



COMMUNITY  
HEALTH NURSES  
OF CANADA



INFIRMIÈRES ET INFIRMIERS  
EN SANTÉ COMMUNAUTAIRE  
DU CANADA



National Collaborating Centre  
for Determinants of Health

Centre de collaboration nationale  
des déterminants de la santé

**PUBLIC HEALTH NURSING  
LEADERSHIP DEVELOPMENT  
IN CANADA**

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**This report results from a partnership of the Community Health Nurses of Canada (CHNC) and the National Collaborating Centre for Determinants of Health (NCCDH)**

CHNC is a national organization for community health registered nurses to advance practice and to improve the health of Canadians. CHNC represents the voices of community health nurses; advances practice excellence; creates opportunities for partnerships across sectors and networks; strengthens community health nursing leadership; advocates for healthy public policy to address social and environmental determinants of health; and promotes a publicly funded, not for profit system for (community) health. CHNC is an associate member of the Canadian Nurses Association (CNA). This report contributes to the CHNC’s public health nursing leadership development planning, strategies and activities, in part through a Centre of Excellence in Public Health Nursing.

The NCCDH supports public health practitioners and decision makers to better understand and use evidence about how to influence the determinants of health and reduce health inequities. The NCCDH’s Public Health Leadership Development Initiative aims to translate knowledge, foster knowledge use, and accelerate the development of networks in building public health leadership capacity for health equity. This report informs knowledge translation planning for the NCCDH’s Public Health Leadership Development Initiative.

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This report includes a literature scan and a pilot survey of the Community Health Nurses of Canada (CHNC) Board members and members of CHNC standing committees. The literature scan describes leadership issues and leadership development opportunities for public health nursing leadership. The survey includes examples of leadership development opportunities with respect to health equity and the social determinants of health (SDoH) experienced by CHNC members of the Board and its standing committees. A third component is the report of the preconference consultation carried out in June 2013.

## **Part I: Literature Scan**

### **Purpose**

The purpose of the scan of the literature is to locate and describe key literature sources that include examples of, or recommendations for, activities for public health nurses with regard to building capacity for leadership in addressing the SDoH and health equity.

The questions that guide this literature scan include:

1. What literature exists that describe action to develop public health nursing leadership capacity regarding the social determinants of health and health equity?
2. What literature exists that describe action to develop public health nursing leadership capacity in the domains (practice, administration, education, research, and policy) and segments (rural, senior decision maker, frontline manager, frontline, clinical consultant, educator, researcher)

### **Method**

Strategies used to identify literature for the purposes of this literature scan are detailed below. The entire process was documented using an Excel™ spreadsheet. The spreadsheet was used as a tool to document the search terms used, specific searches completed, databases used, websites visited, search results, inclusion/exclusion criteria, sources included in the scan, complete references, and abstracts.

Literature was searched for using Medical Subject Headings (MeSH) terms as well as general keywords; MeSH terms are controlled vocabulary used to index articles in multiple databases. The Cumulative Index of Nursing and Allied Health Literature (CINAHL) was searched using MeSH search terms that included: Public Health, Management, Nursing, Community Health Nursing; Nurses by Role; Organizational Culture; Nursing Outcomes; Leadership, Competency Assessment, Professional Competence, Clinical Competence; and Health Status. CINAHL was searched with general keywords including: nursing; leadership; leadership development; competency; health equity; social determinants of health; public health; effectiveness.

Stakeholder websites were searched for grey literature including reports, reviews, opinion pieces, administrative documents. Websites reviewed include: Community Health Nurses of Canada (CHNC.ca); National Collaborating Centre for Determinants of Health (nccdh.ca); and various leadership and equity sites. A scan of reference lists was also done to retrieve additional relevant literature.

Literature from all sources was given equal weight. Identification of articles best suited was done by four exclusion/inclusion criteria:

1. Must be from countries with somewhat similar public health nursing practices: Canada, United States, United Kingdom, European Union, Australia, and South Africa;
2. English language;
3. Perceived relevant to at least one component of the research question; and
4. Research subjects include a relevant part of the public health nursing workforce.

This selection process was an iterative process as articles that were deemed relevant at first glance may have become less relevant upon further reading. Alternatively, articles originally deemed irrelevant may speak to knowledge gleaned throughout the course of the literature scan. Information collected in the Excel™ spreadsheet made it possible to quickly scan all search results and facilitate the iterative selection process.

