengthen PHNs socio-political efforts to address the causes of poverty. A qualitative descriptive design was used to explore PHNs' views, while an *Appreciative Inquiry* approach was used to draw on participants' successful past experiences in addressing the causes of poverty and their thoughts for the future. Organizational factors thought to empower PHNs' socio-political efforts to address the causes of poverty were identified using Kanter's *Structural Theory of Power in Organizations* as a starting conceptual framework. Fifteen PHNs participated in face-to-face or telephone interviews. Qualitative content analysis was used to describe participants' affirmative experiences, empowering organizational attributes, and desired actions and supports for the future. Three overall themes emerged with respect to empowering organizational attributes: authorities within the health unit 'permit and provide', active associates 'help each other out', and external allies 'contribute and collaborate'. Factors beyond the health unit that would support anti-poverty work were also identified. Findings suggested that action to address the causes of poverty is within the reach of PHNs, and is consistent with their role and the public health mandate, but requires leadership support and political buy-in in order to maximize its effectiveness.

Empowering Public Health Nurses to Address the Causes of Poverty: A Qualitative Descriptive

Study

Although Canada's Gross Domestic Product (GDP) per capita ranks it as one of the

wealthiest countries in the world (Central Intelligence Agency, 2008), its child poverty rate is

one of the worst of all nations belonging to the Organization for Economic Co-operation and

Development (OECD). In Canada, 15.5% or almost 1/6 children live in poverty (UNICEF

Innocenti Research Centre, 2000).

Studies and reports confirm over and over that poverty is damaging to health and can lead

to premature death. Based on an analysis of data from the Canadian Community Health Survey,

The Wellesley Institute and Social Planning Council of Toronto concluded that, "[P]overty is

making Canadians sick – robbing hundreds of thousands of their health and creating huge costs

for the health care system" (Lightman, Mitchell, & Wilson, 2008, p. 1). Indeed, several Canadian

studies demonstrate income gradients whereby the richer fare better than the poorer on a range of

health indicators, including self-rated health, stress and mental health, disability, endocrine and

metabolic conditions, circulatory and respiratory diseases, responsiveness to cancer treatment,

and basic abilities in children (i.e., vision, speech, mobility) (Booth, Li, Zhang-Salomons, &

Mackillop, 2010; Bryant et al., 2010; Lightman, Mitchell, & Wilson; Lightman, Mitchell, &

Wilson, 2009; Orpana, 2008; Ross & Roberts, 1999; Street Health, 2007; Wilkins, Berthelot, &

Ng, 2002). Negative outcomes also are demonstrated in studies analyzing the effects of

neighbourhood or community poverty, including increased risk for preterm birth and low birth

weight, decreased verbal abilities in young children, and increased numbers of child homicide

(Birken, Parkin, To, Wilkins, & Macarthur, 2009; Kohen, Brooks-Gunn, Leventhal, & Hertzman,

2002; Urquia, Frank, Glazier, & Moineddin, 2007). Population-level statistics furthermore point

to increased risk for poverty among Canadian women, unattached adults, individuals from racialized communities or of Aboriginal identity, and those with a disability (Campaign 2000, 2010; Statistics Canada, 2006; Statistics Canada, 2009; The Colour of Poverty, 2007).

Since 2001, the percentage of unattached Canadians living in poverty has remained high at around 30% (Statistics Canada, 2009), while in Ontario family poverty has grown steadily (Campaign 2000, 2007). Many have argued that an inequitable distribution of wealth (e.g., less progressive tax structures that privilege the rich) is to blame for elevated and increasing poverty rates in Canada [Campaign 2000, 2010; Canadian Centre for Policy Alternatives (CCPA), 2010; Raphael, 2002a]. Census data show for example that, from 1980 to 2006, the richest 20% of Canadians had median income increases of 16.4%, while the poorest 20% had a 20.6% drop in earnings (CCPA). Award-winning economist Yalnizkan (2010) observed that, "This generation of rich Canadians is staking claim to a larger share of economic growth that has preceded it in recorded history" (p. 3). Indeed, income inequality – or the gap between the rich and the poor – has been argued to be equally, if not more important to health, than absolute income (Canadian Council on Social Development, 2001; Raphael, 2003b). Research has shown that when there is greater inequality in the distribution of income, there are greater disparities and inequities in health (Collison, Dey, Hannah, & Stevenson, 2007; Kennedy, Kawachi, & Prothrow-Stith, 1996; OECD, 2008).

Given the extent of ill-health to individuals and communities resulting from poverty, it is not surprising that its effects are costly to Canada and its health care system. For instance, Lightman et al. (2008) calculated, conservatively, that if Ontarians in the bottom income quintile received a $1000 increase to their annual income, this would result in 10,000 fewer chronic conditions and 6600 fewer disability days (Lightman et al., 2008). Addressing similar concerns,

a recent report by the Health Council of Canada (2010) emphasized that governments need to

pay attention to societal factors that influence health and change the way they address the needs

of poorer and socially disadvantaged Canadians; otherwise they will be destined to continue to

spend large amounts of dollars on health care.

 Despite poverty's detrimental impact on health and health care expenditures, empirical

evidence suggests that the Canadian health sector does a poor job of addressing poverty. Public

health, especially, has been a focus of criticism given its mandated role in health promotion.

Health promotion is defined as: "The process of enabling people to increase control over, and to

improve, their health" [World Health Organization (WHO), 1986, p. 1]. It involves going beyond

health care to address social determinants of health[1], such as poverty (WHO). In Ontario, public

health units are mandated to implement programs "designed to promote the health of the

population as a whole [and] reduce health inequities" [Ministry of Health and Long-term Care

(MOHLTC), 2008, p. 1]. Given the health effects of income, there is recognition that the public

health sector ought to take more meaningful action to reduce poverty rates – particularly by

addressing the social, political and economic conditions that contribute to poverty (Raphael,

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[1] "The social determinants of health are the economic and social conditions that influence the

health of individuals, communities and jurisdictions as a whole. [They] determine the extent to

which a person possesses the physical, social, and personal resources to identify and achieve

personal aspirations, satisfy needs, and cope with the environment... These resources include –

but are not limited to – conditions of childhood, income, availability of food, housing,

employment, and working conditions, and health and social services" (Raphael, 2004, p. 1).

2003b; Williamson, 2001).[2] PHNs, who make up the predominant number of public health workers, are key to making this happen. However, they have expressed powerlessness in being able to bring about change that would benefit economically disadvantaged individuals and families (Reutter & Ford, 1996).

Socio-political activity has been identified in nursing and public health literature as a key strategy for altering the 'causes of poverty' or, in other words, the social, political and economic conditions that contribute to it.[3] While empirically-based barriers to engaging in socio-political

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[2]In the context of this study, 'the social, political and economic conditions that contribute to poverty' refer to systemic factors that contribute to maintaining or increasing poverty rates. Examples of such factors include, but are not limited to: taxation policies that contribute to an inequitable distribution of wealth; lack of affordable housing, daycare, and post-secondary education; social ignorance and systemic oppression (i.e., classism, racism, sexism); inadequate social assistance rates and government benefits (e.g., for children/ seniors/ unemployed workers); and oppressive labour policies (e.g., low minimum wages; lack of employment training).

[3] The term 'causes of poverty' was chosen to conceptualize the 'social, political and economic conditions that contribute to poverty', as it stands in contrast to the term 'consequences of poverty'. For the purposes of the study, it was important to emphasize the distinction between these two concepts. For example, some public health activities target the consequences of poverty by helping people cope with economic burden and/ or barriers to health, while other public health activities target the 'causes of poverty' by addressing why poverty rates are maintained/ increasing in the first place.

activity in the nursing profession have been identified (Cohen & Reutter, 2007; Liepert, 1996), there has been minimal research exploring which activities would be most promising for addressing the causes of poverty in public health and how these may be enacted by PHNs.

Poverty is a powerful determinant of health, yet little research has been done to explore how socio-political efforts to address the causes of poverty could be strengthened within Canada's provincial public health systems. Using a methodology that focuses on past and future success, the proposed study explored the efforts of PHNs in Ontario to generate knowledge about what has been working – however limited it may be – as well as what is possible for the future and what might be necessary to bring this to action. This study will give voice to the experiences and ideas of PHNs to generate recommendations for moving beyond barriers and challenges to a more solution-focused approach to addressing the causes of poverty through public health in Ontario.

Literature Review

Why the Health Sector Should Address Poverty

It could be argued that it is not the responsibility of the health sector to address poverty. Indeed, the elimination of poverty requires a multi-faceted approach – from investments in childcare and education to affordable housing, a livable minimum wage, and much more. This warrants cooperation and action from many government sectors from a municipal to federal level. So why should the health sector be a predominant focus of criticism for its lack of initiative?

Given its harmful effects, all government sectors should be criticized for not taking meaningful action to address poverty. The health sector, however, is unique in its potential to mobilize action towards the elimination of poverty and perhaps this is why it is targeted. Health care professionals are among the few who actually bear witness to how social conditions, such as

poverty, influence the lives of individuals in their homes and communities (Reutter & Duncan, 2002). As such, they have valuable knowledge of the effects of policies and systems that create and maintain poverty, making them well positioned to propel a social mandate to address it. The tenets of health promotion and primary health care – integral strategies for optimizing health – furthermore emphasize a focus on social determinants of health. While hallmark documents, such as the *Declaration of Alma-Ata* (WHO, 1978) and the *Ottawa Charter for Health Promotion* (WHO, 1986), advocate for intersectoral collaboration to execute these strategies, health care workers and the health sector are designated with specific responsibilities, suggesting they have an important role to play.

The public health sector, in particular, has been identified as instrumental in addressing poverty and other social determinants of health. Raphael (2008) notes that there are thousands of Canadian citizens whose occupations are concerned with public health. He argues that such a collective force could be used to raise awareness about the importance of social determinants of health among the general population. "In models of how research leads to action, awareness of a health issue is a necessary precursor to any policy change" (Whitehead et al., 2000 as cited in Raphael, 2003a, p. 401). Diet, physical activity, and smoking are the common behaviours targeted by public health workers in Canada – so much so that they have been collectively referred to as the "holy trinity" of public health (Raphael, 2003a). While such risk factors are associated with (ill) health (e.g., heart disease, diabetes, obesity), so too is poverty. To raise awareness about the former – and not the latter – is misleading. Such misguided awareness of health issues will consequently impede the development of healthy public policy and create barriers to optimizing the health of Canadians – the antithesis of an effective public health system.

In Ontario, regulatory and practice documents for health professionals – especially those within the public and community health sector – do incorporate a focus on the social determinants of health, including poverty. The newly developed *Ontario Public Health Standards*[4] (MOHLTC, 2008), for instance, maintains that the health of individuals and communities is influenced by "complex interactions between social and economic factors" (p. 1). In this binding document, boards of health (i.e., public health units) and its workers are advised that: "Addressing determinants of health and reducing health inequities are fundamental to the work of public health in Ontario" (p. 2). The *Canadian Community Health Nursing Standards of Practice* [Community Health Nurses Association of Canada (CHNAC), 2003] further echoes this sentiment by dictating that community health nurses should embrace principles of primary health care, including a focus on social determinants of health such as poverty. An additional practice guideline states that PHNs should consider broad determinants of health, including "income and social status" [Canadian Public Health Association (CPHA), 2010]. Finally, the Canadian Nurses Association (CNA) maintains that nurses can play an important role in addressing poverty and other social determinants of health through individual practice, reorienting the health care system, and healthy public policy (CNA, 2005). These documents suggest that addressing poverty is indeed within the required scope of practice for nurses and other (public) health workers in Ontario.

Some have argued, however, that funds for poverty are better left outside the health care budget to preserve a larger budget for social services. Indeed, poverty is impacted by many non-

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[4] The Ontario Public Health Standards (MOHLTC, 2008) is a document that specifies the guidelines and minimal requirements for the provision of mandatory public health programs and services in Ontario.

health-sector policies; to eliminate poverty, money must be allocated from a number of

government budgets (i.e., Ministry of Municipal Affairs and Housing, Ministry of Education,

Ministry of Community and Social Services, among others). This argument, however, is

fallacious. Poverty experts and activists do not claim that the government should earmark funds

to the health care sector to eliminate poverty; indeed, this would be ineffective. Rather, they

recognize that broad public awareness and support is needed for the elimination of poverty.

Community organizations and institutions (e.g., public health units, community groups, schools,

businesses, etc.) are critical for building the masses needed to pressure governments to change

their damaging policies. This requires such bodies to allocate their funds towards poverty, be it

the health sector, education sector, housing sector, volunteer sector, or mental health sector,

among others. Until there is improved government policy regarding poverty, community

organizations and residents will shoulder the burden for raising awareness about the issues and

supporting those affected by such harmful policies. This is challenging given limited resources –

and unfair. Why should communities be expected to react to poverty rather than have their

governments address it?

One explanation is the impact of political traditions on poverty. Child poverty is strongly

correlated with left cabinet[5] share in national governments ($r = -0.72$) (Rainwater & Smeeding,

2005). Canada and the United States have the lowest left cabinet share compared to other

democratic nations; unsurprisingly, they also have the highest child poverty rates (Rainwater &

Smeeding). This, in part, is associated with government transfers (Rainwater & Smeeding;

Raphael, 2008). Sweden (which has a large percentage of left cabinet share) and Canada, for

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[5] In Canada, the number of seats held by the New Democratic Party would represent its left

cabinet share.

example, have comparable child poverty rates before taxes and transfers are taken into account

(23-24%). After these are accounted for, however, Sweden drops to 2.6%, while Canada falls to

only 15.5% (UNICEF Innocenti Research Centre, 2000). A study by Navarro and Shi (2001)

showed that countries with "political traditions more committed to redistributive policies (both

social and economic)... such as social democratic parties, were generally more successful in

improving the health of populations" (p. 1). Canada – a *Liberal* country characterized by a full

expression of market forces, little interference from the state, and poor redistributive policies –

was found to have one of the largest income differentials and the lowest rates of improvement in

infant mortality rates (Navarro & Shi). On a provincial level, evidence suggests that Canadian's

propensity towards left or right leaning political parties may impact support for poverty-related

policies. Telephone interviews of 1203 Albertans indicated that those who would vote for Liberal

or New Democrat parties were more likely to support poverty-related policies, such as child care,

increased welfare allowance, housing, and nutrition programs, than those who would vote

Progressive Conservative or Reform (Reutter, Harrison, & Neufeld, 2002). These studies suggest

that until political traditions shift left in Canada, community organizations and institutions will

have to react to the effects of poverty and decide whether to join the efforts of those trying to

eliminate it. For the reasons mentioned above, the health sector – public health in particular – is

well positioned to play a key role in mobilizing such action.

Addressing Poverty in the Health Sector

  An overview of existing strategies. Within the health sector activities to address poverty

can focus on consequences or causes. Empirical evidence suggests that the health sector is more

involved in addressing the consequences (Cohen & Reutter, 2007; Frankish et al., 2007;

Williamson, 2001). Attending to the consequences of poverty generally involves helping

individuals and families cope with economic burden and/or barriers to health (e.g., free/ low-cost

dental services, case advocacy, providing information about community resources). Addressing

the causes of poverty, on the other hand, usually involves socio-political activity.

Socio-political activity aims to bring about evolving community-based emancipatory

social movement (Whitehead, 2003). It includes, "participation in public health policy formation,

social education[6] programme development, political advocacy and critical consciousness raising

activity" (Whitehead, p. 670). Raising awareness about poverty, analyzing the effects of policy

on poverty, and putting poverty on the agenda of organizations are some examples of how the

health sector can address the causes of poverty through socio-political activity. In the Ontario

public health sector, such actions have also been referred to as 'poverty reduction initiatives/

activities' [Joint Ontario Public Health Association (OPHA)/ Association of Local Public Health

Agencies (alPHa) Working Group on Social Determinants of Health, 2010].

Before exploring these strategies further, the health sector's response to poverty will first

be reviewed. This will help to demonstrate the use of strategies addressing the 'consequences'

and 'causes' of poverty, and create a context for further discussion.

The Canadian health sector's response to poverty. Considering poverty's damaging

impact on health and the marked role for health workers in addressing this issue, the Canadian

health sector's response to poverty has been woefully inadequate. When Williamson (2001)

collected information about poverty initiatives from 12 provincial/ territorial health ministries

and 99 health regions/ district health councils across Canada, over half (n = 50) of health region

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[6] "Social education is the conscious attempt to help people to gain for themselves, the

knowledge, feelings and skills necessary to meet their own and others developmental needs"

(Smith, 1982).

respondents reported that their respective health regions did not have any initiatives addressing

poverty. For the health ministries and regions/ district health councils that did, she found that

almost two thirds of these (64.7%) focused on the negative consequences of poverty. Williamson

noted that initiatives often centred on helping families buffer the daily stressors and challenges

associated with poverty. "Much less frequent were initiatives that aim to: raise awareness about

poverty; prevent people from becoming poor; enhance skills and education of people in poverty;

and alter social and economic conditions contributing to poverty" (p. 178). Williamson

acknowledges that her study is a snapshot of what employees from health regions and ministries

perceive as poverty-related initiatives rather than a comprehensive inventory of such.

Nonetheless, the study's broad sampling strategy (of all Canadian health ministries and regional/

district health councils) and high response rate (100% and 72%, respectively) strengthens the

generalizability of findings, suggesting that, indeed, while Canadian health ministries and

regions are helping individuals and families cope with poverty, they are not doing enough to

reduce it.

     In a study examining the implementation and use of provincial and territorial health goals

in Canada, Williamson and colleagues (2003) found that such goals addressed a range of health

determinants that extended beyond the health sector. While the social and economic environment

was one of the most common priorities across provincial/ territorial health goals, only 16% of

health regions in provinces and territories acted on these: health care goals often were given

priority over goals related to broader social determinants of health. This multi-level case study

used three sources of data: a document review (to provide an overview of the health goal

processes, strategies, and activities of each province/ territory); interviews with one health

ministry employee from each province/ territory; and a health region survey (to examine the

extent to which provincial/ territorial health goals were being used). Although such data

triangulation increases the credibility of findings, the authors note inconsistencies between some

provincial-level findings (indicating health goals were being used) and regional implementation

scores (suggesting they weren't). The authors acknowledge that interviewing more than one

ministry employee in each province/ territory may have decreased such inconsistencies. They

also note that the skewed response rate for the health region survey – low in some health regions

and high in others – suggests that results cannot be generalized to all health regions across

Canada. Despite these limitations, however, findings about the *types* of health goals being acted

on (health care vs. social/ economic) were consistent throughout the study and with other

theoretical and empirical literature mentioned by the authors. Such findings support the

hypothesis that the Canadian health sector is limited in strategic focus and action addressing

social determinants of health and, therefore, in efforts to address poverty.

In another study of health regions across Canada, Frankish et al. (2007) found that

income was a lower priority for internal and intersectoral action than other social determinants of

health, such as personal health practices. The survey used to collect the data was first pilot tested

with two health regions and found to have a reasonable level of content and construct validity.

Respondents were asked to rank the level of action for each social determinant of health

occurring within their health region/ organization and through intersectoral collaboration on a

numerical scale. Overall, 69 health regions responded, for a response rate of 64.9%. Response

rates varied from province to province (a low of 36.7% in Quebec and a high of 100% in

Alberta), limiting the generalizability of the findings to all health regions in Canada. The authors

acknowledge that the self-reports of respondents may differ from others in their region, but note

that respondents were likely credible. They suggest the possibility of under- or over-reporting

biases. Despite these limitations, however, the survey provides useful baseline information on internal and intersectoral action on social determinants of health in Canada. Similar to the studies above, its findings suggest that action to address poverty is limited.

The studies reviewed offer an overall picture of the Canadian health sector's response to poverty. While some response rates present limitations to the generalizing of findings across Canada, and the self-report data present opportunity for bias, taken together the studies suggest convincingly that health sector initiatives to address poverty are inadequate and considered a lesser priority than other health system initiatives. In order to redress this situation, further insight is needed into how the health sector might improve its use of socio-political activities to address the causes of poverty. The perceptions of health professionals are particularly important to explore as these individuals are most familiar with the system and are therefore well-suited to recommend changes that will result in system improvement.

The Canadian public health system's response to poverty. The Canadian public health system, in particular, has been criticized for its poor response to poverty. Dr. Dennis Raphael, a professor and researcher with the School of Health Policy and Management of York University, persistently has criticized public health workers for not taking meaningful action to address social determinants of health, particularly poverty (Raphael, 2002b; Raphael, 2003a; Raphael, 2008). Dr. Ronald Labonte, who holds the Canada Research Chair in Globalization and Health Equity at the Institute of Population Health, has argued that health promotion efforts to deal with underlying determinants of health, such as poverty, have been insufficient to make a difference (Labonte, 2005). Public health discourse about population health has been criticized for detracting from action against economic inequities and supporting the dismantling of Canada's welfare state (Labonte, 1997; Robertson, 1998). In addition, others have noted that public health

professionals ignore social inequalities, including (but not exclusive to) poverty (Ridde, Guichard, & Houeto, 2007).

While empirical evidence suggests that public health is limited in its action to address social determinants of health, very few studies have explored the public health system's response to poverty, specifically. Sutcliffe, Deber, and Pasut (1997), in a comparative study describing public health systems and their projected futures, conducted telephone interviews with key informants in six provinces (Newfoundland, New Brunswick, Ontario, Manitoba, Saskatchewan, and Alberta) and performed a key document review. They found that many provinces had no evidence of mandated public health programs that addressed social determinants of health. Nearly all key informants recognized the importance of these determinants and the need for community involvement and coordinated strategies to address them. However, they cited financial constraints, low morale among staff, and lack of political will as key barriers to action. While the study provided important baseline information concerning social determinants of health activities in public health units across Canada, the rigour of the study is questionable. Most notably, only one person (whose credentials and biases remain unknown) conducted the literature review, created the data collection tool, and conducted the interviews. As well, the authors did not describe how data were analyzed. These circumstances pose a threat to the credibility and dependability of study findings. In addition, findings may not be transferable to the present time as mandated public health programs have since been developed. Despite these limitations, however, its conclusions are corroborated by more recent studies, suggesting that its results held some credibility and that public health action to address social determinants of health is indeed limited.

In 2010, a more recent survey of public health units took place to identify social determinants of health and poverty reduction activities occurring throughout Ontario (Joint OPHA/ alPHa Working Group on Social Determinants of Health, 2010). Medical Officers of Health in all 36 health units were invited to have a 'response team' – made up key professionals involved in social determinants of health activities – respond to an on-line survey. Twenty-three health units participated for a response rate of 64%. Like the previous 1997 study, results suggested that taking action on the social determinants of health was felt to be an important/ necessary public health role. In contrast, however, such activity was much more evident in the 2010 survey. For example, 50% of respondents indicated that social determinants of health activity was identified as an explicit priority in their health unit's strategic plan, while 80% stated that work related to social determinants of health was integrated into all program areas in their health unit. In addition, numerous social determinants of health and poverty reduction activities taking place through/ with the support of health units were detailed. Despite the plentitude of activities listed, reporting frequencies were usually low – that is, only a few health units engaged in any one particular activity (in many cases, $n = 1$). This suggests both a great diversity of social determinants of health initiatives in health units, and also that coordinated strategies to address social determinants of health do not yet exist. In addition, the low reporting frequencies suggest limited health unit involvement in any one particular area, e.g., assessment and reporting, policy advocacy. The only exception to this might be "modification of public health interventions to meet the unique needs and capacities of priority populations" (p. 7). But even then, there were only 70 individual activities reported. On average, this would mean just three to four activities per health unit – a very low number considering the great many activities taking place within health units and the importance of engaging those at greater risk for ill-health. A reporting bias

may have further exaggerated numbers/ activities, given that respondents might have wanted to report favourably about their health unit.

Also identified by the survey were activities related to health unit involvement with Ontario's Poverty Reduction Strategy programs. While several programs were listed, again only a small number of health units reported involvement in any one particular program. Exceptions to this included Healthy Babies Healthy Children (HBHC), Children in Need of [Dental] Treatment (CINOT), Early Years programs, and school-based initiatives (*n*= 17 to 23). Interestingly, many of the programs did not aim to reduce poverty rates and, instead, aimed to address the consequences of poverty by helping individuals/ families cope with barriers to health (e.g., by providing low-cost/ free services, free vaccination/ immunization programs). This, however, was not acknowledged in the report. The study concludes with glowing commendations about health unit activity, but these seem to be overstated. For example, the report concludes that "Health units seem to be prioritizing collaborative work to address the fundamentally basic needs (food, shelter, income) of their populations" (p. 37), however, this is not apparent in the data. For instance, health unit involvement in programs addressing food, shelter, and income was low relative to other initiatives. Furthermore the extent of participation – or priority given to – any one activity was not measured or qualified; therefore, it cannot be stated that priority was given to such activities. An additional contradiction was that only 25% of 'response team' members were front-line workers (compared to 50% of directors/ MOHs and 25% of managers), leaving it debatable as to whether front-line workers are yet key professionals involved in social determinants of health activities and questioning the entrenchment of a social determinants of health culture in health units.

The study remains, however, a valuable mapping of social determinants of health and poverty reduction activities occurring through public health units in Ontario. Indeed, by identifying the specific activities occurring throughout the province, it helps to emphasize the importance of such action in health units and to normalize their role in public health. While results seem impressive relative to other studies that address social determinants of health and poverty in health units, a closer analysis of the data suggests that action is still limited and that much improvement is needed. While the survey also identified information about gaps, challenges, and areas for systemic support, further research is required to describe poverty reduction/ socio-political activities on a micro-level – including the role of public health workers – in order to move forward with promising practices and make them amenable to implementation.