A draft of the literature and its findings was provided to the CHNC Working Group for this project, and advice was provided regarding literature that was missing and recommendations that ought to be highlighted. This process uncovered a number of additional resources about leadership and health equity, for leadership development, and suggested some further strategies to generate information about the segments of interest, for example, resources from rural and remote health research. A list and brief description of the literature included in this project is included as Appendix A.

## **Results of the Literature Scan**

This report contains a scan of the literature; it is neither a systematic nor a critical review. It presents the results of the scan first by defining the determinants of health and health equity, then by presenting a description of leadership. It further presents a scan of leadership literature and leadership development in public health nursing. It concludes with an assessment of the gaps in the literature.

### **A. Social determinants of health and health equity**

According to the NCCDH definition, the determinants of health are the range of personal, social, economic and environmental factors that determine the health status of individuals or populations. These determinants intersect and interact with one another, so that the health of any individual is a complex summation of factors. Social determinants of health can be understood as the social conditions in which people live and work (2010, p.7).

The Public Health Agency of Canada lists twelve determinants: income and social status; social support; networks; education and literacy; employment/working conditions; social environments; physical environments; personal health practices and coping skills; healthy child development; biology and genetic endowment; health services; gender; and culture.

Mikkonen and Raphael (2010) add other determinants: Aboriginal status; disability; housing; early life; income and income distribution; education; race; social exclusion; food insecurity; social safety net; and unemployment and job security. Linguistic minority status has also been identified as a determinant (Personal communication, C. Armistead, April 7, 2013).

Health equity is defined by the WHO Commission on the Social Determinants of Health as:

... the absence of avoidable or remediable differences among populations or groups defined socially, economically, demographically, or geographically. Health inequities, therefore, involve more than inequality—whether in health determinants or outcomes, or in access to the resources needed to improve and maintain health. Health inequities also emphasize a failure to avoid or overcome such inequality that infringes human rights norms or is otherwise unfair (Public Health Agency of Canada & World Health Organization, 2008, p.12)

Health equity, according to Alberta Health Services (2011), means that all persons have fair opportunities to attain their health potential to the fullest extent possible. “Health inequalities” is a generic term used to designate differences or variations in health outcomes between population groups. Some health inequalities reflect random variations (i.e., unexplained causes), while others result from individual biological endowment, the consequences of health behaviours, social stratification, economic opportunity or access to health care. The term “health disparities” is more commonly used in the U.S. while “health inequalities” is used more often in the Canadian context.

The NCCDH uses the following definition:

Health equality/inequality: the generic terms used to designate differences, variations, and disparities in the health achievements and risk factors of individuals and groups ... that need not imply moral judgment. Some inequalities reflect random variations (i.e., unexplained causes), while others result from individual biological endowment, the consequences of personal choices, social organization, economic opportunity, or access to health care. Public policy is concerned with health inequalities attributable to modifiable factors, especially those that are perceived as inequitable.

Health equity/inequities: those inequalities in health that are deemed to be unfair or stemming from some form of injustice. The crux of the distinction between equality and equity is that the identification of health inequities entails normative judgment premised upon (a) one’s theories of justice, (b) one’s

theories of society, and (c) one's reasoning underlying the genesis of health inequalities. Because identifying health inequities involves normative judgment, science alone cannot determine which inequalities are also inequitable, nor what proportion of an observed inequality is unjust or unfair. (2010, p.7)

Braveman (2013) states further:

Equity means Justice. Health equity is the principle or goal that motivates efforts to eliminate disparities [differences] in health ... Pursuing health equity means reducing health disparities by improving the health of the economically/socially disadvantaged, not by worsening the health of advantaged groups (p.1).

## B. Leadership

NCCDH identifies leadership as a key role for public health action on the determinants of health: "lead/participate and support other stakeholders in policy analysis, development and advocacy for improvements in health determinant/inequities" (National Collaborating Centre for Determinants of Health, 2010). The definition of leadership used by the NCCDH is:

Leadership is about influence that moves individuals, groups, communities and systems toward achieving goals that will result in better health (Betker & Bewick, 2012, p. 31).

The Public Health Agency of Canada (2010) defines leadership in the glossary that supported the development of core and discipline-specific competencies for the public health workforce in Canada:

Leadership is described in many ways. In the field of public health it relates to the ability of an individual to influence, motivate, and enable others to contribute toward the effectiveness and success of their community and/or the organization in which they work. It involves inspiring people to craft and achieve a vision and goals. Leaders provide mentoring, coaching and recognition. They encourage empowerment, allowing other leaders to emerge.<sup>1</sup>

Stamler and Yiu (2005) further describe leadership:

Formal and informal leaders lead their members by influencing the decision making process using their status and position in the community. Formal leaders are elected official politicians such as mayors, members of parliament, or the prime minister. Informal leaders are those with prominent positions in the community, such as religious leaders, executives or representatives of

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<sup>1</sup> <http://www.phac-aspc.gc.ca/php-ppsp/ccph-cesp/glos-eng.php#l> (Modified 2010)

community organizations or professionals, elders of community groups, or local heroes. (p.154).

What does leadership mean in the context of a profession? According to The Performance Juxtaposition Site (Clark, 2012):

Leadership is a process by which a person [or persons] influences others to accomplish an objective and directs the organization [profession] in a way that makes it more cohesive and coherent.

This definition is similar to Northouse's (2007) definition — Leadership is a process whereby an individual influences a group of individuals to achieve a common goal.

The site goes on to state that “the basis of good leadership is honorable character and selfless service to your [profession]. In your members' eyes, your leadership is everything you do that affects the [profession's] objectives and their well-being. Respected leaders concentrate on:

- what they are [**be**] (such as beliefs and character);
- what they **know** (such as job, tasks and human nature); and
- what they **do** (such as implementing, motivating, and providing direction). “

What makes a person want to follow a leader? According to the above website, people want to be guided by those they respect and who have a clear sense of direction. To gain respect, they must be ethical. A sense of direction is achieved by conveying a strong vision of the future.

The discipline-specific core competencies for public health nurses (CHNC, 2009) include leadership as a core competency. It is further identified in the NCCDH (2010) environmental scan as an additional public health role. Public health/community health nurses have been identified/are regarded as suitable leaders to action on the social determinants of health: “They are leaders of change to systems in society that support health” (Canadian Public Health Association, 2010).

Nurses work at the “intersection where societal attitudes, government policies, and people’s lives meet...(and)...creates a moral imperative not only to attend to the health needs of the public but also, like Nightingale, to work to change the societal conditions contributing to poor health “ (Falk-Rafael, 2005, p. 219).

Other authors have called on public health nursing to use their relationship with individuals, families, aggregates and communities to take action on the determinants of health (e.g., Cohen & Reutter, 2007; Falk-Raphael & Betker, 2012; Smith 2007).

*“I used to think that running an organization was equivalent to conducting a symphony orchestra. But I don't think that's quite it; it's more like jazz. There is more improvisation.”*

— Warren Bennis



## How can leadership be developed?

Leadership development is a process that builds on people's skills and attitudes. Development depends on the characteristics of the individual, the quality and nature of the development program (e.g., classroom, experiential, self-efficacy activities) and the general support of management for behaviour change.

### *Undergraduate nursing curricula*

Preparation for nursing practice begins with the undergraduate curriculum.

- Educating future registered nurses for social justice is an urgent, yet complex undertaking in undergraduate education. Although the need for social justice education is often highlighted, few articles describe practical teaching strategies for ensuring that undertaking (Boutain, 2008).
- Undergraduate preparation for developing leadership in advocacy requires a partnership model between clinical placement agencies and the educational program in order for students to bolster PHN capacity and competencies (Falk Rafael 2004).
- Need for theory-based education (Cohen & Reutter, 2007) e.g., critical caring theory.
- CASN has published several documents about the contents of undergraduate community preparation in Canada (2006, 2008, 2010).

### *Front-line practice*

It is imperative that role clarity is enhanced and scope of practice is defined if leadership development is to properly occur at the front line. In this regard:

- "Currently no data set exists to describe PHN practice, and there are no tools that measure PHNs' unique contributions to population health. Public health services must be founded on demonstrated effectiveness of program activities and based on data that is reliable and valid." (Cusack, 2012, p.35).
- "Public health nurses' ability to address child and family poverty [i.e., a determinant of health] effectively will require that they place a high value on social justice and equity, support structural explanations of poverty, believe that social/political action is a legitimate part of their role, and have a positive attitude towards individuals living in poverty." (Cohen & Reutter, 2007)
- PH Leadership frameworks that outline specific competencies are required:
  - Outline transformational competencies, political competencies, transorganizational competencies, and team building competencies. (e.g., National Public Health Leadership Development Network)
  - Leadership development requires competency-based instruction (Wright et al., 2000).