Public health nurses (PHNs) constitute the majority of public health workers within each province, with approximately 3300 PHNs working in health units across Ontario (College of Nurses of Ontario, 2007; MOHLTC, 2007). Because of their predominant role in the public health system, PHNs are often asked to share their experiences in public health as research study participants. As part of an exploratory descriptive study on the discourse of population health within three regional health authorities in Manitoba, Cohen (2006b) asked PHNs about the determinants of health they were most and least likely to influence. PHNs identified low income as a key determinant affecting the health of people with whom they worked in their practice, but reported that it was one of the most difficult to impact. Cohen argued that her findings "lend credence to the observation that despite Canada's reputation as a leader in population health, actual public health practice in Canada does not adequately address poverty and other societal determinants of health" (p. 1576). This study generated important knowledge for improving

public health nursing as it began to highlight some of the barriers that PHNs experience in addressing social determinants of health (such as poverty) through their practice. By providing a description of the regional health authorities sampled, Cohen enables her readers to determine whether study findings may be transferable to other contexts, including public health units in Ontario. Of significance is that challenges to addressing income were noted by PHNs in all three regional health authorities – whose contexts each differed from one another – suggesting that this challenge may be experienced by PHNs more broadly than can be determined from this study alone. Similarly, Cohen (2006a) notes that her findings are consistent with other Canadian studies exploring the perspectives of PHNs on their population-focused health promotion practice.

In 1999 public health nurses and senior public health managers in Ontario were surveyed about the nature and scope of public health nursing (Falk Rafael, Fox, & Bewick, 2005). A survey was sent to all PHNs in Ontario and to one PHN in a senior manager position in each of Ontario's official 37 health units. The response rates were 77% ($n = 2242$) and 87%, respectively. The researchers found that changes in public health nursing in the previous 20 years were incongruent with tenets of primary health care, such as equity, accessibility, social justice, and community participation. They attributed these findings to shifts in public health services, decision-making processes, and perceived (in)effectiveness in meeting the needs of communities. This study was significant as it was the first to describe the nature and scope of public health nursing in Ontario. As such, it represents a valuable baseline for monitoring future changes in public health nursing practice. While public health activities related to social determinants of health, such as poverty, were not studied explicitly, it can be assumed that public health changes

incongruent with equity, accessibility, and social justice would most likely be ineffective in supporting strategies to address poverty and other social determinants of health.

The above studies and expert opinion suggest that the Canadian public health system does a poor job, and indeed creates barriers to, addressing social determinants of health such as poverty. They begin to establish a baseline for public health action on poverty and other social determinants of health, and highlight some general areas for system improvement. While this research verifies that public health sector challenges to addressing poverty exist, research recommendations concerning poverty are vague and therefore difficult to bring to action. A more focused and detailed understanding of how to strengthen efforts to address the causes of poverty through public health nursing is necessary in order to develop meaningful recommendations for action and organizational change in health units.

Addressing the causes of poverty through public health units. "Ultimately, health workers have to decide whether to identify poverty or poverty's effects as the focus for action" (Raphael, 2002a, p. v). This is particularly relevant to the public health sector, which operates under the principles of disease prevention, health promotion and protection, and health policy. Poverty is a cause of many of the behaviours and health issues with which public health workers concern themselves (Raphael, 2002a). However, public health in Canada focuses primarily on downstream behaviours such as tobacco use, physical activity, diet, sexual health, and alcohol use. These programs target individual behaviour rather than dealing with the problem at its source (Raphael, 2002a; Raphael, 2003a). There is little evidence to support their effectiveness, particularly for those at greatest risk (Raphael, 2003a), which threatens to worsen health inequities.

To give such approaches a predominant focus in public health is not only ineffective, it also skews public understanding about the causes of disease and warps policy makers and the media (Raphael, 2003a). A survey of Hamilton citizens involved in community-based organizations, for instance, revealed that less than half (46%) had heard of social determinants of health (Collins, Abelson, & Eyles, 2007). While *maintaining a healthy lifestyle* was assigned one of the highest priorities for action, *income* was assigned the lowest (Collins et al.). Such beliefs mirror the public health approach, yet run counter-intuitive to a plethora of literature that establishes income and income equality as powerful determinants of health. An examination of Canadian newspapers revealed a similar pattern. When over 4300 health stories were analyzed from 13 Canadian newspapers dated 1993 to 2001 (10 English, 3 French), only six percent of sampled stories covered the socio-economic environment and only 0.2% discussed health issues related to income and health. The majority (65%) covered issues related to health service provision and delivery or management and regulation (Hayes et al., 2007). As newspapers are the agenda-setting media (Hayes), these findings are concerning. For instance, telephone surveys with a random sample from Edmonton and Toronto (n = 1671) revealed that media exposure positively influenced recognition of the poverty-health link after controlling for other variables (Reutter et al., 2005).

While many factors are at play in shaping people's perceptions of disease and health, public health's focus on downstream behavioural approaches helps to reinforce erroneous assumptions about determinants of health. This is particularly striking given the role of public health as a health promoting institution. Misguided understandings of the causes of health and disease are, furthermore, not without consequence. Evidence suggests that uninformed perceptions of the income-health link may limit support for poverty related policies. In a study of

how public perceptions of the relationship between poverty and health predicted support for

poverty related policies, Reutter et al. (2002) found that those who chose a structural

explanation[7] to account for the poverty-health link were more likely to support government

spending than those who chose a behavioural explanation[8].

Finally, downstream behavioural strategies are also a questionable use of public health

resources considering their limited effectiveness. The Conservative government, for instance,

provided almost $50 million for the Ontario Heart Health Initiative – to focus on lifestyle factors

such as tobacco use, activity, and diet (Raphael, 2003a) – despite evidence demonstrating that

poverty is a greater risk factor than all three lifestyle factors combined (Raphael, 2002c).

If health promotion and disease prevention can be enhanced through strategies that target

the causes of poverty, the public health sector is clearly accountable for incorporating such

strategies into their operations. The question is: how? There is a paucity of literature that

discusses strategies for addressing the causes of poverty through the health and public health

sectors. In a systematic review of whether Canadian PHNs are supported in a role to address

poverty, Cohen and Reutter (2007) present a framework for action that outlines specific public

health nursing strategies that could be used to address both the causes and consequences of child

and family poverty. Adapted from Blackburn (1992, as cited in Cohen & Reutter), the

framework conceptualizes activities into three broad categories: monitoring (e.g., evaluating the

effect of health sector policies); alleviating (e.g., targeting resources to those in greatest need);

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[7] The structural explanation emphasizes that "poor health results from decreased access to the

material conditions and resources that facilitate health" (Reutter et al., 2002, p. 297).

[8] The behavioural explanation emphasizes that "poor people are unhealthy because they engage

in health-inhibiting behaviours" (Reutter et al., p. 297).

and bringing about social change (e.g., initiating community discussions). While the strategies

are realistic within a public health setting, there is little evidence suggesting that strategies

related to *monitoring* and *social change* – those that would address the causes of poverty – are

currently being used by Canadian PHNs (Cohen & Reutter). Furthermore, there is no empirical

evidence to support their (perceived) relevance, feasibility, or effectiveness.

Other strategies recommended to strengthen public health efforts to address the causes of

poverty can – by definition (Whitehead, 2003) – be classified as socio-political activity[9] and

include: poverty and health profiling assessments; constant public messaging about the

importance of social determinants of health; frequent press releases to the media; telling stories

to shift public, professional, and policymakers' focus; community development; transferring

knowledge, skills, and control to local people (so that they can challenge the social and economic

causes of poverty themselves); providing support for policy action and political engagement; and

putting social determinants of health on the agenda of health associations (Blackburn as cited in

Cohen & Reuter; Raphael, 2008; Raphael, 2009). There is minimal empirical evidence, however,

exploring the use of these strategies within the Canadian public health sector.

One important exception to this is the recent mapping of social determinants of health and

poverty reduction activities occurring within Ontario health units (Joint OPHA/ alPHa Working

Group on Social Determinants of Health, 2010). Some of the major activities reported were:

assessment and reporting on social determinants of health (i.e., report cards, research on priority

populations, surveillance through programming), supporting community and other stakeholders

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[9] Such strategies can be classified as socio-political activity because they contribute to social

education, influencing policy, and increasing critical consciousness (see Whitehead, 2003 for

definition).

in policy advocacy for improving social determinants of health (i.e., access to food/ food

security, fair wages and employment/ employability), and local advocacy on social determinants

of health (i.e., provincial/ national consultations, council presentations). In addition, one survey

question asked specifically about advocacy on the Ontario Poverty Reduction Strategy, including

initiatives related to increasing minimum wage and developing a long-term affordable housing

strategy. While the study is a much needed catalyst for developing promising strategies related to

social determinants of health and poverty reduction, more research must be done to highlight

how activities are carried out on a micro-level, including the supporting role of health units, and

the roles of public health staff and associates.

Finally, ideas for how to target the causes of poverty through the public health sector can

be borrowed from a select number of health units that have been recognized for taking a more

pro-active approach to addressing poverty (see Raphael, 2003a). Waterloo Regional Health Unit,

for example, has created a new division to focus on social, economic, and environmental

conditions of health. This division provides policy, research, and evaluation support for other

divisions in the health unit. Its collaborative work, since 1999, has resulted in six projects and

published reports to-date addressing social determinants of health, including poverty (Waterloo

Regional Health Unit, 2005). Sudbury District Health Unit also has demonstrated a strong

commitment to addressing social determinants of health and poverty, as evidenced by its:

background document on *Social Inequities in Health and Ontario Public Health* (Sutcliffe et al.,

2007); development of initiatives like the *Working Poor Project* (National Collaborating Centre

for Determinants of Health, 2008); and number of resources developed in-house (e.g., *Health*

Equity Mapping Checklist, available through http://www.health.gov.on.ca).

If public health workers are to engage in strategies to address the causes of poverty, more research needs to be done to determine what is feasible, relevant, and effective in public health, including the supporting role of organizations, staff, individuals and communities. PHNs, who constitute the majority of public health workers, are key to identifying promising strategies for addressing the causes of poverty suitable to the present context of public health. As socio-political activities encompass the vast majority of actions suggested for addressing the causes of poverty in public health – and are critical to altering political, social, and economic conditions that contribute to poverty – these in particular need to be explored.

Public Health Nurses and their Role in Addressing Poverty

Demographic profile of PHNs. "The term Public Health Nurse describes those Community Health Nurses who are specifically assigned to public health services such as population health assessment, surveillance, disease and injury prevention, health promotion and health protection" (Underwood et al., 2009b, p.10). According to a recent demographic profile of community health nurses in Canada, in 2007 19.1% of RNs in Ontario were Community Health Nurses. Of these 55.5% worked in Community Health Centres, which by definition included public health units, as well as home care agencies, family practice units, occupational health settings, and nursing stations. This definition was influenced/ constrained by their primary data source – the Canadian Institute for Health Information. The researchers note that, "Because of the variability of how sub-sectors are defined, both over time and across provinces, it is not simple to report how many nurses are working in a specific community subsectors such as public health" (Underwood et al., p. 11).

A role for addressing poverty. There is conflicting evidence about whether Canadian PHNs are supported in a role that includes addressing the causes and consequences of poverty.

To ascertain whether PHNs are supported in such a role, Cohen and Reutter (2007) reviewed

scholarly literature from Canada, the United Kingdom, and the United States as well as

professional standards and competencies for nursing practice in Canada. They found that while

there is theoretical support for PHNs to address poverty's causes and consequences, particularly

from nursing scholars calling for nurses to engage in socio-political activity, this role is often not

identified in professional standards and competencies. They also found little evidence to suggest

that PHNs practiced in this capacity. Where evidence existed, they noted that PHN efforts

focused more on helping low-income families access appropriate services rather than affecting

policy. Factors contributing to PHNs' low levels of socio-political activity were found to include:

PHNs' perceptions of lacking requisite knowledge, skills, and personality; lack of time; lack of

managerial support; an organizational philosophy that does not support socio-political action;

narrow job descriptions; and limited public understanding of the role of PHNs in such activities.

In this review, Cohen and Reutter (2007) began to unravel the professional and

theoretical sources that support a role for PHNs to address child and family poverty. They went

on to make comparisons between such support and documented Canadian public health nursing

practice. Their review is valuable as it synthesized a breadth of literature to highlight areas of

practice that, if focused on, may result in more meaningful public health nursing practice to

address poverty. By establishing positive theoretical and professional support for this role, the

review provided evidence for encouraging it further (e.g., through increased organizational

support and enhanced knowledge and skills). It began to build a case for systemic improvements

to support and improve public health nursing practice concerning poverty.

While synthesizing a wide range of literature supported the trustworthiness of the

review's recommendations, the authors spoke minimally as to how PHNs could carry out such

activities (e.g., socio-political activities) on a micro-level. To partially address this, Cohen and

Reutter (2007) concluded with a framework for action and evidence-based prerequisites for

developing this role. These provided concrete ideas for improvement that warrant further

examination. To build on this knowledge, research must be done to explore the feasibility of

these ideas with PHNs: What of these strategies have worked for them? What organizational

factors do they think would facilitate the use of these strategies? More empirically-based

knowledge needs to be generated regarding strategies that PHNs believe are/ may be useful in

addressing the causes of poverty, and how these are/ could be executed within their public health

units. Such micro-level research (complementary to such reviews) could lead to the development

of more comprehensive and practical policy and practice solutions.

     Socio-political activity. Many nursing scholars have argued that socio-political activity

is key to addressing social determinants of health (see Drevdahl, 1995; Falk-Rafael, 2005;

Reutter & Williamson, 2000; Stevens & Hall, 1992; Whitehead, 2003) – and poverty is almost

always the context used to illustrate their cases. When Drummond and Williamson (2000)

conducted focus groups in Edmonton to evaluate the effectiveness of PHN parenting sessions for

low-income parents (*Primary Health Care – Head Start*), they found that parents' ability to

enhance their children's health was limited at least as much by their low-income status as by

their lack of knowledge. They concluded that health education alone was not enough to improve

the health of the program's children, and that efforts to promote their health would best be

strengthened through socio-political action attempting to address the socio-economic conditions

negatively affecting health.

     In a feminist, post-modern oral history, Falk Rafael (1999a) conducted interviews with 13

public health stakeholders and 14 experienced PHNs to explore changes to Ontario's public

health system and their effect on the practice of PHNs in Ontario. Through the narrators' stories,

she found that the introduction of the Health Promotion and Protection Act (HPPA) in 1983, and

a resulting strengthening of medical control over public health, had resulted in PHNs being

distanced from their communities and less able to engage in social activism and political

strategies (e.g., awareness-raising about the relationship between poverty and health). This is

consistent with the conclusions of other nursing scholars who have noted that PHNs' roots in

social justice have diminished over the century (Drevdahl, Kneipp, Canales, & Dorcy, 2001;

Erickson, 1996; Reutter & Duncan, 2002). Falk Rafael, whose research has been dedicated to

studying public health nursing, is a credit to understanding the history, context, and practice of

public health nursing in Ontario. This particular study is important as it gives voice to PHNs,

allowing them to express how they have perceived changes to their practice, including how

changes in the public health and provincial system have negated their ability to use socio-

political activity as a strategy to address social determinants of health such as poverty.

To determine whether nurses have a professional obligation to participate in socio-

political activities in the United States, Ballou (2000) conducted a historical-philosophical

analysis using licensure and professional practice standards, position statements of the American

Nursing Association, and contemporary literature. Her conclusions were framed in a step-by-step

logic test and demonstrated that nurses are obligated to be involved in socio-political activities as

a valid component of scope of practice. Like Cohen and Reutter (2007), however, her analysis

showed that nurses engage minimally in such activities. She speculated that this "silencing of

nurses" (Ballou, p. 181) is related to the health care environment, bureaucracies, and the

systemic oppression of women. While the study is not Canadian, its overall conclusions are

likely applicable to the Canadian context as nursing practice is similar in both countries (e.g.,

Canada's nursing graduates are able to practice in the United States). Furthermore, its findings

are echoed in Canadian studies such as Cohen and Reutter's literature review, which looked at

whether public health nurses are supported in a role to address poverty.

Empirical evidence suggests that health care users, as well as the nursing profession,

would support that nurses engage in more socio-political activity when it comes to poverty. In

focus groups of 199 impoverished users of health-related services in two large Canadian cities

(Stewart et al., 2005), participants emphasized the importance of nurses partnering with people

living in poverty for socio-political advocacy (e.g., promoting awareness about poverty, targeting

messages to government, and acting as advocates).

Given that socio-political activities are critical to addressing the political, economic, and

social conditions that contribute to poverty, research on facilitators and barriers to PHNs

performing this work is important. Cohen and Reutter (2007), Ballou (2000) and others (Liepert,

1996) have made good progress in this regard by identifying barriers to socio-political activity

from the perspective of nurses. Falk-Rafael (1999a, 1999b) discussed how the context of the

Ontario public health system has contributed to such barriers, although the topic of her research

and discussion papers has not been on socio-political activity and poverty per se. Given that

public health systems function provincially, Ontario-specific research should be done on this

topic in order to stimulate ideas for system improvement. While the above studies have

contributed to knowledge about what *doesn't* work when it comes to socio-political activity and

poverty in public health nursing practice, little research has been done to explore what *does*.

Examining such strengths in public health nursing is important for identifying realistic strategies

for improving poverty work and for capitalizing on the resources and successes available to

PHNs for performing it.

(Dis)empowerment. There seems to be a paradox in the Canadian public health system concerning PHNs and their work with poverty. While PHNs recognize poverty as a problem, there is little evidence to suggest that they engage in this work (beyond helping individuals and families access needed resources). PHNs, however, are not oblivious to this and have expressed powerlessness in their ability to take meaningful action against poverty. In a study exploring the perceptions of 28 PHNs in Alberta (Reutter & Ford, 1996), PHNs stated they felt powerless to bring about change that would benefit economically disadvantaged families as they lacked the skills and resources needed to address the underlying social problems. In a more recent study, Manitobian PHNs reported that they recognize income as a key determinant of health, while expressing that it is one of the most difficult to influence (Cohen, 2006b). Indeed, Canadian-based research suggests that PHNs do not feel empowered in the workplace. In a large study of PHNs and other CHNs across Canada, a random sample of Registered Nurse CHNs and Licensed Practical Nurses stratified across all provinces and territories was surveyed to identify enablers and barriers to practicing to their full scope of competencies (Underwood et al., 2009a). The response rate to the written survey was 57%. The survey identified four theme areas that enable CHNs to practice to their full scope: professional confidence, team relationships, workplace environment, and community context. Work environment was found to be the most important enabler, which included access to material resources, human resource policies, support for nursing, and employer approach to community. Despite this, researchers found that less than half of all respondents agreed that they had adequate time, money or access to learning resources; only half of Registered Nurse CHN respondents felt that provincially mandated policies supported them to do their work effectively; and one-third of respondents did not feel they had adequate employer support to address population health needs, including social

determinants of health. The authors note that, "It is likely that the 38% of Registered Nurse CHN

respondents who reported lack of authority to customize care to meet clients' needs feel

disempowered" (Underwood et al., p. 30). In a Saskatchewan-based study (MacDonald,

Schoenfeld, & Bonnie, 2003), 124 PHNs completed a questionnaire about factors that resulted in

feelings of being devalued, invisible, or powerless in their role. While the low response rate

(25%) meant the results could not be generalized to the province, the PHNs who did respond

emphasized that they lacked in continuing education to develop or increase health promotion

skills. They also reported needing more flexibility, independence, and autonomy in their work in

order to meet community needs. Haugh and Laschinger (1996) found similar results in Ontario

when they surveyed 46 public health nurses and 10 nurse managers in three Ontario public health

units. Using previously validated tools for measuring empowerment, they found that neither

group of nurses had high empowerment scores. Both groups rated their work environments to be

somewhat low in power along empowerment structures such as opportunity, information,

support, and resources. Finally, in a survey of Ontario PHNs and senior managers (Falk Rafael,

Fox, & Bewick, 2005), PHNs ranked their degree of influence over nursing services as 9/10,

with 10 being the lowest. The CEO or MOH, Ministry of Health, and Agency Executive

Committee were ranked 1, 2, and 3 out of 10, respectively.

These studies suggest that Canadian PHNs do not experience high levels of

empowerment in the workplace. While some of the cited studies are old (greater than 10 years),

their results are congruent with studies done less than five years ago, suggesting that their

conclusions are still relevant today. Put simply, empowerment is the ability to take action

(Kanter as cited in Sabiston & Laschinger, 1995). Preliminary research suggests that Canadian

PHNs want to take action to address the causes of poverty, but are limited in their ability to do

so. More research must be done to explore this further in Ontario. If factors of empowerment are, indeed, limiting PHN practice with respect to poverty (and otherwise), generating knowledge about this topic through the perspectives of PHNs will be critical for building a more effective public health.

In Summary

In summary, researchers have demonstrated that the health sector – particularly public health – does not take meaningful action to address poverty in Canada, and have advocated for more meaningful and effective public health action. Despite PHNs' central role in delivering public health services in Ontario, empirical evidence suggests that PHNs are disempowered in the workplace and limited in their ability to address poverty and other social determinants of health. Socio-political activity has been identified as a key strategy for altering the political, economic, and social conditions that underlie poverty. While some empirically-based barriers to socio-political activity have been identified, there has been minimal research done to explore which activities would be most promising for addressing the causes of poverty in public health and how these may be enacted by PHNs.

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Research Question

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The Canadian public health system has been criticized for its inadequate approach to poverty. However, there is little empirical evidence that explores this issue specifically from the perspective of PHNs. Quality improvement experts have noted that, "The more knowledge one has about how the particular system under consideration functions or could function, the better the prediction and the greater the likelihood that the change will result in improvement" (Langley, Nolan, Nolan, Norman, & Provost, 1996, p. xxv). If change is needed to improve public health's response to poverty, then clearly PHNs – as the predominant front-line workers –

must be able to share their experiences and ideas for system improvement. While public health nursing barriers to addressing poverty have been identified in research studies (Cohen, 2006b; Falk Rafael, 1999a; Falk Rafael, Fox, & Bewick, 2005; Reutter & Ford, 1996), these studies have not been designed to investigate public health nursing practice and poverty directly. Thus policy and practice recommendations stemming from the research have not been directed exclusively at improving public health nursing in this regard. Furthermore, it is time to move beyond the identification of challenges and barriers, and give some focus to what *has* been working for PHNs in their socio-political efforts to address the causes of poverty, what could work, and how this work can be strengthened.

Given these considerations, the research question for this study is: How can Ontario public health units help strengthen public health nurses' socio-political efforts to address the causes of poverty? The study will be addressing several gaps in the literature. While Dr. Benita Cohen and Dr. Linda Reutter have published research and discussion papers about Manitoban public health nursing and poverty, the proposed study will be the first to focus on poverty and public health nursing in Ontario. It will build on the recent mapping of social determinants of health and poverty reduction activities in Ontario health units (OPHA/ alPHA Workgroup on Social Determinants of Health, 2010) to detail components of socio-political strategies used to address poverty and describe the supporting role of health units (both present and desired). As such, it will be the first study to generate empirically-based knowledge related to socio-political strategies for addressing the causes of poverty through public health nursing in Canada. The study will provide desperately needed research required to forward the development of promising public health practices related to addressing the causes poverty. Through its strength-based underpinnings, it will furthermore generate evidence more amicable to solutions. The

focus has been purposefully aimed at exploring how to better address the *causes of poverty* (as opposed to the consequences) as such work will help to eliminate poverty, rather than cushion its negative effects.

The impetus for this study came about through my two years as a public health nurse in Ontario, 2004-2006. As a new nursing graduate, I was excited by the prospect of working with upstream determinants of health and chose to work in public health rather than in hospitals. However, I soon became disenchanted when I realized that public health was wrought with bureaucracy and government. Nurses had no autonomy. Although we recognized the importance of social determinants of health, particularly poverty, we had little power to act on them – so focused were we on the 'holy trinity' of physical activity, nutrition, and smoking. In the process of entering a master's program in nursing, I decided to focus my studies on public health nursing, poverty, and health system change. As I progressed in my studies and spoke with other PHNs, I realized that the experiences of others resonated with my own. As I continued to develop in my nursing practice, I came across solution-focused brief therapy, a respectful, empowering approach to helping which uses people's existing strengths and resources to find solutions (TAPE Educational Services, 2009). This increased my awareness of the gains that can be made by focusing on strengths, as opposed to dwelling on problems. It helped me recognize that within every person and system something works and can be used to construct solutions.

Relevance

OECD nations, such as Canada, are currently seeing an increasing number of people living below the poverty line and a widening gap between the rich and the poor (OECD, 2008). This poses a serious threat to health – the consequences of which are recognized internationally (WHO Commission on Social Determinants of Health, 2008). The economic costs of poverty are

considerable. A recent analysis of these costs in Ontario (OAFB, 2008) found that poverty has a

very significant total economic cost in Ontario equal to 5.5 to 6.6 per cent of Ontario's GDP. It

also reported that poverty costs the federal and Ontario government at least $10.4 to $13.1 billion

a year – the equivalent of 10.6 to 16.6 per cent of the provincial budget (OAFB, 2008). The

proposed study is timely, given the increasing costs of health care and current economic crisis, as

it aims to generate knowledge that will help fuel the fight against poverty.

The proposed research will result in rich descriptions of PHNs experiences in addressing

the causes of poverty through socio-political activity, their ideas about what could and should be

with respect to such work, and their thoughts about how this can be made a reality within their

public health units. The results will be useful to PHNs, public health leaders, and government

officials wishing for ideas to enhance the public health system's capacity to meaningfully

address the causes of poverty. Findings will have potential to be used to stimulate action for

system improvement and for future research aiming to investigate facets of this topic in more

detail across the province.

Methods

Research Methods

Qualitative description informed by Appreciative Inquiry was the research method used

to guide this study. Qualitative description is the research method used when straight description

of phenomena are desired (Sandelowski, 2000). Appreciative Inquiry is "a way of studying and

exploring human systems, when they are at their best" (Carter, 2006, p. 50). It recognizes that in

every society, organization or group, something works (Hammond, as cited in Marchionni &

Richer, 2007) and seeks to build on "peak moments in organizational life when individuals or

groups experienced success" (Marchionni & Richer, p. 90).