- Efforts for political socialization/structured political socialization are needed (e.g., mentor groups, professional associations) (Deschaine & Schaffer, 2003)
- Increased visibility to develop society's trust in nurses, recognizing contributions, and public understanding of public health nursing and different roles (Ganann et al., 2010)
  - Recognition of the value of knowledge PHNs glean through practice and promotion thereof
  - Acknowledgement/respect of knowledge gained through practice. As discussed by Falk-Rafael and Betker (2012a), relationships are foundational/key to PHN practice and through these relationships PHNs garner valuable knowledge from disenfranchised populations. As quoted by one participant: "The advantage that public health nurses have is we're in the homes, we're in the community, and we see what's happening and we've got that knowledge base to move it up." (p. 320) another example: "But [my mentor] taught me you can hang out and sit and let people talk to you and you listen. And she fortunately said, "That's valuable work."" (p. 320)
- Continuing education is also helpful to developing PHN leadership:
  - (Falk-Rafael & Betker, 2012a)
  - Professional PH leadership development requires competency-based instruction (Wright et al., 2000).
  - Training program offered by National Public Health Leadership Institute (US) to develop collaborative leaders found to be effective (Umble et al., 2005)
- Consider innovative models to develop leadership at the front line:
  - New model of practice (Cusack, 2012) affording PHNs in Winnipeg a leadership role in promoting population health and health equity.
  - Nurses in leadership/management positions and their involvement in program planning enables front-line public health nursing leadership (Ganann et al., 2010).
  - Reflective practice: during program planning and delivery, look at short/long term health impacts, how SDoH are targeted, and implications for health equity (Gore & Kothari)
  - Monitoring/Assessment: "Quality improvement process to develop clinical leadership among front line PHNs" (Mills & Schneider, 2007, p.64)
  - Knowledge is power; consider the dominance of biomedical paradigm and power attributed to medical disciplines vs. experiential/relation based knowledge and power attributed to social justice/health equity and "pre-medicalized public health" (Falk-Rafael & Betker, 2012b)
  - "CARE was proposed as an acronym of 4 sources of power—credentials, associations, research, and expertise—available to and essential for effectively speaking truth to power"(Falk-Rafael, 2005, p. 100)
- In Ontario, the new SDoH PHNs require information. Reported information sources: Agency data; health reports; health surveys/studies; risk factors; stakeholders (Peroff-Johnston & Chan, 2012, slide 12)

- Capitalize on “learning by doing” (Moloughney, B. (2010). NCCDH Environmental Scan) and ensure stories are shared with other PHNs

### *At the organizational level*

Motivate an organizational culture shift to develop leadership at the organizational level by:

- Fostering an organizational culture shift to reflect SDOH perspective. Recognize that the health system itself as a social determinant of health equity (Gilson et al., 2007). Health sector can provide leverage for intersectoral action (Gilson et al., 2007)
  - For example role of SDoH PHNS in Ontario as a way to change organizational culture. SDoH PHNs build capacity within the organization. Raise awareness of SDoH, priority populations, applying a health equity lens to programs and services, application of practical tools to identify priority populations and address barriers, develop SDoH information resources including communication and online resources, develop partnerships with external organizations. (Peroff-Johnston & Chan, 2012)
  - Cusack argues that in Winnipeg Health Authority, PHNs ideally situated to take on leadership role to reorient/establish model of practice to address complex health issues/health equity/SDOH lens. (2012, p.46).
  - “One of the key differences between the adoption of innovation by individuals versus organizations is that for the latter, buy-in and leadership from the organization’s senior management are essential. The reason is that leadership is essential for establishing action on health determinants as a priority, allocating resources, modelling desired behaviours, and overseeing implementation” (National Collaborating Centre for Determinants of Health, 2010, p.35)
- Enhancing Chief Nursing Officer effectiveness by giving the CNO a leadership position as a member of senior administration, involved in organizational decision making, and reporting to the head of the organization (Peroff-Johnston & Chan, 2012).
  - Succession planning to recognize high-potential PHNs and “bring them along” (Discussion summary, OPHA 2009)
- Adopting a social change opportunity:
  - “For us, the value of a human rights and health perspective lies in its potential as a framework within which the social change orientation of health promotion can engage the more deterministic population health model. In so doing, it actively promotes a multidisciplinary conversation that explicitly brings the language of health and medicine face to face with the language of power and social inequality.” (VanderPlaat & Teles , 2005)
  - Empowerment and risk-taking by management that encourages an environment of innovation and creativity. Need to afford CHNs flexibility to engage in community capacity building, debriefing opportunities, (Ganann et al., 2010)
- Recognizing that the health system itself is a determinant of health:

- “The health sector’s vision of health also affected the extent to which it could play a role in any of these intersectoral scenarios. In general, where the vision of the health sector was to control disease, or to modify individual’s risky behaviour it limits the degree to which it can offer leadership on intersectoral action on the determinants of health” (PHAC & WHO “Health equity through intersectoral action” p.v)
- Supporting partnerships/collaborations at the organizational level to develop leadership
  - Intersectoral partnership development contribute to PH leadership SDH capacity (Gore & Kothari, 2013)
  - Illustrate that framing issues with broad social indicators vs. health indicators allows people from all sectors to more clearly identify their role in SDH action (PHAC and WHO case studies p.111)
  - There is a need for academic/practice partnerships to capitalize on leadership that exists within nursing and academia. Partnerships provide a springboard for innovation and action.(Bleich, Hewlett, Miller, & Bender, 2004)
  - Academic/service partnerships required to develop nursing leadership: "The fact is that the nursing profession is well positioned as a discipline to reshape the health care system [in the US] in its various configurations. The intellectual capacity is collectively present, with transformational leaders to marshal change already in our midst. The challenge at hand is that the collective wisdom and experience to create a springboard for action is rarely present in any one organizational entity. It is only through collaborative partnerships that nursing's potential can be fully realized for the benefit of service to our citizenry" (Bleich et al., 2004 pp. 293-294).
- Supporting education, continuing professional development activities for PHN capacity building and leadership development
  - Consider role of evaluation/measuring outcomes and upholding standards (Ganann et al., 2010) to empower PHN practice. Need for empowerment in response to identification of sense of vulnerability, and consequent hesitation to engage in community development work: doing community development work puts you out there in the “public eye” (Cohen, 2006, p.59). Consider role of evaluation/measuring outcomes in empowering PHN role in the community.
- Upholding the PHN standards of practice empowers CHNs (Ganann et al., 2010).
  - Example of developing leadership through quality improvement related exercises: change readiness questionnaire with front line staff, survey clients about experiences with PHN service delivery, group interviews with PHNs and inter-professional teams to id current and desired activities of PHN practice (L. Mills et al., 2012).

## What factors impact effective public health nursing leadership?

Values, role scope, relationships/partnerships, access to data, innovation/creativity and various types of support have an effect on effective public health nursing leadership:

- A recent study outlined characteristics necessary to support PHN practice in Canada. Attributes in the areas of government, organization, and systems were identified. Frontline management support and organizational culture were deemed essential in promoting and sustaining effective PHN practice.” (Cusack, 2012, p. 38; Meagher-Stewart et al., 2010)
- Is there a personality type more suited for individual PHN practice? Community development or advocacy for healthy public policy is perceived to be a matter of interest and not something for everyone, e.g., “I’m not a political person, It’s not my style, I’m a cautious person” (Cohen, 2006, p.59)

Value placed on health equity and social justice influences effective PHN leadership:

- “Public health nurses’ ability to address child and family poverty effectively will require that they place a high value on social justice and equity, support structural explanations of poverty, believe that social/political action is a legitimate part of their role, and have a positive attitude towards individuals living in poverty.” (Cohen & Reutter, 2007)
- Evidence of conceptual confusion: it is important to understand that a population-level approach does not equal population health. This relates to the importance of health equity in program planning and implementation (Moloughney, B. (2010) NCCDH Environmental scan)
- Structure based initiatives are needed to improve health equity (Gore & Kothari, 2013). Need to address distal, structural (Social/political/economic) systems to see improved health and long term social change.
  - Structural tailored PH work needed to impact determinants of health (Moloughney, B. (2010) NCCDH Environmental scan)
  - Focus on individual behaviours and proximal determinants that inevitably lead to catering to middle class vs. priority populations.
- Lack of professional guidance, “equivocalness of CNA code”. Leadership in health inequality issues is not afforded formal support in practice standards: “the non-compulsory nature of political activism to address broader health inequities communicated by the CNA Code is reinforced by the practice standard in Ontario.” (Falk-Rafael & Betker, 2012b, p.100)

Role scope and clarity impact effective leadership at the level of practice:

- “Practice is narrowing to a focus on clinical care and health education; there is an inability to practice to full scope; lack of understanding regarding the role; and PHNs are feeling devalued and powerless to promote change” (Cusack, 2012, pp. 45-6).
- Focus on service delivery trumps development of strategic partnerships/relationships with community (Moloughney, B. (2010) NCCDH Environmental scan)
- PHN role eroding with the introduction of health promotion specialists. PHN may have been mistakenly trying to “do it all” which has contributed to lack of confidence/clarity in their role (Discussion summary OPHA 2009)
- Scope of practice and job descriptions do not always correspond with the Standards (CHNC, 2011) and the discipline-specific competencies (2009).

Development of relationships and intersectoral/interprofessional partnerships stimulates effective leadership at all levels:

- Performance measures for PHN do not address the actions needed to impact the SDoH and health inequity; partnerships, relationships, trust-building and planning with intersectoral partners take time.
- Importance of relationships. Relationships developed through practice are necessary for obtaining valuable information and enacting influence on clients i.e. effective practice (Falk-Rafael & Betker, 2012a)
- Advocacy and “trombone slide of nursing” (Falk-Rafael & Betker, 2012a) – community work requires a balancing of priorities, relationship development and the building of capacity and trust.
- Effective collaborations require clear definition/understanding of PHN roles and contributions (Discussion Summary, OPHA, 2009)
- Organization-to-organization partnerships are required for effective leadership development, mutual understanding, and efficient use of resources (e.g., community, academic and service agency cooperation, collaboration and partnerships to develop best practices and leadership at all levels).
- Community agency and academic relationships are important for ensuring adequate public health, social justice and health promotion content in nursing curricula (both undergraduate and graduate), appropriate clinical placements that offer opportunities to see action on the SDoH, and mutual continuing education and leadership development for both practitioners and faculty.
- Analysis of international examples of intersectoral action on health equity highlights importance of health sector’s diplomacy role in integrating health objectives in equity policies vs. enforcement of health targets upon other sectors. Example: Quebec ministries and agencies must consult with ministry of health and social services on anything that may impact health (p.17). Resistance is plausible as the health sector may be regarded as operating beyond its reach/mandate.

Access to and collection of data fosters effective leadership at the all levels:

- Need for population based data on health indicators. “Health disparities are the metric by which we measure progress towards health equity” (Braveman, 2013, p.2).
- “Interviewed physicians emphasized the need for community level data. Data within primary care practices could help to assemble community wide databases of health information, including information on the social determinants. You still need to ask questions about the social determinants of health even if you aren’t working in a disadvantaged population. This data is now regularly collected at the community level in Newfoundland and Labrador and Quebec. It can help physicians understand the needs of their practice and what interventions may or may not be helpful. It can be used to conduct equity assessments as well. Innovative programs within the Saskatoon Health Region and the Centre for Addiction and Mental Health in Toronto use data collected on health outcomes for various groups to find barriers and identify ways to ensure greater access and equity for all patients” (CMA, 2013,pp 6-7).
- Gaps in evidence base present challenges to PH action (Moloughney, B. (2010) NCCDH Environmental scan)
  - Specifically, there is a need for wider understanding of health determinants and pathways to health outcomes (Moloughney, B. (2010) NCCDH Environmental scan)
  - Understanding how health disparities are produced/mitigated is essential for developing effective SDH strategies towards health equity (Braveman, 2013)
- Braveman (2013) suggests use of life-course perspective to understand how health disparities are produced. This requires consideration of how social /economic factors shape health throughout an individual’s lifespan (or a cultural group’s history)
  - Although not outlined or referenced by Braveman, the specific elements of Elder’s life course perspective: “(1) historical time and place: that the life course of individuals is embedded in and shaped by the historical times and places they experience over their life-time, (2) timing in lives states that: the developmental impact of a succession of life transitions or events is contingent on when they occur in a person's life, (3) linked lives: lives are lived interdependently, and social and historical influences are expressed through this network of shared relationships, (4) human agency states that individuals construct their own life course through the choices and actions they take within the opportunities and constraints of history and social circumstances” (Elder 1998, pp. 3-4))

- Organizations need data to determine where resources are best placed to have an effect on the SDoH and health equity.
- Managers need data to ensure that priorities are ranked appropriately and that programs are properly resourced for effective delivery.
- Performance data are required to identify, recognise and develop high potential nurses and set them on a leadership path.

Innovation and creativity influence effective leadership at the level of practice:

- OPHA suggest a need to support and strengthen innovation among public health nurses (Discussion summary, 2009)
- Scan suggests that there is a lot of “learning by doing” in PH practice. Sharing these stories and learning from others’ innovation and creativity presents a challenge as publication is not a priority at the level of practice (Moloughney, B. (2010) NCCDH Environmental scan)
- Professional autonomy “A strong sense of professional autonomy may lead nurses to finding solutions within their organizations to overcome some of the barriers they face in addressing social and health inequities.” (Falk-Rafael & Betker, 2012b, p.111)
- Williams (2011) maintains that the agency of individual actors, their creativity and determination is pivotal. Williams describes Boundary Spanners as people with a set of skills that facilitates collaboration. In PHN these are actors that can build relationships and collaborate horizontally across sectors as well as vertically with clients and management. While structural support for collaboration is beneficial, Williams considers personal agency to be paramount.