Qualitative description and Appreciative Inquiry were chosen for their fit in answering the research question, as well as their strengths as research methods. By using qualitative description, for instance – which involves staying close to the surface of the data – there was increased descriptive and interpretive validity to the study, as the straight description of phenomena portrayed a clearer account of participant responses compared to analyses with more layers of data interpretation (Maxwell as cited in Sandelowski). Appreciative Inquiry allowed participants to focus and build on what is already working well. This process has been utilized and reported as being effective and transformative in many aspects of organizational change and change management (Carter, 2006). Appreciative Inquiry, for example, was one of the research methods used in the National Community Health Nursing Study (Meagher-Stewart et al., 2010). This study examined organizational attributes that would assure optimal utilization of PHNs (an objective very similar to the current study).

While the use of qualitative description affected how the data were collected and analyzed, the use of Appreciative Inquiry guided the questions in participant interviews – the only mode of data collection in this study. One of the principles underlying Appreciative Inquiry is: "What we focus on becomes our reality" (Hammond as cited in Marchionni & Richer, 2007, p. 90). Cooperrinder and Srivastva (1987), the originators of Appreciative Inquiry, noted that whereas the traditional focus of research is to identify a problem to be solved, Appreciative Inquiry refers to "a research perspective that is uniquely intended or discovering, understanding, and fostering innovations in social-organizational arrangements and processes" (Cooperrinder & Srivastva, n.p.). The benefits of this focus are well described by Postma (1998):

There is much to be gained, learned, affirmed, and celebrated when we draw upon moments of organizational experience within which members felt personal satisfaction,

high levels of commitment, and excitement because of their role in organization's work.

When we stop and reflect upon good things that have already happened in our

organization, we may very well uncover some powerful ingredients that can move us

forward, in our planning, our doing, and even our defining of where we wish to go. (p.

54)

While we often *look around* to others for examples of their experiences, their lessons

learned, and their best practices, there is an insufficient amount of *looking backwards* or *looking*

within one's own organization to discover what is or has been working (Postma, 1998).

Appreciative Inquiry encourages this 'appreciative' inward looking and, in doing so, facilitates

connectedness between the lessons learned in one's own organization and the dreams and plans

we have to make our organizations better (Postma). Because this method's appreciative stance

allows participants to dwell on 'the best of what is' (as well as the worst), researchers who have

used Appreciative Inquiry have commented that it seems to take better care of informants and

participants in research (Carter, 2006; Liebling, 2001).

By using qualitative description informed by Appreciative Inquiry as the guiding

methodology, the study attained rich descriptions of PHNs' affirmative stories in addressing the

causes poverty, as well as their perceptions of what might be, what should be, and what will take

them there with respect to addressing poverty within their public health units.

Sampling Strategy

In contrast to quantitative researchers who aim for larger numbers of context-stripped

subjects in order to gain statistical significance, qualitative researchers work with small samples

of people in their context for in-depth study (Miles & Huberman, 1994). These samples are

selected *purposefully* to yield information-rich cases "from which one can learn a great deal

about issues of central importance to the purpose of the inquiry, thus the term *purposeful*

sampling" (Patton, 2002, p. 230). There are several different strategies for purposefully selecting

information rich cases (see Patton). This study used *criterion sampling* and *snowball sampling*.

The logic of criterion sampling is to study cases that meet predetermined criterion of importance

(Patton). This strategy can be useful for revealing system weaknesses and opportunities for

program or system improvement (Patton). It has been noted to be helpful when doing small,

exploratory studies (Miller et al., 1994 as cited in Kuzel, 1999). Snowball or chain sampling is

used to locate information-rich informants (Patton). This is done by asking people to recommend

others who may know a lot about the study topic (Patton).

   The study sampled from a broad pool of PHNs across the province. It was decided that

because socio-political efforts to address the causes of poverty are uncommon, a broad pool of

PHNs would need to be invited to participate in the study in order to identify an adequate

number of information-rich informants. As part of the invitation to participate, PHNs were asked

a set of questions to determine whether they met sampling criteria (see Appendix A). PHNs were

asked if they have worked the equivalent of two or more years in their current health unit. It was

felt that such PHNs would likely have an adequate level of proficiency suitable for envisioning

change and making organizational (and other) recommendations. For example, nurses working

for at least two to three years in a job are able to plan based on considerable conscious, abstract,

and analytic contemplation of a problem (Benner, 1984 as cited in Sonoma State University,

2001). In addition, it was noted that the *Community Health Nursing Standards of Practice*

(CHNAC, 2003) – which states that PHNs should incorporate a social determinants of health

perspective into their practice – furthermore maintains that standards should become basic

practice expectations after two years of experience. PHNs were also asked whether they have

ever been involved in socio-political efforts to address the causes of poverty as a public health nurse. A list of activities was provided to help them identify whether they have been involved in such efforts. Finally, they were asked whether they would be willing to share and extrapolate on such experiences. Together, these questions determined whether PHNs are rich sources of information suitable for the inquiry.

Several strategies for snowball sampling were used: (1) PHNs were encouraged to forward the study invitation to colleagues to help identify key informants; (2) invitations to participate in the study were sent to PHNs known to have engaged in socio-political action to address the causes of poverty; and (3) following interviews, study participants were asked to forward the principal investigator's contact information and the study invitation to PHNs they felt would be good participants for the study.

Participant Recruitment

A study invitation was sent via email to members of the *Community Health Nurses' Initiatives Group* (CHNIG), after seeking permission from its president. CHNIG is an interest group of the *Registered Nurses' Association of Ontario* (RNAO). Its mission is to "act as the voice of Community Health Nurses influencing the health care system, and health and social policy in areas which affect the work of Community Health Nurses and the public [they] serve" (CHNIG, n.d.). Its members include community health nurses (i.e., public health nurses) from across Ontario. A study invitation was also sent via email to individuals subscribed to the *Street Nurses' Network* listserv. The Street Nurses' Network is a group of nurses, based primarily in Toronto, who discuss and intervene on issues relevant to the homeless and underhoused. Many of them work with such individuals and/or communities. There are some public health nurses subscribed to this list. In the case of one health unit, a director agreed to distribute the email to

PHNs in her organization. Finally, recruitment e-mails were sent to PHNs known to have

engaged in socio-political action to address the causes of poverty.

The e-mail (see Appendix B) briefly explained the study and identified the criteria

necessary to be a participant. It encouraged recipients to forward the study invitation to PHNs

who have in-depth knowledge about the study topic. PHNs were asked to contact the principal

investigator via phone or email for more details about the study. More information was provided

by answering questions directly or sending the consent form/ letter of information (Appendix C)

to interested persons, which included the risks and benefits of participating.

Participants were given a $20 honorarium for participating in the interviews. They were

not compensated for participating in the member checking process. Some participants chose to

donate their honorarium to causes committed to helping those in poverty.

Data Collection

Semi-structured face-to-face and telephone interviews were the only modes of data

collection used for this study. This allowed participants to reflect on their individual perspectives

and at the same time provided a consistent framework for gathering data. Face-to-face interviews

were conducted whenever possible, unless travelling was too onerous for in-person meeting

(more than a two hour drive). Individual interviews were chosen over focus groups as

participants were asked to discuss a personal experience: the 'best of what is or what has been'

with respect to addressing the causes of poverty – and this experience differed for each

participant. While focus groups generate a discussion of similarities and differences among

participants, the individual interview provides a detailed account of a person's unique and

personal experience (Morgan, 1998a as cited in Brown, 1999). Face-to-face interviews were

conducted whenever possible to facilitate rapport with study participants.

Interviews were conducted using a semi-structured interview guide that addressed the objectives of the study (Appendix D). As some of the questions might have been difficult to answer without preparation, participants were sent the interview guide ahead of time so they could give thought to the questions should they want to. Although saturation was achieved after the twelfth interview, fifteen participants were interviewed to be sure there was a saturation of all themes. Participant responses were recorded during the interviews using two high quality digital recorders (in case one broke down or the batteries died).

Appreciative Inquiry was the framework used to guide the selection of interview questions. The framework consists of four consecutive phases that connect with one another in a circular manner – named the *4-D cycle* (see Appendix E). The first phase, *Discover*, is focused on appreciating 'the best of what is and what has been' through affirmative stories (Carter, 2006). The second phase, *Dream*, is about exploring 'what might be' by envisioning positive future results and thinking outside usual boundaries (Carter). *Design*, the third phase, is focused on co-constructing and transforming 'what the ideal should be' (Carter). *Destiny*, the final phase, is focused on "sustaining the envisioned futures or 'what will be' through on-going learning and innovation" (Carter, p. 54). An *Affirmative Topic* is central to the cycle and represents the choice of what to study.

In this study, participants were asked a series of questions that fit consecutively with this *4-D Cycle* and that were focused on the following affirmative topic: How Ontario public health units can help strengthen PHNs' socio-political efforts to address the causes of poverty. PHNs were allowed to draw on successes outside their current program, so long as they occurred during their practice as a PHN in Ontario. It was thought these successes would benefit the inquiry, as

contributing factors might inspire strategies useful for PHNs' current public health units. It was

also thought they might highlight context-specific barriers and how they were overcome.

A secondary framework was used to prompt further detail during the interview. In

particular, it was used to highlight factors relevant to PHNs' public health units that contributed

to their affirmative experiences and that, in the opinion of PHNs, influenced what could and

should be done within their organizations. Rosabeth Kanter's *Structural Theory of Power in*

Organizations (see Appendix F) was chosen since it delineates factors that contribute to

employee empowerment or, in other words, an employee's ability to take action (Kanter as cited

in Sabiston & Laschinger, 1995). As the study aimed to describe organizational factors that may

advance PHNs ability to *take action* to address the causes of poverty through socio-political

activity, the concept of empowerment and the factors that contribute to it were therefore relevant.

In her theory, Kanter maintains that employee work behaviours are a response to work

conditions and situations, not the result of inherent personality traits (Laschinger, 1996). She

posits that one's access to empowerment structures in the workplace is contingent on one's

access to formal and informal power. Formal power is gained through jobs that are visible,

central to the organization, and that allow discretion in decision-making (Laschinger). Informal

power is acquired through alliances inside and outside the organization – sponsors, peers,

subordinates – that create the cooperation needed to get things done (Laschinger). She asserts

that individuals with a high degree of formal and informal power will gain access to structural

lines of power and opportunity (empowerment structures[10]) (Laschinger). While opportunity

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[10] The structure of proportions, although identified as an empowerment structure in Kanter's

theory, was not used for the purposes of the study, as it is poorly defined and researched in the

relates to job conditions that enable employees to advance in the organization or develop their

knowledge and skills (Laschinger), structural lines of power include lines of information,

support, and supply. Lines of information refer to the knowledge and information necessary for

employees to do their jobs; lines of support relate to the sources of support that enable employees

to maximize their work effectiveness (e.g., positive feedback, job discretion); and lines of supply

include having the ability to obtain the materials, money, and rewards necessary for achieving

job demands (Laschinger). The degree of access to these lines influences employee attitudes and

behaviours and, ultimately, work effectiveness.

The conceptual relationships in Kanter's theory have been tested with nurses and nurse

managers in various settings across Ontario (see Haugh & Laschinger, 1996; Laschinger, 1996;

Sabiston & Laschinger, 1995; Wilson & Laschinger, 1994). Dr. Heather Laschinger of the

University of Western Ontario has played a lead role in pursuing these investigations and

disseminating their results. The extensive research that has been done to validate this theory

suggests that it is useful and credible in helping to look at nurse empowerment. The fact that this

research has been conducted within Ontario hospitals and public health units further supports its

transferability to the context of this study.

During the interview, as participants were asked to reflect on phases of the *4-D Cycle –*

Discover, Dream, Design, and *Destiny*, they were prompted to describe how formal and informal

power as well as access to empowerment structures may (have) influence(d) their reflections on

what has been and what could and should be. Hawkesworth (1988) noted that theory represents a

fundamental, and yet powerful, means through which we organize our perceptions and

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literature. The structure of proportions refers to the social composition of people in

approximately the same situation (e.g. gender, race) (Laschinger, 1996).

experiences about the world. By using Kanter's theory to systematically explore PHNs responses, a deeper and more sophisticated understanding of their perceptions and experiences was possible.

Data Analysis

Recorded interviews were transcribed verbatim. Interview data were entered into and analyzed with the assistance of NVivo8 qualitative analysis software (QSR International, 2008). The analysis focused on descriptions of PHNs' best experiences with respect to addressing the causes of poverty as a PHN, what they would desire in a health unit that ideally addressed the causes of poverty, how they thought health units could support more effective public health nursing efforts to address the causes of poverty, and what actions they thought would generate a better approach. Together, the responses to those questions illuminated how public health units can help strengthen PHNs' socio-political efforts to address the causes of poverty.

Qualitative content analysis was used to analyze the data. This is the strategy of choice in qualitative descriptive studies (Sandelowski, 2000). The transcripts were read and re-read to obtain a general sense of the data and to reflect on their overall meaning (Creswell, 2003). Descriptive codes – akin to category labels and entailing little interpretation – were assigned to words, phrases, sentences, or whole paragraphs that embodied study-relevant meanings (Miles & Huberman, 1994). Text was coded deductively and inductively. Deductive coding was used to label segments of text pertaining to organizational supports. Codes were created/ organized according to the concepts in Kanter's *Structural Theory of Power in Organizations*. Inductive coding was used otherwise (e.g., to describe participants' experiences and their visions for the future) and also to break-down the concepts in Kanter's framework (also the deductive codes) into specific types of organizational supports. For example, under the concept *lines of supply,*

inductive codes were developed to label participant responses concerning funding, human resources, and material resources. While the deductive approach helped to keep the analysis focused on the research question, the inductive approach ensured codes were grounded empirically in the data,

Data collection and analysis occurred simultaneously. Cycling back-and-forth between these activities has been noted to help qualitative researchers think about existing data and generate strategies for collecting new, often better data (Miles & Huberman, 1994). Segments of text were organized and retrieved using the codes assigned to them (Miles & Huberman). Segments were then be clustered into more condensed chunks to set the stage for drawing conclusions (Miles & Huberman).

Rigour

Several strategies were used to ensure the data were collected and analyzed in a rigourous fashion. Extensive and regular notes were kept on coding decisions and how data were reduced for analysis and interpretation (audit trail) (Sandelowski, 1986). Thesis committee members also reviewed some of the transcripts and the coding scheme. This form of investigator triangulation helped to verify and increase the trustworthiness of study conclusions (Creswell, 1998). Findings were also shared with PHNs for confirmation (member checking). This technique has been noted to be "the most critical technique or establishing credibility" (Lincoln and Guba, 1985 as cited in Creswell, 1998). Eleven of fifteen PHNs participated in the member checking process and were asked to review a summary of the findings. All participants confirmed that their thoughts were reflected in the summary. Small edits were made to enhance clarification where requested. A few participants also asked that certain points be added to or emphasized in the analysis. In most cases, however, these points were already included in the detailed write-up. A few quotes were

added to augment the findings as per participants' suggestions. These enriched the analysis, but did not change the overall themes. Finally, thick, rich description was used to describe the participant responses and the context from which they came. This will enable readers to determine whether findings can be transferred to other settings based on shared characteristics (Creswell).

Ethics

Ethics approval was obtained from the Hamilton Health Sciences/ McMaster Universit Faculty of Health Sciences Research Ethics Board. The following considerations were adhered to: participation was voluntary; participants were informed of the study purpose and the personal risks and benefits of participating (see Participant Consent Form/ Letter of Information); participants were encouraged to respond only to questions they felt comfortable answering; participants were allowed to request that their data be deleted from the study up to one month following the interview; participants were allowed to withdraw from the study without consequence up to one month following the interview; personal information remained confidential; participants were assigned pseudonyms and numerical code for their interviews; participants remained unidentifiable when using quotations; digitally recorded interviews were deleted after they were transcribed – transcription occurred as soon as possible following interviews; until transcription occurred, digitally recorded interviews were stored in a locked metal box; all identifiers and data were stored in an encrypted file; data sent to Supervisors were passphrase protected; and backed-up data were encrypted and stored in a locked metal box. In addition to these, direct identifiers will be destroyed one year following the completion of the study, and non-direct identifiers and data will be stored until the completion of the study and findings are released (a maximum of three years).

Findings

About the Participants and their Work Settings

A total of 15 Public Health Nurses (PHNs) participated in the study. Nine of 36 health units in Ontario were represented, spanning across 10 of the 14 Local Health Integration Networks (LHINs). All participants were female, with ages ranging from 21 to 65 years (mean age approximately 46 years). Two participants were masters prepared while the rest had bachelor degrees in Nursing. Of these, two had partially completed masters degrees in Nursing or Education. At the time interviews were conducted, 10 participants had been practicing as a PHN for 10 or more years (eight of these for 20 or more years). PHNs practicing for more than 10 years were identified as experts for the purposes of the analysis[11]. Three participants had been a PHN for less than three years. All but three participants had been employed with the same health unit their entire PHN career. Of the remaining three, all had been employed in their current health unit for more than 10 years.

The majority of participants (*n* = 9) worked in Sexual Health and Reproductive/ Child Health. Four participants worked in outreach or needle-exchange programs. Other mandated programs represented included: Prevention of Injury and Substance Misuse, Chronic Disease Prevention, Vaccine Preventable Diseases, and Infectious Diseases Prevention and Control. One

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[11] There is no consensus in the literature on 'the time it takes' to become an expert, although many sources would suggest five or ten years. Ten years was chosen to define 'expert' in this study as 1) it was observed that participants with greater than 10 years experiences tended to have 'a deep understanding of the total situation' – a defining characteristic of an expert (Benner, 1984, as cited in Sonoma State University, 2001), and 2) such a definition left an optimal number of participants in each category (expert and non-expert) in order to make comparisons.

PHN was a consultant for her health unit and another was a generalist, and thus were not assigned to any particular program. Some PHNs worked across more than one program, while others had specialized roles or qualifications, including a Nurse Practitioner, a program manager, and a Lactation Consultant. Participants engaged in a wide range of work-related activities, the predominant ones being: working in clinics and/or providing health services (i.e., immunizations; testing for or treating diseases/ ailments); consulting to community organizations or other professionals; health promotion; health education; supporting young families; and providing referrals or information. They worked with children and youth, service providers, the 'general public', and/ or individuals from marginalized groups (i.e., people who are homeless, use substances, live with mental illness or HIV, or identify as lesbian, gay, bisexual or transgendered).

Within their health units, study participants most often worked alongside other PHNs, but sometimes worked with health promoters or educators and other health providers (i.e., nurse practitioners, dentistry professionals), as well as with clerical and support staff. Accountability structures were similar, with participants reporting to their managers, who then reported to senior managers/ directors, who then reported to Medical Officers of Health. The governance structures for Boards of Health varied. Five were autonomous, one was semi-autonomous (with council members and citizens), and three were Regional Councils.

Participants were asked to comment on whether they felt their program addressed the consequences and the causes of poverty. When asked about the consequences, most participants responded that their programs were at least sometimes effective in this respect. As one participant said, "I think we're doing reasonably well on that end, helping people make the connections with appropriate services as well as trying to educate...".

When asked about whether their program addressed the causes of poverty, only two participants acknowledged that their program did so. The majority of participants (*n* = 11) felt that their programs did not address the causes of poverty or that they could do more in this respect. As one participant said, "I think in public health we really address poverty by reacting to it."

Another PHN observed that, "But the causes of poverty, I don't think my work involves anything to address the causes of poverty... [C]auses of poverty is like upstream... So our work was mainly focusing on the um, the downstream." Participants voiced several reasons why they felt their programs did not address the causes of poverty. These included poor leadership, a narrow focus on lifestyle in their health unit, challenges with the public health nursing role, and lack of political support, funding and resources. One participant, for example, stated that her previous manager had no idea what poverty meant "and didn't even know what you were talking about even if you addressed it with her". Another depicted her health unit as a "white picket fence organization... very focused on things that might not seem attainable for those living in poverty... for example, eating healthy food". Another participant described her program as "sort of crumbs the government is offering". Finally, one participant expressed that, "There's so many non-nurses doing nursing... It's really watered down what public health nursing really is".

Experiences with, and Ideas about, Poverty

Participants were asked to share their work experience related to poverty. They were also asked what socio-political activity and causes of poverty meant to them. These questions were asked to help clarify participants' frames of reference (with respect to poverty, nursing, and public health) and to create a context for the subsequent study questions.

Experiences working with people who live in poverty. All participants had direct experience working with individuals or families living in poverty, and discussed gaining such experience (at least in part) through their work as a PHN. The vehicles for such experiences included working with young families [e.g., Healthy Babies Healthy Children (HBHC)] or in low socioeconomic status (low-SES) neighbourhoods; providing one-on-one support (e.g., through home visiting or outreach); working in public health clinics (e.g., sexual health); or implementing specific programs or initiatives. As exemplified by the two quotes below, over half of the participants described working with poor clients across more than one public health program or as a 'generalist' PHN working with a range of clientele/ communities.

> Quote 1: So, as a home visiting nurse I visited with children under six years of age and taught prenatal classes to teenagers which are usually either on welfare, they were single mums, they were teenage parents... As a school public health nurse I worked in schools that were based in poor neighbourhoods... As a sexual health public health nurse I counselled clients in clinic settings who are engaged in high risk behaviours due to their living conditions augmented by poverty... And as a public health nurse from the [health bus] I saw people facing poverty for many different reasons...
>
> Quote 2: So, from my earlier days in public health when we were kind of generalists and did everything… So, school nursing, home visiting... and we used to do a lot of visiting to seniors as well. So, you see kind of the impact of poverty right throughout the life cycle. And different roles of the nurse,

Four participants talked about experiences gained through previous employment, such as home care (community health) nursing and volunteering. One participant with volunteer-experience explained, "I also have work that I do out in the community on a personal level

simply because it's []^{12} something I see as important to me... working with our community

kitchens or groups that will help people who are homeless."

Over half of study participants ($n = 9$) had extensive experience, often over 10 years, of

providing direct nursing services in low-income neighbourhoods or with individuals/ families

who struggled to meet their basic needs of living (due to financial constraints). These experts

often described their experiences as dating back to early in their PHN careers, and in all cases,

gained by way of home visiting. Some participants spoke additionally to clinic work, school

nursing, and group facilitation. The following expert describes how her career began:

> I've been working as a public health nurse for 31 years. I started out in [X
>
> neighbourhood], so that was a community of poverty as well []. So when I started out it
>
> was people that were involved with CAS or people living in poverty a lot of 14, 15 year
>
> old teen moms living on their own.

Four participants described their experiences with individuals and families living in

poverty as intermittent or less direct (e.g., by lieu of working with persons of all socio-economic

statuses or through group facilitation with a variety of people). The remaining two had day-to-

day experiences but for a lesser period of time (less than three years). One of these also had

experiences with individuals in poverty through home care for an unspecified period of time.

In the course of discussing their experiences of working with individuals or families

living in poverty, participants sometimes shared specific stories or poignant observations. Many

also depicted common challenges experienced by those living in poverty in the context of

witnessing it in their everyday work. One participant, who worked closely with a recently

immigrated family, reflected that:

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^{12} [] signifies that a portion of the participant's response has been removed from the quote.

What I only give them is the tip of the iceberg. For December yes, they would have

diapers, they would have [] formula. You know, the toys might be more longer but that's

only [] a two year old toys. What happen if the kids are four years old? You know, they

won't have toys. So, I can only put the band aid on. I can only actually serve them for

the December time. But what about January and February? You know? They will go

back to the square one again.

What it means to address the causes of poverty. Participants relayed a breadth of

responses when asked what it means to address the causes of poverty. Over half ($n = 8$)

responded that addressing the causes of poverty meant ensuring individuals receive sufficient

income through employment or adequate social assistance. For example, one participant stated

that, "I think we need to make sure people have enough income either through work or whether it

be Ontario Works or whatever so that they can meet the necessities of life."

Many participants ($n = 8$) also expressed that addressing the causes of poverty meant

ensuring access to other social determinants of health, such as housing, food, and education, as

well as through demonstrating social inclusion and promoting healthy childhood development.

Several ($n = 5$) also specified attention to vulnerable groups, including: Aboriginals; individuals

who use substances, live with mental illness or disabilities; newcomers to Canada; and women.

The majority ($n = 9$) conveyed that changing government policy (i.e., through policy advocacy)

with respect to said matters was relevant to addressing the causes of poverty. While the

following quote highlights several of these topics, it was more common for participants to talk

about them separately or to discuss a specific issue in greater detail:

Well addressing the causes means advocating for the changes that need to come

from government in terms of policies and funding for education, housing,

daycare, community services for families of children, nutritional programs, for

example, [] employment, support employment training. [] For young children, the

effects to them specifically – emotionally, socially. Like, it starts in childhood,

right? I mean it's a cycle, right? And it's very hard for people to break out of.

There's a big stigma.

As illustrated in the quote above, the comments of participants often suggested a

connection between addressing the causes of poverty and addressing other social determinants of

health. Indeed, one-third of participants ($n = 5$) specified a link between these two or described

how they related to one another, for example, by outlining how a lack of access to social

determinants of health can lead to poverty. One participant commented that "The causes of

poverty are so intercepted with all the other social determinants. And one informs the other. So if

you're poor, it's harder to get an education and if you have a good education it's not likely that

you're poor." Another explained:

Poverty to me is kind of the resultant state, whether it's financial poverty or poverty that

can be [] poverty of mind, body, spirit almost. It's a result of unmet needs within the

social determinants of health. And I think that what I see much of... you know, those

things like access to health care, education, housing, employment, food security – all of

those things are so essential to achieve health. And when any of those are missing or

certainly if a combination of those are missing most often we see families in poverty.

One-third of participants ($n = 5$) believed that addressing the causes of poverty involved

critical public awareness of poverty and related issues. Of those who made this suggestion, most

observed that non-poor individuals (e.g., those with a higher SES) lacked awareness of poverty

issues and ought to become more attentive to such matters or empathic of those living in poverty. As noted by one participant:

Your middle class person doesn't have any understanding of what poverty is. And, so if there was a whole movement on that, everybody became much more aware of what really poverty is and the causes of poverty and socialization [] and people had a clear understanding of that, I think that, yes, indeed it could make change.