Organizational culture impacts effective leadership:

- Leadership helps shape culture; in turn, culture shapes leadership. They both drive performance. Leaders influence an organization’s culture and in turn its long-term effectiveness. Leaders set the agenda; they are seen as role models and people look to their leaders to see if their actions are consistent with the organization’s values.
- In the case of CNOs, an organizational culture that is committed to nursing and nursing practice is necessary for effective leadership (Public Health Chief Nursing Officer Working Group, 2011).
- Falk-Raphael describes public health agencies as being based on a biomedical model; recommends moving to a critical care and advocacy model for public health nursing practice. PHN are “silent” or “silenced” because their language and approach to service are inconsistent with a biomedical model (Smith, 2007)
- Shift in organizational culture is needed to prioritize SDoH and health equity so as to position public health nursing to work with structure-based initiatives, thereby reaching multiple populations in multiple settings (Gore & Kothari, 2013)
- Critical to include social justice as an explicit concern in policy agendas. “Equity means justice” (Braveman, 2013)



- PH interventions must attend to larger socio-environmental aspects that create inequities in order to address social justice (Drevdahl, 2013)
- Organizational structure impacts leadership
  - Scope and mandate of PH organizations
  - Unclear/ variable capacity of PH Organizations (Moloughney, B. (2010) NCCDH Environmental scan)
  - Especially with regard to assessment/surveillance
  - Lack of ACCOUNTABILITY – unclear/inexplicit expectations of PH impact sets the stage for a lack of accountability (Moloughney, B. (2010) NCCDH Environmental scan)
  - Some public health organizations criticized as being overly bureaucratic and operating almost as three separate organizations: senior management, middle management and front-line staff, with each level potentially acting as a barrier to the agenda of the others (National Collaboration Centre for Determinants of Health, 2010, p.17).
  - Highlights the importance of ground up initiatives and public participation in community planning and program development vs. top down (ibid, p.III).

External influences on the public health system as leaders in SDoH and social justice:

- Political climate that favours focus on individual behaviour/lifestyle choices over social context for lifestyle/behaviour choices. Also, it is not a popular idea to reallocate resources from middle class/upper class to priority populations (Moloughney, B. (2010) NCCDH Environmental scan)
- Lack of public understanding of the nature of PHN work, lack of appreciation of PHN expertise and value of input (Cusack, 2012; Deschaine & Schaffer, 2003)
  - Public doesn't recognize legitimate role for PHNs in community development or advocate for healthy public policy (Cohen, 2006)
  - Traditional view of nursing profession as non-confrontational/passive thereby jeopardizing leadership role in community development or policy development/change (Cohen, 2006)

### How can knowledge uptake among Public health leaders be encouraged?

Foster platforms where PH leaders can influence priorities:

“Leadership is essential for establishing organizational action on health determinants including its influence on priority setting, allocation of resources, modeling desired behaviours, establishing strategic partnerships, and overseeing implementation. As such, public health leaders will require particular attention and support in the work of the NCCDH (National Collaboration Centre for Determinants of Health, 2010)

Recognize that knowledge/data can be used as a catalyst to action e.g., NCCDH Winnipeg Case Study:

“The urban health report provided local, timely, comparative health data that pointed to serious health inequity in Winnipeg. Preparation for anticipated media questions made the evidence a key catalyst to raise the profile of health disparity among senior management and key leaders at the Winnipeg Regional Health Authority. While the media attention was less than predicted, the presentation of the data by the Population and Public Health staff and the Research and Evaluation team resonated with senior management [...] It countered the interpretation that differences in acute care were solely due to inefficiencies, and pointed to a population that is sicker and has more social complexities than in other urban centres and may, therefore, require more care (p.5)

Build vertical networks (Edwards & MacDonald, 2009):

- Vertical networks serve two functions – identification of timely and relevant research questions and foundation for knowledge translation (Edwards & MacDonald, 2009)
- “A health equity impact assessment (HEIA) is a process used to assess equity, incorporate evidence, and bridge the gap between research and policy. HEIA is one method that can promote “whole of government thinking.”” (Cusack, 2012) p.15
- “Collaboration and consultation amongst interdisciplinary staff across program areas also increased and staff responded very positively to increased opportunities for knowledge exchange. BPSO® candidacy opportunities should be used by health organizations to increase evidence-informed practice and inspire excellence in health promotion practice.” (Dilworth, Tao, Shapiro, & Timmings, 2013)
- Getting people involved through active work groups, expert input, soliciting feedback at conferences. Soliciting input and providing platforms for input (Bakes-Martin, Corso, Landrum, Fisher, & Halverson, 2005)

## Summary of the literature

There is no question that there are many calls for public health and public health nursing leadership on the determinants of health to address health inequities. CHNC itself released public health nursing specific competencies – one among them is leadership (2009). The Blueprint for Action for Public Health Nursing (Community Health Nurses of Canada, 2011) also listed leadership among the imperatives for a robust future for the profession.