Several participants conveyed that widespread buy-in made sense for addressing the causes of poverty as it is an issue that affects everyone. For example, one participant stated, "I think everybody needs to be on-board with understanding that by helping the poorest of our poor, helping the people who have not, we're helping all of us."

One-third of participants ($n = 6$) also discussed community self-determination, that is the idea that individuals, families, and communities should have a say in, or direct, the (public health) services/ resources provided to them. As one participant commented:

The population that we're talking about needs to share some of the power. If that power was shared and they were given that opportunity to, as I said, go back to that critical appraising of their situation... [p]utting more resources in the hands of those people may right the balance.

Finally, for some, addressing the causes of poverty meant increased awareness of and access to services (i.e., health and social services) (n=4), and improved health literacy amongst those who are poor (n=2).

The role of socio-political activity in addressing the causes of poverty. When it came to discussing whether, and how, socio-political activity helped to address the causes of poverty, most participants agreed that it could influence government policy ($n = 12$) and raise critical

awareness among the public – especially middle- and upper-class people – and/ or politicians (*n* = 9). Concerning government policy, one participant expressed that, "I think it [socio-political activity] has a great impact on the causes of poverty, where I think that the government [has] the power to create or form a policy to help reduce the causes of poverty." On raising critical awareness, another voiced that:

I think that to a large degree general members of middle class society and perhaps upper as well have no concept of the degree of poverty that surrounds them. I do think we tend to isolate ourselves. And so I think that people just kind of understanding the level of poverty, how that plays out in our own communities and our schools and our own neighbourhoods... That consciousness raising, I think, is really, really important.

In addition, a few participants also thought that socio-political activity could create opportunities for community self-determination and community mobilization (*n* = 3 and *n* = 2, respectively). As one participant said:

Let the community be in charge. And [] hear their needs. [W]e need to use their strength. They are the ones that will stay in this community [] or want to be, you know. [A]nd you want to [] have them voice out and to have them be the lead for this. A collaborative leadership.

The role of public health in addressing the causes of poverty. Although the interviewer did not ask participants to comment on whether public health units (i.e., PHNs) should help address the causes of poverty[13], several participants spoke voluntarily about this.

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[13] It was assumed participants would agree that PHNs should address the causes of poverty by lieu of their participation and the nature of the study.

For those who commented (*n* = 10), most agreed that public health units or PHNs should help address the causes of poverty. Some participants conveyed this by criticizing the current focus of public health units (i.e., the focus on lifestyle as opposed to SDOH) or by expressing that PHNs should engage in social justice work. One participant observed that:

There has to be more understanding, that's all... Like people are upstream and downstream and we're supposed to be upstream and all that. But we don't really do that and we don't put the money into it. Like we put a huge amount of money in this health unit into smoking cessation, lots of money into activities in lifestyle issues and so on.

Two participants, however, felt that addressing the causes of poverty was not for all PHNs. One participant stated that PHNs in her program ought to focus on "healthy messages", leaving upstream poverty work to "Community Health Officers" (PHNs with specific roles in community capacity building). Another PHN argued that the public health model would never work – and that to address the causes of poverty PHNs would have to "emancipate" themselves from this role and become community health nurses: "In a word, I don't think this [public health] model works in terms of addressing the political, social, economic conditions that contribute to poverty. I don't think it works."

Strengthening PHNs Socio-political Efforts to Address the Causes of Poverty

The study sought insight into how Ontario public health units could strengthen PHNs' socio-political efforts to address the causes of poverty. In keeping with the study's conceptual model, Kanter's *Structural Theory of Power in Organizations*, participants felt they would be empowered in their health unit through (1) PHN autonomy and recognition of the PHN role, and (2) sources of opportunity, support, information, and resources provided to them by alliances internal and external to the health unit (so coined 'sources of support' for the purposes of this

study). In this study, the definition of empowerment is borrowed from Kanter's theory (Sabiston & Laschinger, 1995), where empowerment refers to an employee's ability to take action. Participants also discussed factors beyond the scope of Kanter's framework as well as beyond the realm of public health units.

Participants identified similar sources of support across the four phases of the Appreciative Inquiry framework, *Discover, Dream, Design* and *Destiny*. These sources of support included: authorities, active associates, and external allies. In other words, while discussing their affirmative stories (and *Discover*-ing the best that has been), while envisioning (or *Dream*-ing) of an ideal health unit, while *Design*-ing the work that PHNs would be doing if they more effectively addressed the causes of poverty, and while identifying actions that would need to occur in order to fulfill this *Destiny,* participants identified similar individuals, groups of people, and/or organizations as being sources of past and imagined/ future support. Following inductive coding, codes were subsequently classified under one of three categories: authorities, active associates or external allies.

Authorities included those with formal positions of power or immediate influence over the public health unit or its activities. Managers, senior managers, Medical Officers of Health, Boards of Health, and the MOHLTC were included in this category. Supports arising from established health unit processes, systems or cultures were also captured here, for instance, generally supported practices occurring within the health unit or organizational beliefs, values, and attitudes. Active associates included 'partners in activity' or, in other words, those with whom PHNs worked in close organizational-proximity or with whom they had an established partnership. Front-line public health staff and volunteers, staff from other municipal/ regional departments, and those who composed the core workgroup of their affirmative experience

initiative (AE initiative – discussed below) were classified as active associates. Finally, external

allies included persons and organizations external to the health unit whose support was more

peripheral than that of active associates. These included community not-for-profit agencies,

private/ for-profit organizations, community members, schools, researchers, and others.

The nature of support provided by authorities, active associates, and external allies was

similar across the four phases of the Appreciative Inquiry framework. These types of support and

their sources actualize the overall study themes and can be explained as follows: (1) Authorities

'Permit and Provide'. They implement priorities and mandates, 'give the go-ahead', allow the

time, provide money and human resources, demonstrate understanding, create supportive

cultures, and arrange for necessary training. (2) Active associates 'Help Each Other Out'. They

share information and expertise, donate their time, provide mentorship, demonstrate buy-in and

understanding, and work together on common issues/ initiatives. (3) External allies 'Contribute

and Collaborate'. They share information, fund initiatives, provide hands-on assistance, and

render in-kind support (i.e., services, space, and human resources). Table 1 summarizes these

supports and identifies at what point participants discussed them with respect to the Appreciative

Inquiry framework. Table 2 expands on this table by providing operative definitions.

Table 1

Types of Support Provided by Authorities, Active Associates, and External Allies for Each

Phase of the Appreciate Inquiry Framework

	Authorities *Permit and provide...*	**Active associates** *Help each other out through...*	**External allies** *Contribute and collaborate by...*
Discover	Allowances – 'give the go-ahead', time, autonomy, and opportunities for discourse about poverty issues. Positive feedback to make PHNs feel valued. Validation – understand poverty and anti-poverty work; create a supportive culture. Operational support to develop/ implement the initiative. Human resources and funding.	Positive feedback – expressing interest, advocating for the initiative. Validation – understanding and acknowledging PHNs and their work. Committing time to work on the initiative (human resources). Sharing information and expertise.	Providing expertise and information. Providing funding and in-kind human resources. Sharing programming and providing material items, i.e., space and administrative materials.
Dream and Design	Allowances – 'give the go-ahead', time, authoritative direction (i.e., mandate). Positive feedback – expressing value for anti-poverty work; advocating for an anti-poverty approach in health units. Validation – understand and buy-in to anti-poverty work; acknowledge poverty as a public health concern; create a	Validation – understanding and buying in to anti-poverty work. Operative support – working together to develop/ implement initiatives. Sharing information about programs, clients, resources. Providing expertise, sharing experiences, and mentoring each other.	Operative support – help with policy advocacy. Providing expertise. Sharing lived-experiences concerning poverty, i.e., story-telling. Sharing programming and services.

	supportive culture. Funding, human resources, and material items. Training and support for mentorship.		
Destiny	Allowances – the 'go-ahead', time, autonomy, authoritative direction (i.e., mandate). Positive feedback to make PHNs feel valued Validation – understanding and buying-in to anti-poverty work. Human resources and funding. Training and support for mentorship.	Positive feedback – expressing value for PHN role. Validation – understanding and buying into anti-poverty work. Operative support – working together to develop/ implement initiatives. Sharing information. Providing expertise and mentorship.	Providing information about programs/ services. Providing expertise. Sharing lived experiences around poverty, i.e., story-telling.

Table 2

Types of Support: Definitions

Type of Support[a]	Definition
LINES OF SUPPORT	
Allowances	The granting of particular privileges to enable others to increase their work effectiveness and achieve job demands.
Positive feedback	Encouraging statements or actions that help to sustain or accelerate efforts aimed at achieving job demands.
Validation	Environments or sentiments that emanate acceptance for work necessary to achieve job demands.
Operative support	Functional assistance aimed at achieving job demands.

LINES OF INFORMATION	
Information sharing	Sharing or providing information relevant to achieving job demands.
Expertise	Expert advice or opinion from people with established knowledge in a particular area.
LINES OF SUPPLY	
Material items	Money, funding, space, or tangible items worth a monetary value.
Human resource provision	Dedicating human resources to particular activities or programs.
Connecting human resources	'Bringing-together' or linking human resources, i.e., service providers, community members, clients, etc.
OPPORTUNITY STRUCTURES	
Training	Organized education or skill building on relevant topics.
Mentorship	The process by which a more experienced person shares knowledge with a less experienced person in the context of a long-standing relationship (i.e., not just 'one-off' advice).

[a] Bolded types of support are defined per Kanter's *Structural Theory of Power in Organizations.*

While the themes hold true across all phases of the Appreciative Inquiry framework (*Discover, Dream, Design* and *Destiny*), the ways in which 'sources of support' provide their support differs slightly across the four phases. For example, the ways in which authorities 'Permit and Provide' varies somewhat when comparing the best that has been (in the *Discover* phase) with visions of an ideal health unit and designs for more effective public health nursing work (in the *Dream* and *Design* phases). In the sections that follow, these results will be expanded on as the four phases of the Appreciative Inquiry framework are discussed in turn. Approaching the phases separately will contribute to answering the study question by: (1)

revealing how public health units have supported PHNs' socio-political efforts to address the causes of poverty in the past, and (2) conveying participants' thoughts for how this can and should be done in the future.

Participants' best experiences with using socio-political activity to address the causes of poverty as a PHN will first be described, followed by the organizational ingredients that made those experiences successful (*Discover*). Next, participants' thoughts on 'the ideal health unit' (*Dream*) and public health nursing work (*Design*) – relevant to addressing the causes of poverty – will be outlined, followed by suggested organizational supports. Following this, there will be a comparison of these two sections, that is, 'the best that has been' with respect to addressing the causes of poverty (phase one – *Discover*) will be compared with participants' *Dreams* for an ideal health unit and *Designs* for more effective PHN work to address the causes of poverty (phases two and three). This comparison will highlight those desired organizational supports that exist already within health units (with respect to addressing the causes of poverty), and identify those that are missing. Finally, a description of participants' ideas for how to make their *Dream* and *Design* a reality – including the organizational supports that would be needed (*Destiny*) – will complete the report of the study's findings. 'Non-organizational' supports, including those beyond the scope of Kanter's framework or external to the health unit, will be identified accordingly, as well as those responses that ran counter-to the dominant themes. Table 3 provides an overview of how these topics will be discussed in the sections that follow.

Table 3

A Summary of the Sections to Follow

Section 1: Discovering	About participants' affirmative experiences.
	
	Organizational factors that enabled the affirmative experience, including supports from:
	        Authorities
	        Active associates
	        External allies
	
	Other supportive organizational factors, including:
	        Job definition
	        Individual qualities

Section 2: Dreaming and Designing	About participants' dreams and designs.
	
	Desired organizational supports from:
	        Authorities
	        Active associates
	        External allies
	
	Other desired organizational supports:
	        Job definition
	        Individual qualities
	
	Factors beyond the health unit.

Section 3: A Comparison	Comparing 'the best that has been' (*Discover*) with *Dreams* and *Designs.*
Section 4: Destiny	An overview of how to bridge today's reality with dreams/ designs for the future.

Section 1: Discovering the best that has been – The affirmative experience.

Overview. All but one participant shared an experience about 'the best that has been' with respect to using socio-political activity to address the causes of poverty as a PHN – so termed the 'affirmative experience' from this point forward. For two participants, the affirmative experience involved increasing access to health services through mobile or satellite clinics/ services. One

participant spoke to improving the health literacy of her clients, while another discussed her health unit's focus on involving the community. Four participants shared affirmative experiences where opportunities for employment or education were provided to poor individuals. One participant described an intensive home visiting program for new mothers[14], and five participants described initiatives involving various forms of socio-political activity.

For the affirmative experiences involving socio-political activity, initiatives incorporating social education program development and critical awareness-raising were most common. These affirmative experiences included: (1) internal (public health) and external committees focused on social determinants of health and poverty- health issues; (2) youth story-telling about poverty-related experiences; and (3) underscoring poverty-health-education issues in presentations to schools across an Ontario region and at a teacher's conference. Such strategies are relevant to altering the social, political and economic conditions that contribute to poverty, as "awareness of a health issue is a necessary precursor to any policy change" (Whitehead *et al.*, 2000 as cited in Raphael, 2003a, p. 401). In addition, one affirmative experience involved on-going political advocacy through report writing to a Board of Health.

Unlike the affirmative experiences involving socio-political activity, the other sub-set of affirmative experiences did not aim to alter the structural determinants that contribute to poverty or forward community-based emancipatory social movement concerning poverty. Rather, they

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[14] The participant who discussed this initiative wasn't directly involved with it, however, she knew enough about it to be able comment on organizational factors that supported its success. For this reason – and because the initiative was unique compared to others discussed in the study – it was included as an "affirmative experience". In all other cases, participants were directly involved.

attempted to lift individuals out of poverty by increasing their present or potential incomes. These affirmative experiences included: (1) a program for young mothers (pre- and post-natal) aimed at helping them complete high school; (2) a peer outreach program that employs 'at-risk' youth in a rural area; (3) the establishment of a tennis association in a poor urban neighbourhood using community development strategies; (4) the public health unit employment of a low-income volunteer; and (5) an intensive home visiting program for new, low-income mothers and their families.

A point of clarification is necessary here. While both sets of affirmative experiences aim to reduce the number of Canadians living in poverty, the former does so by attempting to alter social, political and economic conditions contributing to poverty, while the latter aims to achieve this by lifting individuals/ families above the poverty line. All such affirmative experiences were included in the analysis[15] given that public health activities that target poverty itself rather than its effects are considered to be worthwhile and needed public health efforts (Joint OPHA/ alPHa Working Group on Social Determinants of Health, 2010; Raphael, 2003b; Williamson, 2001). Table 4 provides more detailed descriptions of the affirmative experiences, including the specific ways the initiatives targeted the causes of poverty (through socio-political activity) or how they attempted to lift individuals/ families above the poverty line.

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[15] In retrospect, the principal investigator/ interviewer was ambiguous about the distinctions between causes of poverty, poverty reduction, and socio-political activity. As a result, the recruitment process was affected: PHNs were invited to participate if they could speak to a poverty reduction initiative, rather than one that more specifically addressed the causes of poverty through socio-political activity. These issues will be explored further in the discussion of the findings.

The remaining affirmative experiences were not included in the analysis ($n = 4$) as they addressed the consequences of poverty rather than its causes. These experiences included: a mobile and satellite health clinic; a health unit's focus on involving the community without a clear intent to address causes of poverty; and a PHN's efforts to improve the literacy of her clients through intermittent support. While increasing literacy rates is a recognized poverty reduction strategy (Torjman, 2008), Torjman discusses this in the context of organized community programming rather than through individual support.

To best highlight 'the best that has been' (*Discover*) with respect to addressing the causes of poverty (or poverty reduction, more generally) only the two sub-sets of affirmative

Table 4

AE Initiatives

Type of Initiative	Description	Composition (Partners/ Participants)	PHN Role	It Addresses Poverty Reduction by…
Internal public health committees (*n* = 2)	1) Focuses on SDOH, including poverty-health issues, e.g., has educated management and staff about SDOH.	1) Senior and front-line public health staff –mostly PHNs and health promoters.	1) Participant.	1) Messaging about the effects of poverty[a]. Putting poverty on the agenda of the organization[a].
	2) Examines community poverty issues. Discussion and research-based.	2) Senior and front-line public health staff.	2) Participant.	2) Putting poverty on the agenda of the organization[a].
External committee	A poverty network comprised of community professionals (with public health unit representation).	Various community agencies who work with individuals/ families living in poverty.	Participates in committee discussions and projects. Shares information and research about poverty, acquired through health unit.	Partnership action targeted, in part, at reducing (community) poverty[a]. Putting poverty on the agenda of organizations[a].

Presentations that underscore poverty issues	A PHN emphasized the effects of poverty on health and education while presenting on a Healthy Schools initiative at a teacher's conference. This information was subsequently included in the health unit's 'Healthy Schools' presentation and used to introduce program to school staff.	PHNs and their direct manager.	Initiated idea to discuss poverty-health link in conference presentation and presentation for schools. Developed, delivered, and revised presentations.	Messaging about the effects of poverty[a]. Putting poverty on the agenda of organizations[a].
Youth story-telling	To help establish a sexual health campaign, youth were invited to speak to sexual health educators about their lived experience with oppression and resiliency, i.e., having limited resources.	Front-line sexual health educators and direct managers. Community youth. Parks and Recreation (facilitated youth connection).	Facilitated meeting between sexual health professionals and youth. Networked. Spoke with contacts to bring people together.	Facilitating story-telling to shift professional focus from individual/ behaviour to social determinants of health[a].
Report writing to a Board of Health	PHNs are regularly encouraged to include their observations and professional recommendations in reports that are sent to the health unit's Board of Health, e.g., to increase municipal share of Ontario Works subsidy.	Public health staff, i.e., PHNs, Public Health Dieticians. Board of Health.	Identifies issues for advocacy. Provides observations and recommendations. Sometimes attends Board meetings.	Identifying issues and providing recommendations for policy action (a socio-political activity).

Employment at PHU	A man with an Ontario Works income volunteered regularly for an injury prevention program. He was mentored by PHNs and received free lunches and bus tokens from the health unit. The health unit eventually hired him on as a permanent staff.	Public health staff, i.e., PHNs, volunteer coordinator, senior management. Volunteer.	Mentored volunteer. Advocated for volunteer to get paid.	Providing a low income individual with public health wages[b].
Peer outreach project	At least six youth are hired on a yearly basis to outreach to peers in a rural community about issues related to social justice, addiction, and sexual health. The youth chosen to participate are often involved/ coping with challenging life circumstances, such as substance use, dropping out of school, or involvement with the legal system. The initiative is governed by a youth-led advisory committee, also composed of other non-profit agencies. An external manager oversees the program, with PHN support.	PHNs . Community youth. Community agencies that work with youth. External manager.	Developed program with community partners. Supported advocacy for program at council-level to get sustainable funding. Attends advisory group, but is a neutral voice – is there for guidance. Provides support to program manager.	Encouraging a positive life trajectory that may have led youth to complete high school[bc].

Establishing a local tennis association	Tennis Canada contacted a PHN to help them set-up a tennis association in a poor urban neighbourhood. The PHN brought different community members together to work with Tennis Canada. Now, the community runs the local tennis association; a community tennis court has been refurbished; there are youth scholarships available for post-secondary education and tennis training; select youth are invited to partake in a tennis camp through the local university free-of-charge; and youth are invited for occasional outings (e.g., they once went to Roger's Centre to meet famous tennis players).	A PHN. Tennis Canada. Community → parents, children, local agencies. Local university. Private organizations.	Mobilized community; brought people together. Advised national tennis association on how to work effectively with the community. Advocated for various components of the initiative. Supported community members and their partners, until the local association was sustainable.	Developing strong social infrastructure via recreational programming and shared community space[bd].
High school program for young mothers	High school education, daycare, and programming on parenting are provided to young mothers and pregnant women up to the age of 21 years, so that they can complete their high school education.	PHNs. School board. A family-focused community agency.	Developed program with community. Seeks funding; fundraises. Assists with program operations. Provides education, information to mothers.	Helping young mothers complete high school[be].

Intensive, nurse home visitation program	Low income, first-time mothers are paired up with a PHN from pregnancy until their child is two years old. Proven benefits, based on longitudinal studies from the United States, include increased maternal employment and improved school readiness.	PHNs. A family-focused community agency.	Provides support, health and development education, and life-coaching to mothers and their family.	Providing poor mothers, and their families, with support[bf].

[a]These initiatives are examples of social education program development and critical consciousness-raising – forms of socio-political activity.

[b]These initiatives target poverty reduction by helping to raise the present or potential income of individuals/ families to levels above the poverty line (e.g., through income provision, educational opportunities, strong social infrastructure, or early childhood development programs). Most can be validated as core components of a comprehensive poverty reduction strategy in *Poverty Policy* (Torjman, 2008).

[c]Torjman (2008) does not recognize youth employment as a core poverty reduction measure. While it is true that youth in rural communities, as well as those who have dropped out of school, have a more difficult transition into the labour market (OECD, 2008), it is unclear whether the skills attained through this program would facilitate such a transition. This initiative was nevertheless included in the analysis, as the participant – who was involved in the program since its inception – reported that many youth, "developed self-esteem, dropped their substance use, and [returned] back to school" through their involvement in the program. Because high school completion is an important springboard out of poverty (Torjman), the initiative was included.

[d]This initiative addresses poverty reduction by establishing strong social infrastructure in the form of community spaces and an

associated recreational program (Torjman). "There are strong links between recreation... and good physical health, mental health and social well-being" (Torjman, p. 25).

[e] Investments in high school completion are an essential component of a poverty reduction strategy; education is one of "the most important springboards out of poverty" (Torjman, p. 7).

[f] Early childhood development initiatives, such as home visiting programs for young, poor mothers, are a core component of a comprehensive poverty reduction strategy (Torjman).

experiences (*n* = 10) will therefore be described[16]. The responses of all participants will be

included, however, in the sections on *Dreams, Designs,* and *Destiny* that follow.

About participants' AE initiatives. Collectively speaking, the AE initiatives involved a

range of goals or purposes. Several, for instance, aimed to enhance community well-being (e.g.,

in schools, neighbourhoods) (*n* = 4). One participant described the goal of her initiative as, "to

get the children and the youth in the community to be more physically active". Other initiatives

aimed to provide employment or educational opportunities (*n* = 4), as suggested by one

participant who said, "The goal [of her AE initiative was] to help teen moms continue their high

school education and to improve parenting skills with the goal of course of decreasing the

chances that they will live in poverty." Two AE initiatives were established in response to health

unit priorities (e.g., objectives in the strategic plan), while others were directed at influencing

policy, increasing knowledge, enhancing individual/ family well-being, or preventing injury/

substance use.

As exemplified by the following quote, PHNs or front-line staff initiated the initiatives

most cases (*n* = 5): "That's why I thought it would be a great idea... They [youth] were really

valuable as far as enhancing our way of practicing. So we thought inviting them to share their

story would get people to realize that they have a voice, and that they should be included." In one

case the idea was brought forth by youth in the community and, in another, by a national

association. Management were the initiators in two cases, whereas a provincial pilot program

was the catalyst for the final initiative.

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[16] Of the 'valid' affirmative experiences, eight health units are represented, spanning across nine

LHINs.

The AE initiatives most often reflected work with youth, young mothers and families, and/ or other service providers. Youth and young mothers/ families were sometimes described as facing financial hardship or as coping with challenging life circumstances. One participant explained that, "The youth that are recruited aren't the A students or the presidents of the student council, but youth that are maybe in trouble with the law or actively using substances or may have dropped out of school."

Activities involved were numerous. Commonly reported were activities related to client support (e.g., instrumental support, linking with resources, responding to individual needs), as well as creating awareness about poverty-health issues (e.g., through presentations, story-telling, report-writing). For example, one participant, involved in an internal social determinants of health committee, reported that:

> So what we have done so far is we have done some presentations [] to managers, to all
> staff, to the Board of Health, and just talking about the committee and how we plan to
> address social determinants of health and how the health unit as a whole can address the
> social determinants of health.

Several participants also spoke to providing opportunities to individuals or communities by way of education, training, experience, or employment. One participant who spoke to training opportunities observed that, "What they [Tennis Canada] want is they want to promote the youth to become the assistant coach to become the coach. So it's like sustainability." Professional support, acquiring resources (e.g., fundraising, proposal writing), examining community issues, and engaging communities through events, outreach, recreation and inviting input were also described by several participants.

AE initiatives' core workgroups or teams were composed of different groups of people. In all cases, the public health unit was a major player. Many workgroups and teams consisted solely of public health staff (e.g., PHNs, managers) ($n = 4$), while a few were agency partnerships ($n = 3$) or had mechanisms for community input ($n = 2$). One participant explained that community input was sought through an advisory committee composed of youth, agency people, and adults. She explained that, "It's youth driven. And there have to be more youth present than adults at any meeting to vote." In one case, the initiative was driven primarily by parents and youth in a community.

During the development and implementation of the initiatives, PHNs assumed the roles of organizer, supporter, initiator, participator, manager, and mobilizer (in order of decreasing frequency). The following quote describes how one participant organized for more awareness of poverty-health issues:

> So, in order to go and present at this poverty symposium I had to make sure that poverty was a big aspect of the talk. [] And then from that we've incorporated more information into our initial presentations about poverty and how Healthy Schools addresses poverty along with education and health. And then also I was supposed to present to the rest of my staff last year but it kept getting bumped. So now I'm rescheduled.

Finally, although not specifically asked as part of the interview guide, many participants also shared some of their initiatives' achievements. These included client success stories, benefits to community social and physical infrastructure, funding obtained, community ownership, sustainability (in the absence of public health support), and spread of the initiative to other entities (e.g., schools, neighbourhoods). This participant shared her high points on a community development initiative that is now being sustained by the community:

That's why I thought: That is one my high points too. Because it's a project from the

community, and it's a project that… not a project… It's not a project 'cause there's no

end… beginning and end. It's like on-going... It's really, really involved by the

community.

Organizational (and other) supports: The ingredients for success.

Authorities: Permit and provide. Authorities were a major source of support in helping to

enable participants' AE initiatives. Indeed, participants spoke to authorities more than active

associates or external allies. Support from direct managers and 'the public health unit' (i.e., its

culture and systems) was discussed most often, however, municipal and provincial governments,

senior management and Medical Officers of Health were identified as sources of support as well.

Almost all participants (*n* = 8) described how their direct managers helped to empower

their work in their AE initiative by providing them with allowances. These allowances were most

often 'giving the go-ahead', allowing autonomy, permitting relevant discourse (about poverty or

the initiative), and allowing them time to work on it. Such support was demonstrated in the

following participant's quote about her work on an internal social determinants of health

committee:

I think having support from our managers to embark on this and to meet twice a month

with our committee has been great to have their support because [] they might not allow

to take time away from their program to be on a committee.

Expert participants (those with greater than 10 years experience as a PHN) also spoke to

the ways in which management (i.e., direct and senior managers, Medical Officers of Health) or

'the public health unit' validated the work they were doing, for example, through expressing

understanding, a supportive organizational culture[17], or valuing their work. One participant

commented that her manager, "is very understanding and supportive of health promotion in the

traditional kind of community development". Another participant depicted how political

advocacy to a Board of Health was a common part of her organizational culture:

> We're aware of when the Board meets and encouraged to... Like, if anybody wants to put
>
> an item before the Board, the process is... we know how to access the process to do that.
>
> How to get the information about that. So, I think it's [] an avenue that is available to
>
> people. [Interviewer: It's just a part of the culture?] Yeah. Oh I would say so for sure.

Participants commonly mentioned the provision of human resources and funding

as helping to enable their AE initiatives ($n = 6$ for both). Speaking to a home visiting

program for new mothers, one participant said, "They [Boards of Health, city council]

actually allotted... So, there's a manager – a program manager – and she has a team of I

think maybe four or five nurses and those nurses specifically follow those families. So,

there's FTE time that's been given." Funding was described as coming from the health

unit, as well as regional councils and provincial governments. The following participant

spoke to the value of receiving provincial funding:

> We did an awful lot with very little in our communities. I mean I've received a hundred
>
> and thirty thousand dollars here – not a lot of money industry-wise. They gave back
>
> almost a million dollars in in-kind. Because of the little bit we had we were able to work
>
> as a community and make it a much bigger value.

Participants also described the health unit as instrumental in providing material items

such as space, equipment, and client incentives. As described by one participant, "And then of

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[17] A supportive culture is captured under authorities because culture is shaped by those in power.

course we were allowed whatever we needed to be able to do the presentation. Like, we were allowed to get hand-outs and some coloured printed papers." Expert PHNs were more likely to discuss funding and material items compared to non-experts.

A few participants mentioned that operational support, from direct or senior managers, to develop/ implement the AE initiative was empowering. One participant described how her senior managers established an internal committee, while another explained that her direct manager was "very involved" in a peer outreach program. Training (provided or endorsed by the health unit) was not considered to be a relevant factor in facilitating the AE initiatives by nearly a third of participants ($n = 3$), although some made mention of general training for staff related to social determinants of health.

Active associates: Help each other out. Active associates, in the context of the AE initiatives, included public health staff and those who made up the core workgroup/ team of the AE initiative (the 'initiative's composition'). Participants described these groups as supportive in terms of their positive feedback, validating responses, sharing of information and expertise, and commitment of their time. In addition, expert participants tended to view their partners in the initiative's composition as supportive in terms of their ability to seek and obtain funding.

Positive feedback from active associates included 'going to bat' or advocating for participants' AE initiatives and expressing interest towards poverty-health issues. For example, one participant described how colleagues on her team expressed interest in learning about poverty, as it relates to Healthy Schools, through a team survey. Another participant described how positive feedback from a woman involved in her initiative's composition helped to secure funding for a peer outreach program when she lobbied Regional Council:

We had this young woman who was very articulate and we could do a lot of advocacy

work through her because she wasn't an employee of the health department. So she did a

lot of work presenting to regional council over and over again so that they now fund [the

initiative].

Positive feedback was discussed by four participants and, in the area of active associates, was

one of the most commonly discussed supports (along with seeking funding and time

commitment).

Another commonly discussed support was validation, including understanding and

acknowledgement of the type of work that PHNs were doing. Nearly one-third of participants (*n*

= 3) stated such support helped to facilitate their AE initiative; all were expert PHNs. The

following participant conveyed how team understanding helped to facilitate youth story-telling in

her AE initiative:

I asked them [my team]. I told them. And they understood the importance of it. And

they valued that, the story telling part of it [] and letting and empowering youth by

sharing their stories with us.

For those who stated expertise was a useful support (*n* = 3), some were referring to their

own expertise (in community) while others were referring to expertise available in the health

unit. One PHN described how her expertise – "having worked with young mothers and people in

poverty for about 30 years and knowing the gaps in services [], about how the system works and

how to find out more" – enabled her to mobilize action around a school for young mothers. The

same participant commented on expertise within her health unit, explaining she "had one staff

member [working as part of her initiative's composition] who did evaluation and funding

proposals and [] helped [the team] find sources of funding and [] with some strategic planning."

Expert PHNs tended to speak more in-depth about expertise compared to non-expert PHNs.

For those who stated sharing of information was empowering, the source of such information was usually other public health staff and the types of information included research articles, statistics or the work-/ lived-experience of such staff. Staff experiences, for one participant, were used to make suggestions to a Board of Health, "We will have a discussion, spend a little time at a team meeting about what that would look like – what our experiences have been, what our observations have been. And then that would be weighed into writing up a report that is presented to the Board."

External allies: Contribute and collaborate. Participants discussed support from external allies the least (compared to authorities and active associates). Major sources of support included community not-for-profit agencies and community members (residents or 'the community' in general). Participants described these entities as supportive in facilitating human resources (through volunteering or in-kind provisions), sharing organizational programming and material items (such as space and administrative materials), and providing expertise and information (e.g., individuals' shared their lived experiences with PHNs). Researchers and public institutions (e.g., schools) were discussed to a lesser extent, providing support through expertise and in-kind provisions, respectively. Again, experts tended to discuss expertise in greater detail compared to non-experts. The following quote exemplifies some of the in-kind supports provided by community agencies and public institutions for a high school program for young mothers:

They [the school] provide the teacher, that's their main thing, they do the academic thing.

So they also provide the academic support, you know they have a counsellor and they

provide the computers and the text books and the materials for the education. They are

entirely focused on the education and with the enrichment part of having a counsellor –

the school board counsellor, which is a social worker – visit a half day a week.

While private for-profit organizations and funding bodies (e.g., United Way) were

mentioned by a smaller number of participants, these sources of supports provided funding – and

this was a major facilitator (relative to other external allies' supports), discussed by nearly half of

the participants ($n = 4$). One participant, for example, conveyed how external funding in support

of a recreational activity helped to sustain benefits for residents of a poor urban neighbourhood:

> And they actually [] because they also have funding, some funding from 407. So, they
>
> actually refurbished the tennis court because [it] is [] not good. I mean you cannot play
>
> when the equipment is lousy. So, that's another thing. The cost is like that. And so the
>
> children doesn't have to actually go to a TTC to some place; just come down from their
>
> apartment and they can play tennis.

Other organizational supports. PHNs' job definition, including autonomy of the PHN

role, was discussed in detail by half of the participants and, in that sense, was a notable enabler

(relative to other supports). In the following quotes, PHNs express how their job definition (i.e.,

discretion in decision-making) empowered them to work on/ in their AE initiatives:

> Quote 1: The manager trusts our ability to research and make decisions on what
>
> information is important to both the teachers and to do this actual presentation and then to
>
> revamp the presentation to meet the staff's needs. Our own staff needs.
>
> Quote 2: Yeah, they give us the autonomy to do it. I mean we always have to provide
>
> rationale, right? You can't just say I want to do something without sort of backing it up,
>
> but once, you know, you back it up they're pretty much very open to letting us do things
>
> that we feel would be meaningful.

It was not uncommon for participants to interpret job definition as job description. When this happened, participants would often respond that this was not a relevant factor in facilitating their AE initiatives.

Participants also spoke about various topics of information as helpful in facilitating their AE initiatives. These were more likely to be mentioned by non-expert PHNs than experts. Although these can be traced back to identifiable 'sources of support', they are better illustrated by grouping them together. Many participants ($n = 6$), for instance, reported that community based-information was helpful in facilitating their AE initiative, including anecdotal experiences from community members and staff, epidemiological data, and information from other jurisdictions doing similar initiatives. For example, on participant explained:

I like to work with data, numbers, statistics as a starting point and then I use a lot of anecdotal... I mean if I need to translate a message to the general public – people who've never experienced the poverty or homeless issue in their lives, I need to find a story that's going to pull their heart strings.

Other types of information included research and health promotion literature, information pertaining to public health unit activities and strategic directions, and information on upcoming conferences[18].

Finally, over half of the participants ($n = 6$) talked briefly about the internal qualities of staff and, to a lesser extent, clients, as helping to facilitate their AE initiatives. These qualities most often included a charismatic personality, motivation, and skills/ expertise. Internal qualities were more likely to be discussed by participants with a bachelors degree, compared to those with

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[18] One participant explained that an advertisement for a teacher's symposium sparked the opportunity for a PHN to speak about poverty-health-education issues (her AE initiative).

more education[19]. The following participant voiced how empathic staff qualities facilitated client involvement in her AE initiative, "So, you know, little differences of treating somebody kindly and offering them an opportunity to build some skills and increasing their self-esteem can make a huge difference."

Section 2: Dreaming of an ideal health unit and designing the work of PHNs.

Overview. For these segments of the interview, participants were asked to: (1) envision and describe a health unit ideally suited to addressing the causes of poverty, and (2) share their ideas on what the work of PHNs would look like if they more effectively addressed the causes of poverty. These questions corresponded to the *Dream* and *Design* phases of the Appreciate Inquiry framework. The responses of all participants were included in the analysis ($n = 15$).

About participants' visions (Dreams) and the work of PHNs (Designs). Political advocacy was the most talked-about feature in PHNs' visions of a health unit ideally suited to addressing the causes of poverty. Three-quarters of participants spoke expansively to this topic ($n = 11$), with bachelors-prepared participants more likely to speak to it than those with a higher level of education.

Participants envisioned health units that lobbied governments for improved poverty-related policy (e.g., affecting newcomers, child care, and social assistance rates). They saw PHNs as anti-poverty advocates and educators, with direct access to politicians [e.g., Members of Provincial Parliament (MPPs), counsellors] and decision-makers (e.g., Boards of Health). As one participant put bluntly, "As opposed to collecting data and just talking about it, we would be out there lobbying politicians for changes at the political level."

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[19] Those with "more" or a "higher level of education" refers to those participants with a masters or partially completed masters degree.

Most conveyed that policy advocacy would need to be done in-sync with others (e.g.,

from within one's health unit, with other health units, or with external advocacy groups). Several

– mostly expert PHNs or those with a higher level of education – expressed that the success of

such efforts would be heightened by having poor individuals or PHNs share their lived

experience with poverty or working with (those experiencing) poverty. One participant stated:

> It would be terrific if the voices and experiences of the front line staff and clients
>
> could be compiled and shared with government at all levels regarding the changes
>
> that are needed. That staff are actively involved in shaping policy. That staff are
>
> actively involved in advocating at all levels of government.

Engaging communities was another popular element envisioned by participants.

Engagement-like activities included: spending time with communities – getting to know and

understand them; mobilizing communities to address their needs (often through strength-based

approaches); and increasing access to services (e.g., through satellite clinics). One participant

envisioned that, "[PHNs] would [] spend less time trying to get people to the food banks and free

birth control pills and a lot more time working with community members to help them or to

assist them to figure out how they are going to address poverty in their community." Another

envisioned her health unit becoming more "flexible" and offering its services in the downtown

core.

Almost half (*n* = 7) expressed that their ideal health units would address the self-

identified needs of their communities rather than bend to political will or impose unwanted

public health programs. Reflecting on the success of national welfare rights organizations, one

participant asked, "Why can't we just organize people around what their needs are as opposed to

going in with what we think their needs are?" Another expressed current challenges with

balancing the "public health menu" with what the community wants, and said that in an ideal

health unit, "There [would be] no menu". A third commented that:

> It's not the top looking down saying, "Okay, here's what you need." One of the things
>
> that has never been successful is, you know, professionals telling the people what they
>
> need. The people need to tell us what they need, and then we need to support that and
>
> move that forward. And so we need to be hearing what people are saying in order for us
>
> to support that.

To help engage communities, participants saw PHNs as being out in the community

"where people are at" (i.e., doing more front-line and less administrative work), carrying out

formalized assessments or "windshield" surveys, and/ or building community capacity. One

participant explained that, "You teach them [the community] how to fish, then they will know

how to fish. But you [] give the fish to them they'll never know. So, you need to involve them.

And give them skills so that they can stand up on their own eventually." Bachelor-prepared

participants were more likely to speak to engaging communities than those with a higher level of

education.

Two-thirds of participants ($n = 10$) described organizational measures that their

'ideal health units' would take to ready themselves for addressing the causes of poverty.

These included (in order of decreasing frequency): redirecting focus away from lifestyle

issues and on to social determinants of health; creating a more horizontal reporting

structure; eliminating governance from regional councils; enhancing staff understanding

and establishing buy-in; developing processes; and supporting professional development.

One participant explained:

I'd like to see it more inclusive. [] We are always talking about eating healthy food...

whereas someone living in poverty might not be able to afford fruits and vegetables... I'd

like to see the whole health unit as a whole, changing its focus and really trying to

improve the health for those living in poverty.

Nearly half of the participants (*n* = 7) emphasized that working together internally

would be important for addressing the causes of poverty, i.e., across public health

programs, divisions, and other municipal/ regional departments. These PHNs reasoned

that collaborative work would strengthen poverty efforts given that different staff work

with the same clients and/ or that various municipal/ regional departments impact SDOH.

Participants saw PHNs as helping to strengthen these internal alliances, as well as

alliances with media, students, and community agencies. As observed by one participant:

Social determinants of health [] doesn't belong to public health; it belongs to

everybody. So, we need to create that dialogue, and I think a lot of us don't know

what everyone else is doing. We should be sitting around the table with people in

housing, recreation – looking for opportunities to create linkages. Start talking to

each other.

More effective programming was discussed by seven participants, including the

provision of universal services (e.g., in schools), planning and/ or committee work around

social determinants of health, and programs with dedicated, sustainable staffing. Such

topics were discussed mostly by expert PHNs or those with higher levels of education.

For example, one participant suggested that in an ideal health unit, Healthy Schools

programming would have a comprehensive breakfast and lunch program, as well as

sustainable staffing. Another participant envisioned a group of PHNs (with varying

expertise in sexual health, chronic disease, etc.) doing collaborative work in assigned low-SES schools or neighbourhoods.

Seven participants suggested that to more effectively address the causes of poverty PHNs would still need to address its consequences, i.e., by helping individuals cope with economic burden and/ or barriers to health through client-advocacy efforts, offering information about community resources, and providing referrals. Bachelors-prepared PHNs tended to mention this more so than participants with higher education. For example, one participant made reference to prenatal programs in Toronto where PHNs visit shelters. Another stated that if PHNs were to more effectively address the causes of poverty they would need to do individual-level advocacy, reasoning that, "sometimes individuals will get lost if you're just looking at the huge population."

Finally, a lesser number of participants saw PHNs being more engaged in research and evaluation efforts ($n = 4$), particularly research around social determinants of health/ poverty and the development of performance indicators that would assess whether poverty and/ or health equity was being addressed through the health unit.

Of note, one participant envisioned "doing-away" with the public health model altogether when it comes to addressing the causes of poverty. She expressed that health units were better off protecting the public through infection control while community health centres – with their more democratic models (e.g., horizontal organizational structures, governance by residents instead of politicians) – would be better suited to engage in activities that would address the causes of poverty. She argued that, "Experience suggests to me that PHNs and other government-paid workers cannot

legitimately or effectively advocate for the poor because we are part of the system that is disempowering them."

Organizational (and other) supports: The ingredients for success.

Authorities: Permit and provide. Support from authorities was a major enabler in participants' dreams of an ideal health unit as well as in their ideal design for more effective public health nursing work to address the causes of poverty. Nearly all participants expressed that training, allowances, validation of PHN work that would address the causes of poverty, human resource provision, and funding – provided or permitted by authorities – would sustain their visions and empower their work. Positive feedback, authoritative direction, and support for mentorship and skill development were discussed by a lesser number of participants.

Participants spoke primarily to formal leaders (i.e., managers, senior managers, Medical Officers of Health), governing bodies (i.e., Boards of Health, MOHLTC), and 'the public health unit' (i.e., its culture and systems) as sources of would-be empowerment. Two participants stated, however, that governance from politicians (as members of their Boards of Health) would not be helpful or empowering. One participant commented that in her ideal health unit "we wouldn't be run by council", while the other stated she would "get rid of council". These participants felt that governance from politicians was oppressive and prevented them from advocating for or addressing the needs of their communities.

Training was discussed by the greatest number of participants ($n = 14$), who envisioned health units that provided or endorsed professional development opportunities for PHNs in one or more of the following areas: political advocacy or process, anti-poverty strategies, community development, social determinants of health, anti-oppression, and building relationships. As one participant reflected, "A lot of the times people don't get involved in something because they

don't understand or they don't [] know how to do it. And I guess that's the biggest thing, right? I

think education is the biggest [] part." Another participant stated: "Yes. Education is key. The

more you can learn about policy change and advocate for it, the better." Participants commonly

stated that "money" and "time" – permitted/ provided by authorities – would be needed for

training. Training was more likely to be discussed by bachelor-prepared and non-expert PHNs,

however, experts and those with a higher level of education tended to speak more in-depth to the

topic.

Many expressed that to be empowered they would need formal leaders to 'give them the

go-ahead' to do work that would address the causes of poverty and allow them time to do it. This

was exemplified in the following comment: "Well, if I can dream about the Health Unit, I would

think that number one they… I guess organizational readiness. So, the senior leader would allow

[us] to do that. Would allow for it to happen."

Also prominent – discussed repeatedly by nearly two-thirds of participants ($n = 9$) – was

validation for work that would address the causes of poverty (i.e., understanding,

acknowledgement, a supportive organizational culture). Many participants, for instance,

expressed that in an ideal health unit formal leaders, council members, and Boards of Health

would understand poverty issues and poverty work. Some participants expressed this by voicing

current challenges in their health units:

> I just think that all the way up the level there's a lack of understanding so that would be
>
> management, that would be the politicians on regional council and so on. They focus on
>
> roads and hockey rinks. They have a hard enough time understanding public health
>
> anyhow, but to get them to understand social determinants of health and how that impacts
>
> [] on all of our health.

One participant elaborated that understanding from authorities would be important "because []

they tell us what to do. They guide our work and if we present ideas to them – if they had a better

understanding – then they would support initiatives."

Some stated that in an ideal health unit, or for PHNs to more effective address the causes

of poverty, authorities would need to acknowledge poverty as a public health concern and "buy-

in" to anti-poverty action. Three participants discussed this by projecting the actions of their

current Medical Officers of Health onto their dreams/ designs. For example, one participant said,

"She's always talking determinants of health and poverty", while another stated, "He's actually

said that to us, and he's had some public meetings where he's talked about poverty and link[ed]

that to health outcomes."

In terms of a supportive organizational culture, a few participants conveyed that cultures

more rooted in nursing philosophy, accepting of poverty work, or geared towards technology

would be better suited to support efforts to address the causes of poverty:

> I think that nurses should be at the forefront [] of Public Health but not in the biomedical
>
> model but in the sort of holistic psycho-social focus on determinants of health model.
>
> Like, asset based, right? Like, that. That should be the focus of nurses as opposed to the
>
> medical, you know, this prevention, disease focus, stuff like that.

Generally speaking, validation was more likely to be discussed by experts compared to non-

experts, especially in relation to comments concerning support from Medical Officers of Health,

Boards of Health, and government.

Funding and human resources – allocated by the health unit or provided by the MOHLTC

or municipal governments – were other major elements in participants' visions for an ideal health

unit and their designs for more effective public health nursing work. Indeed, nearly all

participants spoke to both these topics ($n = 12$ and $n = 11$, respectively). This was evident

through comments like, "I think everybody in-house is concerned about it [poverty]. I absolutely

do. I mean from service area to service area. I think what holds of us back is the purse", and

"You would see more funding coming in and you'd see an increase of staffing", and "I'm going

to say money again. More money for more wages for more nurses."

Participants seemed to agree that additional/ dedicated human resources would increase

the health unit's capacity to do work that would address the causes of poverty. They varied,

however, as to what money could be used for, for example, human resources, technology,

advocacy efforts, professional development, child care/ food, and honorariums. The following

comment reflects several of these items:

> There needs to be money available for things like coffee and stuff like that. A huge part
>
> of community development is the coffee pot right? We don't have good meeting rooms,
>
> places where we can bring people together. We don't have money available for child
>
> care, so those kinds of things that would support involving community members in taking
>
> control of their own health issue.

While non-expert PHNs were more likely to discuss funding and human resource provision,

expert PHNs spoke more to other material items that might be provided by health units, for

instance, (room) space or technology (i.e., cell phones for community work, "teleconferencing

equipment if you're doing advocacy work provincially wise"). As suggested by one expert PHN,

"I think I would hope that we could use technology to create environments for communicating.

So, when we talk about shared experience, how can we use technology to create platforms to

create opportunities for that shared experience?"

The *Ontario Public Health Standards* (MOHLTC, 2008) were mentioned by a few

participants – mostly non-experts – who suggested that to be empowered to do work that would

address the causes of poverty, they would have to be mandated by the MOHLTC to do so. These

PHNs felt that including such work in the standards would enable money to flow to health units

and/ or would provide the authoritative permission necessary to carry-out such work. This was

exemplified through comments like, "I mean if it came out from the Ministry about what our

mandate is [] and [it was] changed to reflect that kind of thing, well yeah then it goes all the way

down the line", and:

> Maybe if it was mandated... If say the Ministry of Health or our senior management, it
>
> was mandated to address the needs of the community regarding poverty. There'd be more
>
> of a push for us to... Like they'd want us to do more and we would want to do more.

> Finally, some participants voiced that formal leaders could support PHN efforts to more

effectively address the causes of poverty by facilitating mentorship or skill development

opportunities and expressing positive feedback towards such work. These participants expressed

that peer mentorship for PHNs would be empowering because it would help new nurses navigate

the public health system and its politics, establish communication skills, and to work effectively

with the community. The following quote highlights one participant's thoughts on mentorship:

> [The] experienced nurse would know how to deal with a community a lot more, and also
>
> [how] to deal with the political situation as well. So that skill would pass on. Because
>
> when you [] fresh start you just say: Okay, these are the [public health] menu and I have
>
> to [] deliver the menu. But [] the experienced staff would know how to deal with the
>
> community as well as the menu. So, that you [] develop more comprehensively rather
>
> than just [] a few programs.

In terms of positive feedback, they envisioned formal leaders lobbying Boards of Health or municipal/ regional councils for an anti-poverty approach within the health unit, standing beside PHNs as they did such work, and demonstrating that they value the PHNs in their health unit, in general:

> The education's important. The skills transferring is important. The knowledge is important to the whole Health Unit, but it does come from the senior management. Sometimes they preach but they don't… And they need to preach and act together. You know? And even lobbying the worth of [] this approach to even their higher manager to the city [] to influence them that a whole city could work like that.

Active associates: Help each other out. By far, participants envisioned validation from front-line public health staff as the greatest enabler from active associates. Whereas nearly two-thirds of participants (*n* = 9) expressed that validation from colleagues – for work that addressed the causes of poverty – would be empowering in an ideal health unit, the next greatest enabler was discussed by only half this number (*n* = 4). Indeed, participants voiced that it would be helpful for front-line staff, particularly PHNs, to be understanding of anti-poverty work and to commit to working together to achieve shared goals around addressing the causes of poverty. This was evident through comments like, "Everybody being on the same page, I think, is the only alliance we need", and:

> It's more just like how we would relate to each other as colleagues. [] Ideally if we all thought the same in so far as like how to address issues [] and then aligned ourselves that way with each other []… I guess ideally that would be nice.

Participants saw PHNs, other public health staff and, to a lesser extent, staff from other city/ regional departments as being helpful also in sharing information about their programs and

clients, engaging in dialogue about clients, poverty-related work and other issues, and assisting with developing/ implementing initiatives. One participant commented:

> Depending on the nature of the topic that we're dealing with, whether it's around housing or whether it's around food, [] there's so many other departments that are addressing those issues in various ways. So you know, I think it makes so much sense to link with those departments. So, right at the very beginning I'd say: "Look it. This is the issue we're dealing with. What role do you want to play in this? And, you know, this is what we're thinking." And start that dialogue and find a direction and set some goals.

On the same topic, another participant said, "Partnerships between programs – like we all may deal with the same type, the same clients that we see living in poverty – and communication between programs about issues that are raised would be key." Additionally, a few participants stated that expertise from epidemiology/ research departments would be useful for collecting/ analyzing local data on poverty.

Finally, some participants envisioned PHNs as helping to empower themselves by sharing their expertise in community and public health, and mentoring each other. For example, one participant said, "I think we need to do a better job of mentoring. So new nurses coming into public health, young nurses coming into public health, need to be supported by some of the more experienced nurses."

External allies: Contribute and collaborate. In participants' dreams of an ideal health unit and designs for more effective PHN work, external allies were the least mentioned sources of support. Several participants commented generally, however, on the impact/ importance of

relationships with community agencies, community members, and the community in general. For

example, one participant observed:

> I mean networking is interesting... And sometimes it's just chance who you will
>
> bump into or someone in that organization could change and all of a sudden the
>
> whole relationship with that organization will change. So, it's really dependent
>
> upon [] the relationships.

> One-third ($n = 5$) envisioned that, in an ideal health unit, community members would be

able to share their experiences with poverty. They identified such information as empowering in

its utility for helping to lobby for funding/ services, identify community needs, and establish

community-based data. As one participant put it, "I think personal stories motivate." Another

participant explained that many people are struggling in Canada due to choices that have been

made by people who have power. She argues that if the poor are given a voice, "they become

part of the discourse, not separate from it".

Expertise from external researchers and health promotion experts (e.g., at "The Health

Communication Unit") was also identified as empowering as was "cutting-edge" research and

data from community agencies.

A few participants ($n = 3$) voiced that advocacy from community agencies, community

members, and politicians would help forward public health nursing efforts to address the causes

of poverty. Alliances with external lobby groups and external researchers were seen as similarly

helpful. Reflecting on her many years as a PHN, one participant explained:

> It's not worth while to develop internal alliances. Wait – it's not that I'm not friendly
>
> with people. But I learned early on in public health nursing that you are way more

effective if you work with the community and the community does the advocacy and

communicating and it's better.

Community agencies were envisioned as supportive in their ability to share services and

resources, as well as in their potential to help obtain funding and other materials. This was

evident, for instance, in the following participant's comment:

So there's certain things we can't do [due to health unit's relationship with the

government], but when we're partner with the community [] they can do it. And that's

what usually happens, like when we apply like for funding for a specific project. We try

to make it like it's their project. We are just [there] to support them with our expertise

instead of funding. Like we can't ask our [] father [the government] for money for them.

Finally, two participants specified that there would be benefits to collaborating with

popular media organizations in order to strengthen advocacy efforts. One expressed that working

with media would help with "advocacy" and "transparency", while the other specified that using

media would be important to "spread the messages, [] like what you want to achieve".

Other organizational supports. PHNs' job definition, including autonomy of the PHN

role, was discussed by nearly two-thirds of participants ($n = 9$). Those with a masters degree or a

partially completed masters degree were more likely to discuss this than those who were

bachelor-prepared. In particular, participants expressed that to do work that would more

effectively address the causes of poverty they would need to have decision-making authority at

the point of contact with clients/ communities and have these professional judgments valued by

superiors. One participant commented that, "PHNs would be allowed to make decisions about

what programming is needed because upper echelon, really, don't know their community.

They're there to manage the staff; they're not to decide what is actually needed." Another

observed:

> Often things get decided without our input even though it's us doing the work and it's us
>
> who have the direct contact with the client. So, it'd be nice [] that our input be valued
>
> every step of the way, which sometimes doesn't happen. Things happen to quickly or
>
> they just [] don't take the time. They don't think of that step... that first initial building
>
> block.

Access to community-based information was mentioned by nearly half of the

participants' ($n = 7$) when describing their visions of an ideal health unit. They expressed that

information derived from community assessments, accounts of lived-experience with poverty,

epidemiological data, and other jurisdictions doing similar work would be useful in helping to

address the causes of poverty. With respect to community-assessments, one participant said,

"There's so much you need to know [] about your specific area. We need to know from the

community what they want []. So, you need community assessment done." With respect to

epidemiological data, another participant stated:

> "I think having an epidemiologist [would be valuable – one] who's focused on carrying
>
> out studies of the poverty in our community so that were aware of statistical data and how
>
> our community is changing in terms of poverty and what the needs are in the community
>
> and [what's] being offered."

Other information reported as useful included: guidance on how to influence policy,

address the causes of poverty, carry-out community assessments or do research; results of health

unit evaluations (to provide feedback as whether/ how poverty is being addressed); descriptions

of program activities within the health unit and other municipal/ regional departments; and

research/ scholarly literature on social determinants of health. Non-expert PHNs were more

likely to discuss the above compared to expert PHNs. Whereas the comments of non-experts were mostly about epidemiological data or internal programs, those of experts were mostly about addressing the causes of poverty or social determinants of health. For example, an expert PHN expressed that:

One of the things [that] Rainbow Nurses is [trying to accomplish is] to get RNAO to develop best practice guidelines for caring for LGBT clients and I'd like to see something like that, best practices around social justice and poverty, like the kind of work that would create reductions in poverty.

Finally, several participants (*n* = 7) spoke about staff qualities that would empower more effective work to address the causes of poverty. These participants spoke to PHNs who were knowledgeable, passionate, motivated, skilful, forward-thinking, flexible, and/ or skilled at networking. They also spoke about managers who were flexible and reliable, like the following participant:

I guess the person [manager] would need to have a very good sense of the theories around [] the basic social determinants of health but also have a sense of the political structure – who the players are, and the skill sets to look at everything from individual health to population health and public policy.

Factors beyond the health unit. In describing their dreams of an ideal health unit as well as their designs for more effective PHN work to address the causes of poverty, several participants (*n* = 7) described factors beyond the health unit that would be empowering. Experts were more likely to discuss these than non-experts.

Such factors included: community programming aimed at reducing or alleviating the effects of poverty (e.g., "increasing daycare spaces", "breakfast programs", "providing school

lunches") and nursing education curriculum with increased emphases on community health promotion and political advocacy. For example, one participant suggested that nursing curriculum, including student placements, should focus more on "social policy information" and that there should be a "more concerted effort to further develop those skills".

Other factors mentioned by a similar number of participants included support from nursing colleges to do social justice work and address the causes of poverty (e.g., through "standards" and "competencies"); anti-poverty government policy; and government and public understanding of social determinants of health and poverty-health issues/ effects. The broad scope of work involved in addressing the causes of poverty is highlighted in the following participant's comment:

> I don't know I can't even imagine that [a health unit ideally suited to addressing the causes of poverty]. It's so much broader than just public health. It's the whole community and there's a global aspect to it. Your whole economy, your attitude, and the resources that are in a community. This is a not a poor community compared to some but there are some that just don't have any money and no jobs. I mean for all of those things, it does become in essence affected by provincial legislation, like you know, the amount of money for Ontario Works, what economic programs they put in, whether they have a decent child care system, and whether people can afford to get an education.

Section 3: The 'best that has been' versus future dreams and designs.

Overview. In this section, the organizational supports identified in participants' affirmative experiences (phase one of the Appreciative Inquiry framework - *Discover*) will be compared with those organizational supports described in their *Dreams* of an ideal health unit and *Designs* for more effective public health nursing work to address the causes of poverty

(phases two and three). The purpose of this comparison will be to identify organizational

attributes that seem to already be established within health units (with respect to addressing the

causes of poverty), as well as those attributes that seem to be missing. The following and final

sections of the analysis will conclude by describing PHNs' thoughts on what actions and

organizational supports might bridge today's reality with ideal visions for the future. This will

correspond with the final phase of the Appreciative Inquiry framework, *Destiny.*

Similarities and differences.

Authorities. Authorities were a major source of empowerment in participants' affirmative

experiences as well as in their dreams of an ideal health unit and designs for more effective

public health nursing work. Indeed, two to three times the number of participants spoke to

support from authorities compared to both active associates and external allies.

While formal leaders in the health unit were commonly identified as sources of support,

participants discussed support from direct managers more so when describing their affirmative

experiences; support from senior managers and Medical Officers of Health was discussed more

when describing their dreams/ designs.

Positive feedback from formal leaders was discussed very little in participants'

affirmative experiences, however, it was envisioned in their dreams of an ideal health unit and

designs for more effective public health nursing work (i.e., that formal leaders would go-to-bat

for PHNs so that they might address the causes of poverty). Similarly, governing bodies (i.e.,

Boards of Health, municipal councils, MOHLTC) played a larger role in participants' dreams/

designs – compared to their affirmative experiences – with participants envisioning increased

human resources, funding, and more supportive mandates from these entities as ideal sources of

empowerment.

Allowances (i.e., time and permission to do anti-poverty work) and validation from formal leaders (i.e., understanding and acknowledgment for work that addresses the causes of poverty) as well as human resource provision, funding and material items from health units and governing bodies were prominent enablers in participants' dreams, designs, and affirmative experiences. Training was discussed by a large number of participants in their dreams of an ideal health unit and designs for more effective public health nursing work, but was not a relevant enabler in their affirmative experiences.

Active associates. Across the board, participants expressed that active associates were, or could be, empowering in their information-sharing practices and validation (i.e., understanding, acknowledgement, and buy-in) for work that addresses the causes of poverty. They envisioned, however, more dialogue between programs and departments in their dreams/ designs, and expressed that these entities ought to work more closely with each other on relevant activities and issues. Active associates included primarily public health staff, but also staff from other municipal/ regional departments and staff/ volunteers involved in participants' AE initiatives.

External allies. In participants' affirmative experiences, dreams of an ideal health unit, and designs for more effective public health nursing work, community agencies were seen as actually or potentially supportive in providing in-kind support, i.e., space, materials, and programming. Community members were identified as important for forwarding anti-poverty work in their ability to share their lived-experiences.

Several differences, however, were noted in this area. Compared to their affirmative experiences, participants envisioned more hands-on support from external allies to address the causes of poverty, i.e., help with policy advocacy from lobby groups. Similarly, they envisioned that external allies would provide more positive feedback around anti-poverty work, i.e., that

community agencies and members would help lobby for public health initiatives that would

address the causes of poverty.

Finally, while funding from private organizations and funding bodies (e.g., United Way)

was a major enabler in participants' affirmative experiences, it was discussed very little in

participants dreams/ designs.

Section 4: Destiny – Bridging today's reality with dreams and designs for the future.

In the final question of the interview, participants were asked to identify actions that could be

taken to help PHNs more effectively address the causes of poverty. This question corresponded

to phase four of the Appreciative Inquiry framework (*Destiny*). The intent of the question was to

uncover present-day actions and organizational supports that might move forward participants'

dreams for an ideal health unit and their designs for more effective public health nursing work to

address the causes of poverty.

Two-thirds of participants (*n* = 10) described actions that would "ready" the organization

for anti-poverty work. Among such actions included gaining buy-in from Boards of Health,

Medical Officers of Health, staff, and the community. As one participant said, "There has to be

buy-in from the top down including the community for [addressing the causes of poverty] to

happen." Another reflected, "How do we [] influence this work environment and get people

really onboard and thinking the same way?"

Developing an organizational culture that accepts and supports work to address the causes

of poverty was another action related to readying the organization for anti-poverty work. One

participant posed that staff use team meetings to communicate regularly about issues. Another

suggested, "I guess leaders being strong leaders. So, really trying to encourage us to address

those needs. [] Really it stands with them to really think about poverty". Another stated:

They [senior management] need to be ready for this. And they need to build a culture of

this – and it's very hard. I know that. To aware, to educate. To lobby for this kind of a

culture that they want to embed in their organization. So that they need to lobby for the

ministry. You know? []'Cause [] it's actually more powerful if the whole health unit [] or

even the whole city are using that approach [addressing the causes of poverty].

Some participants expressed that more effective work could be done if management, and

PHNs themselves, demonstrated greater value for the PHN role: "The work [of PHNs] has to be

valued. If that isn't seen to be valuable [], then it won't happen, right?" Another participant

suggested, "More public health nurses. It's the funding for the Public Health nurse piece. The

awareness that they're important in the health Unit. You know? The value. They [management]

need to value the public health nurse."

Along similar lines, several participants expressed that in order for PHNs to more

effectively address the causes of poverty "more staff" (i.e., PHNs) would be needed for such

activities. For example, it was suggested that human resources in health units should be

prioritized:

I mean it would need to be something that was considered to be priority. So you know the

people [in the health unit] that are spending their time on smoking sensation or sun

block... There's people who do a lot of research into [] obesity and so on. But those

people, if they were given the mandate, you have to work on the root causes of poverty as

part of your work day, that would make a difference. So just prioritizing.

Another action discussed by most participants (*n* = 10) was increasing health unit

understanding and awareness of poverty-health issues and strategies to address the causes of

poverty, i.e., among staff, managers, Medical Officers of Health, and Boards of Health. One

participant reasoned:

> There are people that still believe that poverty is not their problem; it belongs to the
>
> person and they're responsible for why they are in their circumstance. And until we
>
> change that thinking, we're going to have some things that will stop us from moving
>
> forward. So, I think we have to start at our own level, and to get everybody talking the
>
> same language and have everybody understanding that poverty isn't a blame game.

These participants voiced that for PHNs to do more effective work to address the causes of

poverty relevant training should be endorsed or provided to PHNs or at all levels of the health

unit, i.e., on how to address the causes of poverty, engage in political "advocacy", do

"community development", or practice anti-oppression. As one participant said, "If

[management] believes that we could have the potential to make this contribution [to address the

causes of poverty], the next step would be supporting us to gain necessary [] knowledge and

skills to do that."

Some also felt that understanding or awareness may be enhanced through the use of

health unit "epidemiologists" or "librarians", internal or external expertise (e.g., researchers;

political activists like "Cathy Crowe"), or access to external communities of practice (e.g.,

electronic "listservs"/ "blogs" on relevant issues). A few mentioned that public health nursing

mentorship of nursing students and new PHNs may be a worthwhile action with respect to

helping PHNs more effectively address the causes of poverty. For example, one participant said,

"If we had more staff we could take more students in. We could be giving them more

placements. We could be giving them enough experience. Our own nurses could have that

experience."

Several participants (*n* = 6) expressed that in order for PHNs to more effectively address the causes of poverty such activities "would have to be mandated" in the *Ontario Public Health Standards* (MOHLTC, 2008). It was suggested that having the support of the MOHLTC (to address the causes of poverty) would translate into increased funds and staffing to do so. Bachelor-prepared and non-expert PHNs were more likely to discuss these topics than other participants. As one participant commented, "The province has to decide that this is an issue. It has to be funded. There has to be a political will for that to happen."

Several participants also voiced that PHNs should "just get out there and do it" or, in other words, initiate action to address the causes of poverty. One participant described this as "living out the strategic plan". Those with a higher level of education were more likely to discuss this topic compared to those who were bachelor-prepared. Policy advocacy, community development, and public education were the primary activities that participants envisioned PHNs initiating. For example, one participant asked, "How can we increase social awareness across our community around whatever our issue is? I think the initial piece is just getting people to realize it affects everybody, right?"

Many participants conveyed that PHNs would need the 'go-ahead', time, and autonomy from formal leaders in the health unit in order to carry-out such work. Reflecting on restrictions placed on her current practice by leaders in her health unit, one participant stated, "We need to be able to advocate as individuals in our own communities." Another participant, who advocated for a community development approach, recommended that management, "Increase the time to give [PHNs] to address [the causes of poverty]." She also added that, "[If] I don't have to report about the [public health] menu [of programs] and if each public health nurse [is] doing that, I

think they will be very happy." The following participant spoke to the value that PHNs would

bring if they had the autonomy to do work that would address the causes of poverty:

> I think that PHNs have a much better feel of what the needs of the community are, and
>
> how to address poverty, whereas I think that upper management [and] politicians have no
>
> idea. And upper management is trying to make the politicians happy. And so therefore
>
> the needs of the public are not being met. You know? If somebody who doesn't know
>
> what they're talking about is trying to make decisions, I'm sorry it just doesn't come out
>
> right.

A few participants stated that more attention should be paid to appropriate community

evaluation (i.e., attention to "process" as well as outcomes) and that PHNs should be more

involved in "research" or use research in their practice related to addressing the causes of

poverty. One participant felt that "story-telling" would be a very powerful mode of data

collection. Some also stated that internal communication, i.e., "a strong communication

alliance", and program-updates/ information from community agencies would be helpful as well.

One participant made an analogy to work around breastfeeding:

> It used to be we had one team that dealt with it. We've now done in-servicing so that all
>
> the home visiting teams, the health promotion team, the school health team, the child
>
> health team, the young adult team. Everybody's on board for breastfeeding. We need to
>
> do the same thing for poverty.

Finally, over half of the participants ($n = 9$) described actions outside the health unit that

would help PHNs more effectively address the causes of poverty. One of the most commonly

discussed factors was ensuring nursing student curricula (i.e., classes and "placements") prepared

new nurses for roles in political advocacy and informed them of "SDOH" and political process.

For example, one participant stated, "The actions that might need to take place [] starts with education and with nursing students so right from the base [there would] be more of [a] public health nurses' role in advocacy." The other most commonly discussed factor was acknowledgement and support from professional nursing bodies for a public health nursing role that would address the causes of poverty. For example, another participant suggested that, "CNO or RNAO [] maybe have a conference on [addressing the causes of poverty]." Also discussed was increased partnering with the RNAO to "lobby" governments, and increased public awareness and understanding of social determinants of health issues and the role of PHNs. The necessity of broad public support was explained in this final comment:

> I mean the community as a whole needs to value the work that we do and support us because um the Board of Health is only going to go for it if the community's behind it because they are the voters. They're the ones who vote them back into office []. So, I think our community as a whole has to be supportive and want to help um with that, and understand that the work that we do directly relates to the people who are in [] greatest need in our community. And they have to understand why it's important for us to help them and not just think of themselves.

Discussion

The Context

In 2009, Dr. Heather Manson of the Ontario Agency for Health Protection and Promotion (OAHPP) emphasized that reducing health inequities is a mandated requirement for Ontario health units and highlighted income as an important determinant of health. In December 2010, alPHa and OPHA reported on a pan-Ontarian survey of health units to identify numerous poverty reduction activities occurring throughout the province (Joint alPHa/ OPHA Working Group on

Social Determinants of Health, 2010). The findings of the present study are consistent with these

directions as the PHNs who participated in the research believe that addressing the causes of

poverty through socio-political activity should be part of their role. In addition, they highlighted

the organizational attributes they believe would empower them to do so.

The Challenges

While most study participants expressed that PHNs should address the causes of poverty

via socio-political activity, they described limitations in their ability to take action. Such findings

are similar to other Canadian research indicating that while PHNs recognize income as a

powerful determinant of health, they feel powerless to address it (Cohen, 2006b; Reutter & Ford,

1996). In the current study, challenges identified by PHNs included limited autonomy, poor/

oppressive leadership, and a narrow focus on lifestyle in their health unit. This was noteworthy

given that the interview questions were solution-focused and perhaps suggests that such issues

are indeed onerous for PHNs.

Another common concern identified during the interviews was ensuring that public health

services are driven by client and community needs, which also was reported in a study of PHNs

across Canada (Underwood et al., 2009). Participants in the current study emphasized the

importance of community-driven services and stated that community self-determination is

necessary for addressing the causes of poverty. They expressed, however, that responding to

community needs is sometimes at odds with mandated public health requirements or direction

from senior leaders and Boards of Health. Such findings are similar to research done in Ontario

by Falk-Rafael et al. (2005), who found that PHNs perceive the community to have the least

influence over the nature and scope of public health nursing practice, whereas Medical Officers

of Health and Boards of Health have the most influence. Such findings also resonate with the

view that health promotion practice is political and tied to the will of elected government officials (Sparks, 2009), for example, electorates on Boards of Health.

Indeed, many participants voiced that to be empowered to address the causes of poverty they would need buy-in and understanding from Medical Officers of Health, Boards of Health, and politicians. In contrast, community members and agencies were among the least cited sources of empowerment in participants' dreams of an ideal health units, designs for more effective public health nursing work, and affirmative experiences. Although it could be argued that it would not be logical for external organizational alliances to have a great influence over employee empowerment, it creates doubt as to whether the wants and desires of communities are truly the catalyst for public health action.

The Opportunities

PHNs are well-suited to address the causes of poverty. Despite systemic and organizational challenges, study findings suggest that it is both appropriate and possible for PHNs to address the causes of poverty through their work in Ontario public health units. It seems appropriate given that PHNs in the study demonstrated understanding about poverty and its effects on health, and because they spoke to several contacts with individuals or groups inside and outside their health units. It seems possible given participants' affirmative experiences (which addressed the causes of poverty), and because a number of suggested changes for improvement are within PHNs' reach.

Throughout the interviews, participants demonstrated they possess assets that would be valuable for addressing the causes of poverty. In other words, they possessed "gifts" (Duncan, n.d.) that could be used to combat poverty and to help alleviate its harmful effects. One "gift of the head" (Duncan) that participants possessed was extensive knowledge of poverty, its ill-

effects to health, and the impact of government policy. What was noteworthy, in particular, was that many participants spoke about the effects of poverty in the context of their work as a PHN. They were able to describe its negative impact on the health of their clients and communities and discuss challenges that poverty creates for individuals and families. This observation lends credence to the statement that nurses are indeed in close contact with the vulnerable public and, as such, bear witness to how policies and public conditions influence people's lives (Ballou, 2000; Reutter & Duncan, 2002). Such proximity and understanding further reinforces that PHNs are good conduits of knowledge and can help engage and inform others about the links between poverty and health, and the effects of damaging government policy. Sparks (2009) argues that informing and enlightening others about the political nature of health is a key strategy for reducing health inequities.

Not only were participants in close proximity to poor individuals and neighbourhoods, they also spoke of numerous community contacts, for example, community agencies, academic institutions, schools, businesses, and members of the general public. This is consistent with the findings of a recent environmental scan of public health in Ontario, which identified health units as having multiple inter-dependencies and relationships (Public Health Division, MOHLTC as cited in Valaitis, Ehrich, O'Mara, & Brauer, 2009, p. 30). These contacts are important for two reasons. Firstly, because individuals – those among the 'general public', as well as those within institutions – possess gifts that can be used to reduce poverty or address its causes. For instance, two low-income mothers may discover that they can take care of each other's children (a "gift of the hand") instead of paying for daycare when they go to their part-time jobs. To give an example from the study, one PHN described how a local university enrolled children from a low-income neighbourhood in their tennis camp each summer at no-cost. Indeed, in the context of

effective community development "finding and connecting assets is the most important work a

community can do" (Chrzanowski, Rans, & Thompson, 2010, p. 7). By lieu of their contacts,

PHNs are indeed well positioned to mobilize such gifts to help reduce poverty. Secondly, such

contacts are important because they provide PHNs with opportunities to engage people in

discussions and debates on how to reduce poverty-related health inequities and enlighten others

about the political nature of health. Sparks (2009) argues that these strategies, which promote

recognition that health is political and the need to be involved in political process, are approaches

that health promoters can employ to reduce health inequities.

The final gift that participants possessed was a "gift of the heart" (Duncan, n.d.) as

participants were passionate about eliminating poverty. This was evident in their choice to work

with people living in poverty, the grounded manner in which they spoke about the consequences

of poverty, and in their expressed frustrations with not being able to address it meaningfully in

their health units. While passion might not seem to be a remarkable asset, John McKnight noted

at a 2009 conference for Asset-Based Community Development that it is passion that brings

groups of people together to pursue common interests and goals. He explained that these groups

of people – also known as associations – are significant, for it has been associations, and not

institutions, that have been responsible for mobilizing any great change in society, e.g., women's

right to vote, slavery abolition, gay marriage. This is not to ignore the fact that PHNs belong to

an institution (public health), but rather to identify that their passion can help mobilize further

action to address the causes of poverty within the neighbourhoods and communities with which

they work.

Another opportunity highlighted by this study was *that it is possible* for Ontario PHNs to

address the causes of poverty. Nine participants described in great detail initiatives they had been

involved in that aimed to address the causes of poverty or poverty reduction, more generally. While successes were modest and unlikely to have a significant impact on poverty rates (if any), they exemplified that the causes of poverty and poverty reduction can be addressed through PHN practice and confirmed that organizational attributes needed for such successes do exist within a number of Ontario health units. If similar initiatives were carried out on a larger scale or in more jurisdictions across the province, the impact on reducing poverty would likely be greater.

Another optimistic finding was that the most frequently cited organizational attributes that supported participants' affirmative experience initiatives were also among the most frequently cited attributes that participants desired for the ideal health unit or to support PHNs to do more effective work addressing the causes of poverty. These included allowances from authorities (i.e., time, 'go-ahead', autonomy), validation for work that addresses the causes of poverty, human and material resources, and funding. This confirms the possibility that similar work can be carried out or repeated in the future as some elements of the ideal are already in place within health units (although, without doubt, others still need work).

Further to this point, participants identified several factors beyond the health unit that they envisioned would empower PHNs to better address the causes of poverty, i.e., changed public and government perceptions, changes to nursing education; however, these factors were not a part of participants' affirmative experiences. This suggests that while such factors would, indeed, create the best social milieu for addressing the causes of poverty in health units, these do not have to be in place for PHNs to begin this work. In fact, anti-poverty work by PHNs may actually help to create such a favourable environment. For example, if PHNs were to "inform, enlighten, and empower individuals and communities so that they [were] aware of the political

nature of health equity" (Sparks, 2009, p. 201), public opinion might be swayed and ultimately impact government's direction concerning poverty as set by the popular will.

Finally, it is possible for PHNs to address the causes of poverty in their health units because some of the ideal organizational attributes discussed by participants can be executed by PHNs themselves. These include demonstrating understanding and support for colleagues' anti-poverty work and providing mentorship to new or inexperienced PHNs and nursing students, for example, around health unit politics[20] and community development. While participant responses suggest that managerial support and buy-in from senior leaders would help this (as will be described below), this observation is made to highlight that PHNs have some control for forwarding an agenda to address the causes of poverty. Indeed, most of the affirmative experience initiatives that participants spoke about were either initiated by PHNs or facilitated by PHNs (after an entity/ person in the community brought the idea forward). Study findings suggest that expert PHNs compared to non-expert PHNs may be more apt to lead such efforts as they seem to have more of an internal locus of control when it comes to envisioning activities related to addressing the causes of poverty. This is similar to McMurray's (1992) study of novice and expert community health nurses, which found that experts have "an ability to get right to the problem at hand" (p. 71). For example, non-expert PHNs were more likely to discuss changing the public health mandate (an external locus of control), while expert PHNs were more likely to

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[20] Health unit politics, in the context of participants' responses, includes balancing community needs with the "public health menu", and working strategically with external alliances to maximize the effectiveness of, or funding for, an initiative when bureaucracy within the health unit won't allow for this.

say "just get out there and do it" or to discuss strategies for navigating around health unit politics, for instance, by working with external partners.

       Socio-political activity is consistent with public health practice in Ontario. Study participants envisioned health units where leaders would support them to advocate for improved poverty-related policy concerning housing, daycare, social assistance, and immigration, among others. Public health unit support of PHNs' socio-political efforts to address the causes of poverty would be consistent with the *Ontario Public Health Standards* (MOHLTC, 2008) and accepted roles/ activities of the Canadian public health nurse. Advocating for healthy public policy is recognized as one of the most effective strategies for improving population health and reducing health inequities (Canadian Public Health Association, 1996; Determinants of Health Working Group, 1997; Reutter & Duncan, 2002; Sparks, 2009). The *Ontario Public Health Standards* (MOHLTC, 2008) states that, "Addressing determinants of health and reducing health inequities are fundamental to the work of public health in Ontario" (p. 2). If advocating for healthy public policy is, indeed, one of the most effective strategies for reducing health inequities, it would seem logical then to promote/ support such activities within health units – especially around income and income distribution, which have a profound impact on many of the issues with which public health is concerned with (i.e., chronic disease, infectious diseases, family health).

       Another relevant document is *Public Health ~ Community Health Nursing Practice in Canada* (CPHA, 2010), which describes the roles and activities of public health/ community health nurses. Indeed, the activities that participants envisioned in an ideal health unit, or if doing work that more effectively addressed the causes of poverty, are consistent with the roles and activities of a PHN outlined in this practice document. For example, participants envisioned

contributing to political processes and influencing policy, engaging and mobilizing poor

communities towards better health, creating public awareness of the links between poverty and

health, and working together with other health unit staff and external alliances regarding such

matters. These activities have a clear link to the public health nursing roles identified in the

document including, "advocacy", "building capacity", "building coalitions and networks",

"communication", "community development", and "policy development and implementation"

(CPHA, p. 19-26). In addition, the key aspects of nursing knowledge identified in the document

mirror participant views on social justice, social determinants of health, reducing inequities, and

promoting healthy public policy.

Sparks (2009) observes that health promotion workers recognize the need for political

action to reduce health inequities, yet rarely discuss their role in stimulating such action – in

large part because they are employed by governments or depend on them for funding. The

comments of several participants in the study echoed this view, while also pointing to additional

organizational factors that influence nurses' ability to engage in socio-political activity. Such

factors reinforce the findings of previous nursing studies. For example, similar to Ballou's

(2000) historical-philosophical report on nurses' obligation to participate in socio-political

activities, participants voiced that they engaged minimally in such activities to address the causes

of poverty in their current programs/ health unit. Ballou speaks to "the reasons for nursing's

silence" (p. 181) in her analysis and, indeed, for some participants they could not engage in

socio-political activity because they were silenced by their employer or were not allowed to

speak out politically about health in their communities. Similar to the findings of Liepert (1996)

and Cohen and Reutter (2007), participants expressed that they would value more time as well as

increased knowledge and skills in order to engage in socio-political activity to address the causes

of poverty. Participants stated that training/ professional development on political advocacy and process would be empowering. Finally – similar to Cohen and Reutter (2007) – participants also spoke to the need for increased managerial support, an organizational culture that encourages socio-political activity to address the causes of poverty, and enhanced understanding of and support for the role of PHNs in such activities.

Indeed, PHNs likely experience significant barriers with respect to engaging in socio-political activity in their health units, especially with respect to advocating for improved government policy concerning poverty. Although the *Ontario Public Health Standards* (MOHLTC, 2008) – endorsed by the provincial government – state a commitment to reducing health inequities and social determinants of health, the last two decades have suggested that Canadian governments have been reluctant to implement changes that would reduce health inequities, for example, concerning child and family poverty, housing, and tax and transfer policies (Raphael, 2011; Bryant, Raphael, Schrecker, & Labonte, 2011). Raphael suggests that this is because policy-making is done in the interests of the wealthy and powerful. If policy is good for business, then the argument stands that it should be good for all – and if it is not, it is not the fault of the policy, but rather the poor lifestyle decisions made by individuals. Perhaps this is the reason why health units – which are funded and run by governments – have not been willing to support socio-political activity whole-heartedly, for indeed such activity stands to threaten the vested interests of governments in the wealthy and powerful to whom they cater.

Sparks (2009) notes that "Without political change, there will be no changes in health equities of health outcomes" (p. 201). While such a statement may seem daunting for health promotion workers – especially PHNs who are tied to government-run institutions – there is opportunity to be gained through this knowledge. For example, study findings suggest that PHNs

recognize the need for political action and would like to engage in socio-political efforts to address the causes of poverty. Advocating for improved poverty-related policy is seen to be an ideal and has, in fact, occurred within some Ontario health units. This was suggested by one participant's affirmative experience in contributing to reports to her Board of Health. Further evidence of this is also apparent in the report on social determinants of health and poverty reduction activities occurring in Ontario health units (Joint OPHA/ alPHA 2010 Working Group on Social Determinants of Health, 2010). In other words, policy advocacy can happen.

Somewhat more realistically, however, until there is more full-fledged support for socio-political activity to address the causes of poverty within health units PHNs can still act politically, even if on an individual – rather than a mass organizational – level. For example, they can seek out more knowledge regarding political determinants of health or, more specifically, how poverty related policy drives health inequities. They can request professional development days on this topic, if necessary, drawing on the public health mandate or identified roles of the Canadian public health nurse as rationale for their decision. CHNETWorks – a community network for professional development in population health – may be one avenue for exploring such opportunities. They can use this knowledge and their experience working with poor individuals and communities to inform and enlighten others about the political nature of health inequities, even if this occurs through informal conversations with their colleagues or community contacts. While health unit support for organized initiatives would, clearly, have a greater impact (in terms of addressing the causes of poverty), raising awareness of the issues – even if on an individual level – will start to create the awareness needed to mobilize community action to eliminate poverty.

Several participants spoke about the value of PHNs sharing their stories about poverty to help educate the broader public and governments about poverty and its harmful effects. Some also stated it would be important to make the stories of poor individuals and communities known. These comments reinforce the views of Bryant (2002; 2003) who reasoned that personal stories constitute valid knowledge that should contribute to health policy development. They also echo the observations of Michael Shapcott (personal communication, May 26, 2011) who noted that, in the area of housing and homelessness, personal stories can inspire others to participate in action to improve policy. Raphael (2008) has furthermore argued that public health workers should tell stories to help shift public, professional, and policy-maker focus from dominant bio-medical and lifestyle paradigms to a social determinants of health perspective. It should be noted that while using popular media, such as newspapers, television and radio, to spread key messages is recognized as a socio-political strategy relevant for addressing SDOH (Raphael 2008; Raphael 2009), this was rarely mentioned by participants.

Engaging others in discussions about poverty, politics, and health equity will help to create the need to motivate governments to change their damaging policies. Such socio-political activities are within control of PHNs, even if there is little organizational support for addressing the causes of poverty. Of course, as study findings and related literature suggest, leadership support in health units is pivotal to maximizing the effectiveness of such efforts.

Public health unit leaders can strengthen PHNs' efforts to address the causes of poverty. Throughout their interviews, participants identified plausible ways for public health units to strengthen their support of PHNs' socio-political efforts to address the causes of poverty. A further look at participants' comments suggests that many of these changes can be made within the health unit, but would require formal leadership to do so. In literature on spreading

improvement, Massoud and colleagues (2006) noted that leadership support "cannot be emphasized enough" (p. 5) in both acknowledging the need for an improvement project and supporting the plan to spread that improvement throughout the organization.

Similar to the findings of the National Community Health Nursing Study (Meagher-Stewart et al., 2010; Underwood et al., 2009), the importance of effective and empowering leadership emerged in the data. Participants reported that they were empowered to engage in their affirmative experience initiatives when their managers gave them the 'go-ahead' to do so, allowed them time to do it, and gave them autonomy to practice as needed. When Meagher-Stewart et al.conducted 23 focus groups with PHNs, managers, and policymakers across Canada to identify organizational attributes that enable PHNs to practice effectively, they likewise found that "participants strongly associated management practices with optimal public health nursing practice" (p. 436).

Another similarity between the National Community Health Nursing Study and this study included the finding that, to work more effectively, PHNs desired support for autonomous nursing practice and the flexibility to meet client needs (Underwood et al.). Also similar was participants' desire for health unit managers to support regular communication sharing between PHNs and management, their peers, and within interdisciplinary teams (Meagher-Stewart et al.). Most participants in the current study, for example, expressed that increased dialogue between internal programs and municipal/ regional departments would facilitate efforts to address the causes of poverty.

The importance of health unit leaders' recognition of the contributions of PHNs and demonstration of value for staff's work was another commonality between these studies (Meagher-Stewart et al., 2010; Underwood et al., 2009). Participants in the current study also

specified that health unit leaders should show value for PHNs' work related to addressing the causes of poverty. In addition, they expressed that managers and senior managers ought to allocate human resources or PHN full-time equivalents to do this work.

One of the most commonly desired supports mentioned by participants in the current study was training endorsed or provided by the health unit on such topics as political advocacy/ process, anti-poverty strategies, and anti-oppression. This finding echoes the results of previous nursing studies. A pan-Canadian survey, for example, found that one of the top 10 learning needs for community health nurses was how to advocate for healthy public policy and participate in policy making activities that impact health determinants (Schofield et al., 2009). In addition, PHNs in the National Community Health Nursing Study expressed that they valued when public health units invested in education and training (Meagher-Stewart et al., 2010; Underwood et al., 2009). Several participants furthermore pointed to the value of extensive peer mentorship for new or novice PHNs so that these nurses could better navigate through health system politics and enhance their understanding of effective health promotion strategies (i.e., community development). Such great wanting for professional development reinforces findings from the capacity review of Ontario health units, which found there was a lack of such opportunities in these organizations (Tamblyn et al., 2006).

Another point emphasized by participants in the current study was that to be empowered to address the causes of poverty they would need buy-in and acknowledgement from Medical Officers of Health and Boards of Health. In particular, they envisioned these authorities endorsing that poverty is a public health concern and stating explicit support for addressing its causes. Some suggested that managers/ senior managers ought to go to bat or advocate for such an approach within their health units. These findings resonate with the focus group findings of

Meagher-Stewart et al. (2010) that public health champions are needed and that "local boards of health [] have to support public health workers for effective health promotion to happen" (Underwood et al., 2009, p. 7).

Participants in the current study and the National Community Health Nursing Study also spoke to the value of having time to develop relationships with their communities and co-workers, and "noted the importance of partnerships involving community groups, agencies, providers, and fellow team members" (Meagher-Stewart et al., p. 437), practices that are influenced by managerial support. Working together as public health staff to address the causes of poverty, for example, was a source of empowerment identified by many participants in the current study. In addition, some participants voiced that action to address the causes of poverty would by strengthened by joining the efforts of groups that lobby for improved poverty policy, e.g., 25-in-5, RNAO. Indeed, participants identified their internal and external alliances as sources of empowerment far more so than their formal power as a PHN (i.e., power gained through the centrality or visibility of their role or their decision-making discretion). This finding suggests that managerial support to help PHNs foster such alliances would be important for strengthening their effectiveness in addressing the causes of poverty.

To summarize, study findings suggest a number of realistic practices that managers and senior leaders in the health unit can adopt to strengthen PHNs socio-political efforts to address the causes of poverty. As outlined above, it would seem that many of these practices would not only increase PHNs' ability to more effectively address the causes of poverty, but also would increase their ability to practice more effectively in general, given that they reinforce the findings of the National Community Health Nursing Study (Meagher et al., 2010; Underwood et al., 2009). Poor leadership and the need for staff to feel valued were issues that similarly arose

during a capacity review of Ontario's public health system (Tamblyn et al., 2006). For these

reasons, it would seem prudent for formal leaders in health units to incorporate these into their

practices. While the discussion thus far has focused on opportunities available to formal leaders

and PHNs that might further empower PHNs' socio-political efforts to address poverty, the

following section will speak to supportive factors that lay beyond the reach of these individuals.

The Gaps

Funding and human resources. Greater funding and more human resources were

among the most frequently cited supports participants identified as being essential to

strengthening their efforts to address the causes of poverty. Such views coincide with the

observations of others concerning challenges with human resource and funding constraints in the

Canadian public health system (Canadian Coalition for Health in the 21st Century, 2004; CPHA,

2001; Meagher-Stewart et al., 2010; Tamblyn et al., 2006; Joint Task Group on Public Health

Human Resources, Advisory Committee on Health Delivery and Human Resources, & Advisory

Committee on Population Health and Health Security, 2005; Valaitis et al., 2010). While

participants reported that funding from external bodies (like the United Way) facilitated their

affirmative experience initiatives, they stated that sustainable funding from municipal or

provincial governments would be best when describing their dreams of an ideal health unit and

designs for more effective public health nursing work.

It could be argued that money to address the causes of poverty should go directly to the

people who need it as opposed funding the salaries of PHNs to do such work. While this

argument is valid, it needs to be considered in light of Canada's current political structure.

Canada has been identified as a liberal welfare state or one where the distribution of resources

and goods is driven by market interests (Navarro & Shi, 2001; Raphael, 2006). In this sense,

businesses – particularly large corporations – have the ability to influence governments in a number of ways (i.e., by threatening to shift investment capital to another location or to raise borrowing rates) (Raphael, Curry-Stevens, & Bryant, 2007). In addition, those who have the financial means necessary to run for dominant political parties may either come from the business class and/or hold those values (Raphael et al.) Neo-liberalist processes, such as these, have been shown to worsen poverty and income inequalities (Coburn, 2004). Raphael (2003), for example, listed a number of economic and social policies undertaken by the Ontario Conservative party that resulted in increasing rates of poverty and homelessness. So long as neo-liberalism remains the dominant discourse related to political and economic processes in Canada (Raphael, 2006), population health and the organization of health care will continue to be threatened (Coburn). Given that Canadian governments are unlikely to institute policies to eliminate poverty, it is valid and necessary to ask for/ allocate public health dollars to initiatives aimed at reducing health inequities resulting from poverty. This is best achieved by focusing on poverty's causes, as opposed to its consequences. One very successful example of this is the Vibrant Communities initiative (http://tamarackcommunity.ca/g2_WhatIsVC.html). This initiative, which provided funding to grassroot collaborations in 12 communities in Canada, has resulted in reduced poverty for more than 170,000 households in Canada and raised over $19.5 million through local efforts (http://tamarackcommunity.ca/g2_VC_Evaluation.html).

      The mandate of Ontario public health units. Another systemic issue that participants spoke about was the mandate of Ontario public health units. Several participants commented that a mandate to do work to address causes of poverty would empower them to engage in socio-political efforts to do so. When asked to comment on whether the current *Ontario Public Health Standards* (MOHLTC, 2008) enabled them to address the causes of poverty, several respondents

did not feel the new standards were supportive in this regard or in encouraging an evaluative

process that valued community development work. Others had not read the standards or stated

they did not know enough about the subject to comment. This suggests that when the *Ontario*

Public Health Standards (MOHLTC, 2008) are revised, the effects of income and income

distribution should be further emphasized with specific actions outlined on how public health

units should engage in anti-poverty work. Of course, for reasons explained above, such actions

are likely to conflict with the political ideology of the elected government party and may not

come to fruition. That is, governments – and the wealthy and powerful they cater to – have a

vested interest in policies that support poverty (Raphael, 2003); it wouldn't make sense for them

to support poverty-inducing policies on the one hand and provide health units with funding to

advocate against them on the other. Interestingly, no participants drew the link between the limits

of the public health mandate and the effect of neo-liberalism as the dominant political ideology.

This perhaps reflects a need for increased awareness on the subject.

Regardless of whether future mandates will support work to address the causes of

poverty, the *Ontario Public Health Standards* (MOHLTC, 2008) are not due for revision until

2013 (Salamo, 2008). While it would be ideal for the public health mandate to include explicit

direction to address the causes of poverty, for example, through a topic- or program-specific

Protocol[21], PHNs and health units should not wait for changes to the mandate to do anti-poverty

work.

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[21] There are 26 topic- or program-specific Protocols incorporated into the *Ontario Public Health*

Standards

(http://www.health.gov.on.ca/english/providers/program/pubhealth/oph_standards/ophs/ophsprot

Factors beyond the health unit. In their dreams of an ideal health unit, designs for

public health nursing work that would more effectively address the causes of poverty, and

actions that would fulfill these destinies, participants described several factors beyond the health

unit that they believed would be empowering. Changes to nursing education were among the

most popular, with participants expressing that nursing students should receive greater

instruction in community health, especially with respect to social determinants of health, and

political action. These ideas coincide with the views of nursing scholars who have called for a

greater focus on policy advocacy in nursing education (Reutter & Duncan, 2002; Reutter &

Williamson, 2000). In addition, some expressed that clinical placements should provide nursing

students with the opportunity to learn more about poverty and health, and that PHNs should

mentor students in effective community development and anti-poverty strategies. Similar

empirically-based recommendations have been made by others (Sword, Reutter, Meagher-

Stewart, & Rideout, 2004).

More support from professional nursing bodies also was mentioned, with some

participants stating that the College of Nurses of Ontario and Canadian Nurses Association

should make greater effort to promote nurses' role in social justice and political advocacy. This

is consistent with Cohen and Reutter's (2007) review of scholarly literature from Canada, the

United States of America, and the United Kingdom, which found that while "nursing scholars

have called for public health nurses to address the causes... of poverty through policy advocacy...

this role was less likely to be identified in professional standards and competencies" (p. 96).

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ocols.html), for example, the Infectious Diseases Protocol and the Healthy Babies Healthy

Children Protocol.

Finally, participants stated that their efforts to engage in anti-poverty work would be strengthened if governments and the public better understood poverty, social determinants of health, and the role of the PHN. This echoes a discussion had by a large group of community health nurses at the 2008 *Community Health Nurses' National Conference* who expressed that the role of the community health nurse is poorly understood. Similar findings have been found among Albertan PHNs (Reutter & Ford, 1996). In terms of a poor public understanding of the social determinants of health, Raphael (2003a; 2008; 2009) and others (Collins et al., 2007; Hayes et al., 2007; Reutter et al., 2005) have implied that this has impeded progressive action and policy development in this area. Such consensus in the literature would suggest that participants' comments on the need for more informed publics and governments are indeed valid.

Recommendations for Strengthing PHNs Socio-Political Efforts to Address the Causes of Poverty

The following recommendations build on the findings of the study and take into consideration other relevant nursing, public health, and health promotion literature. Recommendations for PHNs, health unit leaders, researchers, public health associations, and governments are provided.

PHNs Should...

Recommendation 1: Start now. Work to address the causes of poverty is possible within Ontario public health units. While leadership support is pivotal, PHNs have the power to move forward on this issue today by supporting/ understanding each other's work related to poverty and community development, mentoring one another (including students), sharing contacts and connections, and initiating/ encouraging discourse poverty-health issues. Such actions will foster the relationships needed to do anti-poverty work. They will also help bring

awareness to and challenge the political and economic structures that contribute to poverty, even if through one person or a few people at a time.

       Recommendation 2: Increase PHNs' understanding of poverty and health equity, and how to address the causes of poverty. PHNs need to be informed about the relationships between poverty and health, and the political nature of health equity, in order to engage others in meaningful and effective discussions about these issues. Sparks (2009) argues that engaging others in discussions about the political nature of health is one of the most important things that health promoters can do to reduce health inequity. Strategies exist to address the causes of poverty in health units. PHNs should read literature by Dr. Dennis Raphael (2008; 2009; Raphael et al., 2007), Dr. Benita Cohen (Cohen & Reutter, 2007), and Dr. Linda Reutter (Reutter & Kushner, 2010) to learn about these strategies. They should remember that popular media, such as newspapers, television, and radio, can help them spread messages about poverty, health, and health equity. Finally, PHNs should talk to their colleagues about how they can incorporate such strategies into their work, and request professional development days to attend relevant conferences and workshops on these issues.

Managers, Senior Managers, Medical Officers of Health, and Boards of Health Should...

       Recommendation 3: Allow PHNs to address the causes of poverty and facilitate their efforts whenever possible. There are several leadership strategies that health unit leaders can adopt to support PHNs' socio-political efforts to address the causes of poverty. Most importantly, they can encourage PHN autonomy, allow them the time, and 'give them the go-ahead' to work proactively with their clients and communities around addressing the causes of poverty. They can support dialogue between internal programs and municipal/ regional departments on such issues. They can also give PHNs time and permission to strengthen their

internal and external alliances. Finally, health unit leaders can express understanding about poverty-health issues and demonstrate value for the PHN role in this area. Addressing the causes of poverty attends to SDOH and health equity, two foundational principles in the *Ontario Public Health Standards* (MOHLTC, 2008).

Recommendation 4: Acknowledge that addressing poverty, not just its effects, is a worthwhile public health endeavour and state explicit support for such work. Participants in the study identified that buy-in from senior managers, Medical Officers of Health, and Boards of Health is pivotal for supporting efforts to address the causes of poverty. The Medical Officer of Health from the Sudbury and District Health Unit – Dr. Penny Sutcliffe – is exemplary in this respect. She has been very public about tackling social inequities in health, addressing SDOH, and the impact of government policy in such matters. This is evident through her authorship of/ participation in various public health documents and research pertaining to SDOH and Ontario public health units (Joint alPHa/ OPHA Working Group on Social Determinants of Health, 2010; Sutcliffe, Deber, & Persaut, 1997; Sutcliffe et al., 2008). Her work exemplifies how health unit leaders can be champions in this area and how they can provide explicit support for work that would address the causes of poverty. Given the powerful impact that income has on health – and the mandated responsibility of health units to reduce health inequities – it would be prudent for health unit leaders to consider her behaviour and suggestions.

Recommendation 5: Support PHNs' professional development needs in policy advocacy, political process, poverty and health, and health equity. This study reinforces the need to support PHNs in increasing their knowledge and skills in policy advocacy, political process, health equity, and the links between poverty and health. Health unit leaders can do this by supporting them in training or by facilitating peer mentorship opportunities, particularly with

experienced PHNs who have expertise in poverty and community development. They can also support the development of such training programs within their health units.

Recommendation 6: Allot PHN FTEs for work that would address the causes of poverty. Busy workloads and competing job demands were identified by participants as a barrier to engaging in work that would address the causes of poverty. Health unit leaders should allot PHN FTEs to do such work so that it is carried out in a manner that respects the job demands of PHNs and the time it takes to do such work effectively.

Researchers Should...

Recommendation 7: Do research to determine what initiatives would be most effective for addressing the causes of poverty through public health unit work in Ontario. More research and analysis needs to be done to suggest what initiatives would be most effective for addressing the causes of poverty through public health unit work in Ontario. What would give the biggest bang-for-the-buck? Such information could be used to guide public health nursing and public health unit efforts to address the causes of poverty.

Schools of Nursing Should...

Recommendation 8: Strengthen the focus on policy advocacy and the health impacts of poverty in nursing student curricula.

Associations Affiliated with Ontario Public Health Units (alPHa, OHPA, OAHPP, CPHA, RNAO) Should...

Recommendation 9: Identify practices for addressing the causes of poverty through public health units and disseminate this information to PHNs and health unit leaders in a strategic way. While most participants understood the causes of poverty to be linked to policy and other social determinants of health, only a few could articulate how this might translate into

public health nursing practice. This suggests that PHNs need more information on how to

address the causes of poverty – perhaps through some sort of best practice guideline[22], similar to

those developed by the RNAO (http://www.rnao.org/Page.asp?PageID=861&SiteNodeID=133).

A pan-Ontarian survey of health units similarly found that for health units to move forward with

addressing social determinants of health and poverty reduction, they need strategies for moving

from awareness to action, as well as information about best practices tailored to local context

(Joint OPHA/ alPHa Working Group on the Social Determinants of Health). These findings

suggest that PHNs and health units would welcome information on how to address the causes of

poverty. Provincial and national associations for health units are well-positioned to disseminate

such information.

Provincial and Municipal Governments Should...

**Recommendation 10: Emphasize the impact that income and income distribution
have on health when the *Ontario Public Health Standards* (MOHLTC, 2008) are revised.
Socio-political activity should become one of the mandated requirements for health units.**

**Recommendation 11: Fund initiatives that aim to reduce poverty or challenge the
structural political and economic conditions that contribute to poverty.**

**Recommendation 12: Most importantly, create whole government policies that will
eliminate poverty.** Governments should pay heed to recommendations from the RNAO, 25-in-5,

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[22] While it may not be possible to develop a best practice guideline on how to address the causes

of poverty based on the scarcity and low level of evidence available, it would still be possible to

create a document that synthesized and discussed socio-political strategies useful for addressing

the causes of poverty on the front-lines.

Campaign 2000, the Wellesley Institute, the World Health Organizations, and other associations/ organizations committed to eliminating poverty.

Study Strengths, Limitations, and the Conceptual Framework

  Study strengths. The study focused on what works, instead of what does not. Such a focus helped to further understanding of the assets and strengths within the public health system related to addressing the causes of poverty as opposed to creating an inventory of the deficits. The benefits of this are illustrated nicely through the following quote by Kretzmann and McKnight (1993, p. 14):

  Think of a carpenter who has lost one leg in an accident years ago. Clearly, he has a

  deficiency. However, he also has a skill. If we know he has a missing leg, we cannot

  build our community with that information. If we know he has a capacity as a wood

  worker, that information can literally build our community.

  Secondly, the study used a validated conceptual framework on nursing empowerment to guide the data collection process, namely, Kanter's *Structural Theory of Power in Organizations.* The use of this framework resulted in participants discussing a much greater scope of organizational factors during the interview. For example, when participants were asked to identify organizational factors that have supported or would support their work to address the causes of poverty, they spoke in greater detail about such supports when prompted by concepts in Kanter's framework than when asked the question in an open-ended fashion.

  Finally, the study's qualitative design allowed for the use of open-ended questions to explore PHNs' perceptions concerning the causes of poverty. This is the first time that such a study has been conducted in Canada. Considering the powerful impact of income on health and

the role of public health units in reducing health inequities, this piece of knowledge is a valuable contribution to the public health sphere and public health nursing.

Study limitations. There were several limitations to the study. To begin, this was the first time I conducted a qualitative study and semi-structured interviews for data-collection purposes. This novice position likely limited the potential of the research design, quality of the data, and adeptness of the analysis. To offset this limitation, however, I had regular contact and advisement from three nursing academics with considerable expertise in qualitative research and public health during all phases of the study. These advisors assisted greatly with the development of the research design, reviewed transcripts to provide feedback on interviewing, assessed the credibility of the initial coding scheme, and edited all pieces of writing.

A second limitation was that I was ambiguous about the terms 'causes of poverty', 'socio-political activity', and 'poverty reduction' throughout proposal development and data collection. This had several consequences. For one, because I believed the terms causes of poverty and poverty reduction to be synonymous, PHNs were invited to participate if they could share a story about the latter when, in fact, the aim of the study was to focus on the former. Clearly, this diluted the answer to the research question; however, it fortunately resulted in other interesting data and the inclusion of very rich informants. During the later part of my coding, I came across an article by Raphael (2011), which helped to clarify these terms[23]. To redress my initial ambiguity, I have tried to clarify these terms in the write-up of the findings.

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[23] Poverty rates can be reduced through strategies that aim to increase the real or potential incomes of individuals/ families above the poverty line. They can also be reduced through actions that alter the structural (political and economic) conditions that contribute to increasing or maintaining poverty (i.e., socio-political activity).

Another consequence stemming from this ambiguity was that I was limited in my ability to clarify why the study was focusing on the root causes of 'societal' poverty and not the root causes of 'individual' poverty. For example, I had difficulty responding when asked by some participants why they couldn't share their best experiences with individual case advocacy (to address the root causes of a client's poverty, i.e., no money, no housing, no job). Indeed, the criterion for 'an experience that addressed the causes of poverty' seemed unclear to participants during the recruitment process as several began the interview wanting to share a story about an innovative service delivery model that addressed the consequences of poverty, not its causes. While I took steps to minimize confusion about this criterion as the recruiting process advanced, they were met with limited success and were not helped by my ambiguity about key terms. As a result, five of 15 affirmative experiences that spoke to addressing the consequences of poverty were not included in the analysis.

Another limitation of the study was that the interview guide was lengthy. Most interviews took more than the expected hour to complete and towards the end the interview it was not uncommon for participants to report feeling "tired" or "brain-fried". As a result, I held back in the later interviews on probing questions about certain organizational factors, which resulted in gaps and inconsistencies in the data.

Another sentiment expressed by participants was the feeling they were being repetitive towards the end of the interview or would have preferred the interviewer to reference earlier parts of the interview so they wouldn't have to repeat themselves. A more thorough understanding of the guiding conceptual framework (Kanter's *Structural Theory of Power in Organizations*) and some upfront planning around the coding scheme would have helped to develop an interview guide that was less repetitive and more concise. Unfortunately, this

limitation had a negative impact on the data gathered in relation to the last interview question as participant responses were often brief or missing.

The final limitation of the study relates to the analysis. Coding for the most part was done by myself alone. This means that findings were filtered through the perspective of one person. It should be noted, however, that a portion of the transcripts were coded by my supervisors – both to assess the credibility of the coding scheme and to test for inter-rater reliability. Only small adjustments were required.

Kanter's *Structural Theory of Power in Organizations*: Reflections. Kanter's theory fit well with the purpose of the study. It assisted with prompting participants to speak about relevant organizational factors, and also helped to organize the initial coding scheme. In this sense, Kanter's theory was further validated as a conceptual framework useful for understanding nurse empowerment. For the most part it was easy to code participant responses under one or more concepts in Kanter's framework. The coding process, however, also brought to light some considerations that may be useful for expanding or enhancing the theory. For example, *lines of support* currently has the very broad definition of "sources of support that enable employees to maximize their work effectiveness" (Laschinger, 1996). However, this definition seems to beg-the-question: Wouldn't any structure of power or opportunity "enable employees to maximize their work effectiveness"? How does this definition help to delineate *lines of support,* when it is as easily applied to *lines of information, lines of supply,* and *opportunity structures*? This became relevant during the coding process. As a result, supports that could not be classified as *lines of information, lines of supply*, or *opportunity structures* – which have more specific, concrete definitions – were classified under *lines of support* by default, so long as they seemed to 'enable employees to maximize their work effectiveness' (which of course they did). This resulted in

several sub-categories, including *allowances, positive feedback, validation,* and *operative support.*

The commonality between the sub-categories was that they constituted actions, environments, or statements that facilitated PHNs' efforts to achieve job demands. In this sense, it was logical that they were classified together under *lines of support.* However, it could also be argued that the sub-categories had differences that warranted separate categories. In any case, it would be prudent to further define this concept going forward. If similar qualitative research on nursing empowerment in the workplace was to be carried out, would similar sub-categories be developed for *lines of support*? Should Kanter's theory be modified to include other, more specific, structures of power in lieu of *lines of support*? These are the questions that would need to be answered.

Secondly, the findings of the study suggested that alliances with organizational authorities are the most empowering for PHNs, compared to alliances with colleagues or external (community) alliances. The concepts in Kanter's theory, however, are not weighted. While such information might enrich the content of the theory, it might also complicate it. Going forward, it would be interesting to explore what alliances and structures of power/ opportunity bring the most empowerment to employees. If consistent patterns were to emerge, there might be value to weighting certain concepts in the theory.

Interestingly, several participants (less than half) identified personality traits – mostly within their colleagues and managers – that they perceived would be empowering. While Kanter created her theory on the premise that it was work conditions – and not inherent traits – that impacted an employee's ability to take action in the workplace, perhaps there is a place for this in her theory. That is, the people one works with (and their personalities) can affect the work

environment or conditions experienced by an employee. Such a premise, however, is debatable and would need to be explored further.

Finally, participants in the study identified several factors beyond the organization that they perceived would empower their work to address the causes of poverty. Kanter's theory, however, does not acknowledge such environmental supports. The findings of the study suggest that adding *environmental supports* to Kanter's theory would bring added value to it as such supports would help to further explain employee empowerment. However, before revising the theoretical framework, there would need to be a greater analysis of other studies exploring employee empowerment to determine such similarities are observed. Expert opinion on Kanter's theory and/ or empowerment in the workplace would also bring value to making such a decision.

Conclusion

Public health units in Ontario by-and-large continue to target individual behavioural/ lifestyle choices such as diet, physical activity, and smoking. Such an approach stands to worsen health inequities as it is likely to benefit those who are already well-off in terms of their health and who already have access to commodities/ resources that would allow for healthier living (e.g., money, housing, a good job). While action around making healthier life choices should be a part of health promotion efforts, this should be balanced by action to address the social determinants of health, which would have far more impact on reducing health inequities. Income and income distribution should be of particular concern given their substantive relationship with morbidity and mortality (that is, the wealthier, the healthier at every rung of the income ladder).

Public health units have enormous potential for addressing the causes of poverty. They employ many workers dedicated to health promotion and are mandated to prevent many of the health issues brought on or exacerbated by poverty. PHNs constitute the greatest number of

health promotion workers and operate under practice standards that expect them to address social

determinants of health, engage in political action, and adhere to values of social justice. As such,

it is appropriate for them to engage in socio-political activity to address the causes of poverty.

Empirical evidence furthermore suggests that they would like to engage in this work.

There are many barriers that PHNs face, however, that limit their ability to act politically

within their health units and to address the causes of poverty. Politics, especially, has had a

major influence in deterring such work and in preventing PHNs from meeting the needs of their

clients and communities. Sparks (2009) notes, "When considering examples of health promotion

shortcomings, politics often gets in the way of good intentions, and worse, gets in the way of

more equitable health outcomes" (p. 199). In Canada, neo-liberalism is the dominant political

discourse (Coburn 2004; Raphael 2006). Given that health units report to the government, neo-

liberalist pressures have likely deterred health units from taking meaningful action to address the

causes of poverty. Despite such barriers, however, there are behaviours that PHNs and health

unit leaders can adopt that would forward momentum for an anti-poverty approach.

Health units can strengthen PHNs' efforts to address the causes of poverty through

managerial practices that allow PHNs to address the causes of poverty, encourage community

relationships, and facilitate PHNs' efforts when possible. Wide-spread understanding and

acknowledgement of poverty health issues, at all levels of the health unit, also would strengthen

such efforts, as would buy-in for work that addresses the causes of poverty, especially at the

levels of Medical Officers of Health and Boards of Health.

While the support of health unit leaders, a more supportive mandate, and increased

human resources and funding would empower PHNs to address the causes of poverty, PHNs can

take action right now to address the causes of poverty. They can increase their knowledge of

poverty-related health inequities and the impact of policy, ideally through training endorsed by their health units. They can support each other's poverty-related work, demonstrate understanding, and share and develop community contacts. Most importantly, perhaps, they can engage others in discussions on how to reduce poverty-related health inequities and create awareness of the political nature of health (Sparks, 2009).

Author Maria Robinson said, "Nobody can go back and start a new beginning, but anyone can start today and make a new ending" (n.d. as cited in Canfield, Hansen, Millman, & Wentworth, 2003). While Ontario health units (as a whole) have been neglectful in taking meaningful action to address the causes of poverty (Labonte, 2005; Raphael 2003a; Raphael 2008), there are opportunities available to help them move forward on this issue. Addressing the causes of poverty is possible within health units. While more work is needed, there are instances where success has been achieved and there is evidence of supportive organizational attributes within health units across the province. Furthermore, there are PHNs in the public health system who are knowledgeable and passionate about addressing the causes of poverty. Work by alPHa, OPHA, the OAHPP, and the RNAO suggest there is energy in Ontario to engage in anti-poverty work. The time is right to begin noticing, connecting, and capitalizing on the assets within the public health system to mobilize action towards the elimination of poverty. A new ending is possible if action begins today.

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Appendix A

Questionnaire

1. Have you been working at least two years full-time (or the equivalent) as a public health nurse in your current public health unit?

2. Have you ever been involved in efforts to address the causes of poverty as a public health nurse in Ontario? This may include, but is not limited to, any of the following activities:

- Public messaging about the relationship between poverty and health or the health effects of poverty-related policies via:

  - speaking to an audience (e.g., public, professionals, policy-makers);

  - presenting at a conference (e.g., poster presentation/ round-table/ other);

  - written materials (e.g., newsletters, pamphlets);

  - media releases;

  - media exposure (e.g., newspapers, local television channels)

- Facilitating story-telling to shift public, professional, or policy-maker focus regarding poverty.

- Transferring knowledge, skills, and control to local people (so that they can challenge the political, social, and economic causes of poverty themselves).

- Poverty and health profiling assessments.

- Partnerships targeted at addressing poverty (e.g., coalitions).

- Providing support for policy action (e.g., forums, petitions, letters of support).

- Putting poverty on the agenda of organizations and health associations.

3. Are you willing to share your successes and discuss how elements of these successes could be used to strengthen efforts to address the causes of poverty within your public health unit?

Appendix B

Email to Recruit PHNs

Fellow Public Health Nurses,

You are invited to participate in a study that will explore how Ontario public health units can help strengthen public health nurses' socio-political efforts to address the causes of poverty.

The study is being done because we know little about how to enhance public health nursing efforts to address the causes of poverty. The findings from this study will help identify factors, relevant to Ontario public health units, that can be targeted to strengthen public health nurses' ability to address the political, social, and economic conditions that contribute to poverty.

If you have worked in your health unit for at least two years (or the equivalency), have been involved in socio-political efforts to address the causes of poverty (no matter how big, small, or seemingly insignificant!), and are willing to be direct in sharing and extrapolating on your experiences, you are eligible to participate.

Socio-political efforts may include, but are not limited to:

- Messaging about the relationship between poverty and health or the health effects of poverty-related policies. For example, through:
  - speaking to an audience (e.g., public, professionals, policy-makers);
  - presenting at a conference (e.g., poster presentation/ round-table/ other);
  - written materials (e.g., newsletters, pamphlets);
  - media releases;
  - media exposure (e.g., newspapers, local television channels)
- Facilitating story-telling to shift public, professional, or policy-maker focus regarding poverty.
- Transferring knowledge, skills, and control to local people (so that they can challenge the political, social, and economic causes of poverty themselves).
- Poverty and health profiling assessments.
- Partnerships targeted at addressing the causes of poverty (e.g., coalitions).
- Providing support for policy action (e.g., forums, petitions, letters of support).
- Putting poverty on the agenda of organizations and health associations.

If you choose to participate in the study, you will be asked to participate in a face-to-face or telephone interview. You may also be invited to comment on preliminary findings.

Please see the attached Letter of Information for more details. If you have any questions about the research or are interested in participating, please contact Jeri Dunne, R. N., B. N. Sc. at 416-301-7294 or dunneja@univmail.cis.mcmaster.ca. If you know of other public health nurses who may be suitable participants, you are welcome to forward this invitation to them.

Your participation is greatly appreciated.

Sincerely,

Jeri Dunne, R. N., B. N. Sc.
Masters Student
Department of Nursing
McMaster University

Appendix C

Participant Consent Form/ Letter of Information

Participant Consent Form/ Letter of Information

Title of Study: **Empowering Ontario Public Health Nurses to Address the Causes of Poverty: A Qualitative Descriptive Study**

Principal Investigator: **Jeri Dunne, R. N., B. N. Sc.**

Faculty Supervisors: **Dr. Wendy Sword, Dr. Ruta Valaitis, Dr. Donna Ciliska**

You are being invited to participate in a study conducted by Jeri Dunne, Masters student in the Graduate Nursing Program at McMaster University. In order to decide whether or not you want to be a part of this study, you should understand what is involved and the potential risks and benefits. This form gives detailed information about the study and whom to contact if you have any questions.

Why is this research being done?

This study is being done because we know little about how Ontario public health units can help strengthen public health nurses' efforts to address the causes of poverty. This information will help identify factors, relevant to Ontario public health units, that can be targeted to strengthen PHNs' ability to address the political, social, and economic conditions that contribute to poverty.

What is the purpose of this study?

The purpose of the study is to learn more about how public health units in Ontario can help strengthen public health nurses' socio-political efforts to address the causes of poverty.

What will my responsibilities be if I take part in the study?

If you volunteer to participate in this study, you will be asked to participate in a one-hour face-to-face or telephone interview. The interview will be tape-recorded. In this interview you will be asked questions about an affirmative experience related to addressing the causes of poverty as a public health nurse, your ideas on how to improve efforts to address the causes of poverty in

your health unit, and how you believe such improvements may be enacted. You will be prompted to speak about various organizational factors. Demographic information will be collected.

You may be invited to review a narrative of the results and provide comments on its accuracy. This will help us ensure that we have properly captured your responses.

What are the possible risks and discomforts?

There are no known risks to you if you take part in this study. However, as a participant in the study, you do not need to answer questions that make you uncomfortable or that you do not want to answer. Until one month following your interview, you may request that any or all of your data be excluded from the study.

How many people will be in this study?

Approximately 10-12 public health nurses will be asked to take part in interviews and later invited to comment on a narrative of the results.

What are the possible benefits for me and/or for society?

We cannot promise any personal benefits to you from your participation in this study. However, your participation may help individuals and communities served by public health units in the future. The findings will generate important knowledge on how to more meaningfully address the causes of poverty through public health in Ontario.

What information will be kept private?

Your personal information will remain entirely confidential. You will be assigned a pseudonym and a numerical code for your interview. Your identity will remain anonymous and there will be no way that you can be identified.

All information will be securely stored in a locked metal box in my home where only I will have access to it. It will be stored until the completion of the study and the findings have been released. Your personal information will be destroyed within one year after the study is complete.

Can participating in the study end early?

Your participation in the study is voluntary. If you decide to participate, you can decide to stop at any time, even after signing the consent form or part way through the study. If you decide to stop participating, there will be no consequences to you and you will still receive payment. You can choose whether you would like the incomplete interview data to be used for research purposes or destroyed.

Will I be paid to participate in this study?

You will receive a $20 honorarium for participating in the interview. You will not receive an additional honorarium, however, should you choose to review preliminary results and provide feedback.

Will there be any costs?

Your participation in the study will not involve any additional costs to you.

If I have any questions or problems, whom can I call?

If you have any questions about the research now or later, please contact Jeri Dunne at 416-301-7294 or the Faculty Supervisor, Dr. Wendy Sword, at 905-525-9140 ext 22307.

If you have any questions regarding your rights as a study participant, you may contact the McMaster Research Ethics Board Secretariat at 905-521-2100 ext 23142.

CONSENT

I have read the information presented in the information letter about a study being conducted by Jeri Dunne, a graduate student at McMaster University. I have had the opportunity to ask questions about my involvement in this study, and to receive any additional details I wanted to know about the study. I understand that I may withdraw from the study at any time, if I choose to do so. I agree to participate in this study and have been given a copy of this form.

_____
Name of Participant

_____
Signature

Appendix D

Interview Guide for Public Health Nurses

I'd like to thank you for taking the time to be interviewed today. During this interview, we'll be exploring your thoughts on how public health units can help strengthen public health nurses' socio-political efforts to address the causes of poverty.

Poverty is the inability – due to lack of financial resources – to participate in the kinds of activities expected of an average Canadian in an advanced industrial society.

Before we begin, I'd like to remind you that the interview is voluntary and if there are any questions that you don't feel comfortable answering, please let me know and I'll go to the next question.

Demographic Questions

1. Please tell me the age-range you fall within: 21-25, 26-30, 31-35, 36-40, 41-45, 46-50, 51-55, 56-60, 61-65, or 66-70 years?

2. What is your highest educational background?

3. What is your current position as a public health nurse?

4. How long have you been in this role?

5. Please describe your current program. If you work in more than one program, please describe the program to which you think this study is most relevant (e.g., to which you would implement improvements).

   - PROBE: program goals, perceived program effectiveness regarding ability to address poverty (causes/ consequences), relationship to community, accountability structure, staff – number, mix.

Study Questions

1. Briefly describe your experience in working with individuals/ families/ communities living in poverty.

2. What does addressing the causes of poverty mean to you?

3. How do you see socio-political activity as helping to address the causes of poverty? Socio-political activity is one way to address the causes of poverty. It aims to bring about community-based emancipatory social movement. It includes political advocacy and critical consciousness raising, participating in public health policy formation, social education program development, and participation in public health policy formation.

4. What has been your best experience with respect to addressing the causes of poverty as a public health nurse?

   - PROMPTS: public messaging about the relationship between poverty and health or the health effects of poverty-related policies; facilitating story telling to shift opinion; transferring knowledge, skills, and control to local people; poverty and health profiling assessments; partnerships; providing support for policy action; putting poverty on the agenda of organizations and health associations.

5. What would you dream for in your public health unit with respect to addressing the causes of poverty?

6. What would the work of public health nurses in your public health unit look like if it more effectively addressed the causes of poverty?

7. What actions would operationalize this more effective approach to addressing the causes of poverty in your public health unit?

Probing Questions

The following questions are applicable to study questions four to seven, to be used for prompting further detail.

1. How did/ might your job definition affect this (e.g. visibility and centrality of role, discretion in decision-making)?

2. What alliances internal and external to the organization facilitated or might facilitate this?

3. What opportunities (knowledge, skills, or organizational advancement) facilitated or might facilitate this?

4. What information (e.g. technical knowledge, expertise, informal information) facilitated or might facilitate this?

5. What supports (e.g. positive feedback; job discretion) facilitated or might facilitate this?

6. What resources (e.g. money, materials, time) facilitated or might facilitate this?

I'd like to thank you for participating in this interview today. Your responses will help generate knowledge that can be used to inform decisions on how to create a public health system more responsive to poverty.

Preliminary results will be sent to interested participants to review for accuracy. Would you like me to contact you at this time to see if you are interested?

Finally, do you know any one who might have a lot to say about addressing the causes of poverty through public health nursing in Ontario? If so, would you mind giving them my contact information and a study invitation?

Thank you again for your time. It is much appreciated.

Appendix E
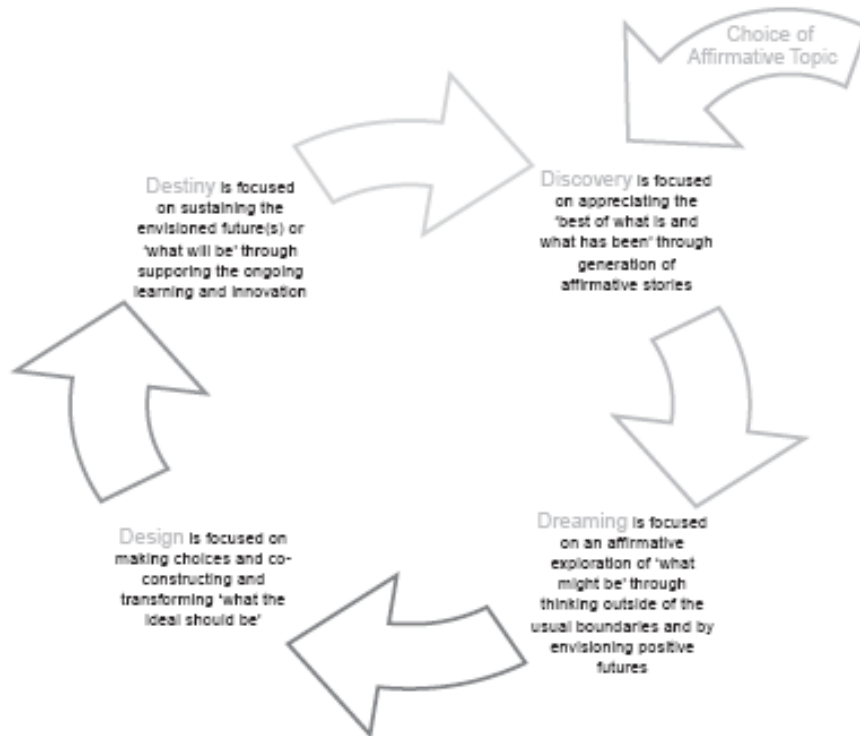
Appreciative Inquiry: The 4-D Cycle

Figure 1   The 4-D cycle.

(Carter, 2006, p. 54)

Appendix F

Rosabeth Kanter's Structural Theory of Power in Organizations

SYSTEMIC POWER FACTORS ———————→ ACCESS TO JOB-RELATED ————→ PERSONAL IMPACT ————→ WORK EFFECTIVENESS
                                                        EMPOWERMENT STRUCTURES   ON EMPLOYEES

Location in formal &
informal systems

Formal Power
Job definition
discretion (flexible) recognition (visible) relevance (central)

Access to

opportunity structures
power structures
resources information support
proportions structure

influences

leads to

results in

increased
self-efficacy

high motivation

increased
organizational
commitment

lowered
burnout level

increased
perceived
autonomy

increased
perceptions of
participative
management

increased job
satisfaction

achievement and
success

respect and
cooperation in
organization

client
satisfaction

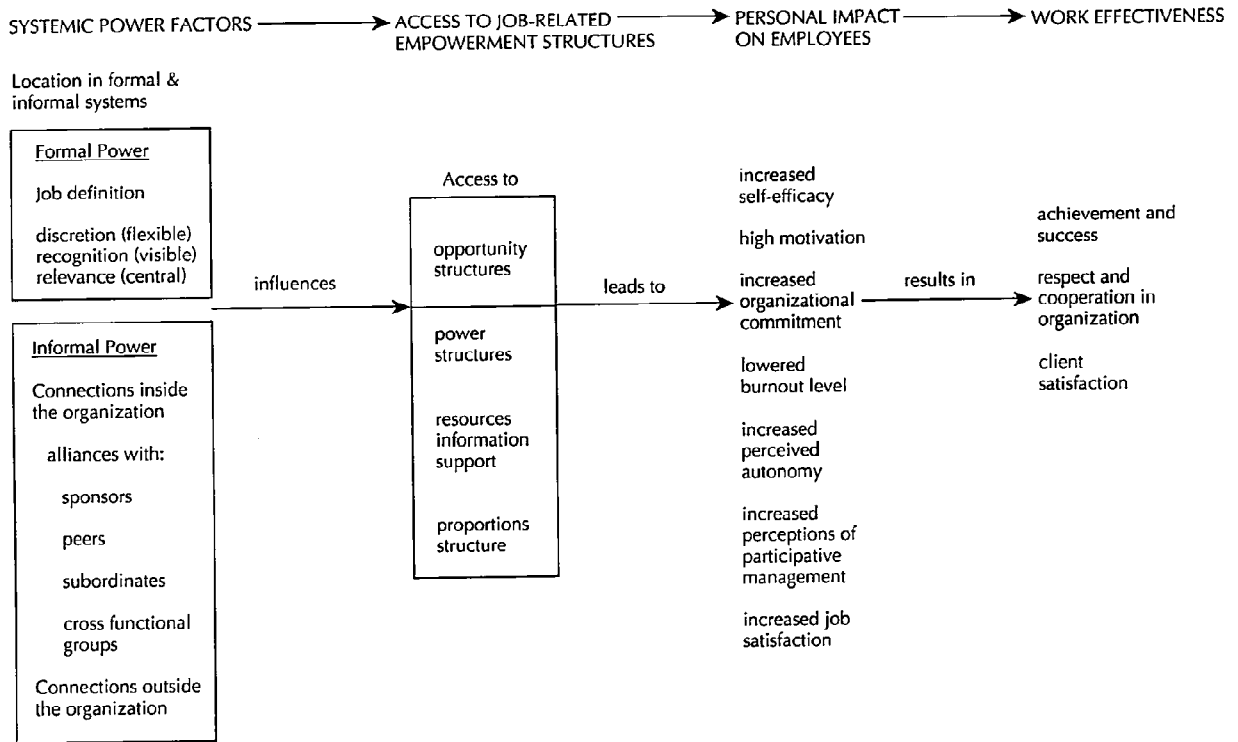| Informal Power |
|---|
| Connections inside the organization |
| alliances with: |
| sponsors |
| peers |
| subordinates |
| cross functional groups |
| Connections outside the organization |

Figure 1. Relationships of concepts in Kanter's Structural Theory of Power in Organizations.

(Laschinger, 1996, p. 27)