The National Collaborating Centre for Determinants of Health (2010) conducted an environmental scan and found that public health leadership to address the determinants of health and health equity needs to be strengthened in Canada. However, they stated, there is little consensus or evidence about effective leadership practices and supporting or limiting factors (Underwood, 2013 (reference embargoed)). Underwood found, in an appreciate inquiry

of 14 public health leaders in Canada, that conditions for leadership require organizational, community and professional capacity. Organizational capacity refers to policy commitments that are visible throughout an organization – in budgets, human resources strategies, high quality data collection, and adherence to external policies and standards. Community capacity refers to strategic public health leadership being involved actively in coalition-building and being a voice for the community while also supporting activities with expertise and funds. Professional capacity refers to the knowledge, skills and attitudes required to advocate for health equity.

Cohen and Reutter (2007) argue that public health nurses are in an ideal position to be leaders in addressing health inequities. However, they contend that the limited involvement of PHNs to date has to do with their perceived lack of knowledge, skill and personality to engage in social action; belief in personal responsibility for health; lack of time, management support and organizational philosophy; narrow job descriptions and workload measurement tools that don't support community action; as well as the limited understanding on the part of the public and colleagues in the PHN role in addressing health equity.

Three aspects of leadership in action for health equity relate to the PHNs personal knowledge, attitude and skills for action on the determinants, having a legitimate role to play in intersectoral action and community development, and an organizational culture that values action on the determinants within a population health context.

In relation to the domains of public health nursing practice, the literature is mostly silent on the role of PHN educators and researchers in leadership for action on the determinants of health. They can, however, as educators, influence the preparation of the nursing workforce by designing curricula and instructional activities (and clinical placements) with a focus on social justice, whether in the community or in hospitals and long term care settings. Researchers can help to more fully explicate public health nursing practice and contribute to the development of theory and best practice. There are calls for more research and more curricular content on leadership for advocacy on the SDoH and health equity, but few examples of courses that contain relevant content.

Certain segments of the PHN population were used as lenses to examine the literature. Most of the literature relates to action by front-line nurses, support from front-line and senior managers, and senior administration. Certainly there is literature that supports the distinction between managers (as “bosses”) and leaders (as “change agents”) but little reference is made regarding how to build leadership skills within the management group, plan for succession, or develop high-potential personnel.

There is little to no urban/rural specificity in the public health nursing leadership literature. There are case studies of urban and rural action but these are not specific to public health nursing; rather, they involve actions of intersectoral and interdisciplinary teams. There is no literature at all regarding the role/segment of the clinical consultant.

## Part II: Survey

The intent of the survey is to gather information about public health leadership development opportunities that currently exist and to articulate a vision for leadership, in particular the leadership required to promotion action on health equity. The survey was designed and developed by Jane Underwood of Underwood and Associates with Lesley Dyck of the NCCDH and piloted on a sample of registered nurses (n=46) from the CHNC Board and its standing committees. It consists of six general questions to assess the background of respondents and the regions of Canada in which they live, and ask for their definitions of leadership, and information on up to 5 opportunities they have experienced to support their growth in health equity leadership.

There were 35 responses to the survey (76% response rate). All respondents were registered nurses, with the bulk of them (71%) in the 50-59 year age group and 63% working in public health. Of these only 14% identified themselves as staff nurses, the remainder held positions of added responsibility, were faculty members, or were in other positions such as consultants, quality assurance or informatics. The majority (77%) had 16 or more years of experience. Nine provinces were represented among the respondents, about half were from Ontario.

In describing leadership, several themes emerged; the characteristics of leaders, what leaders do, and the competencies leaders have (knowledge and skill).

One respondent said “Leadership is action, not a position”; this concept was evident throughout the data. In other words, leadership exists throughout the organization, from front-line staff to people in management positions, but not all front-line staff and not all managers are leaders. Leadership is also described as an interpersonal relationship.

Leaders have certain characteristics/qualities that include:

- A vision that they share
- Action orientation
- Courage; willingness to take risks and be a change agent
- Caring, awareness, concern for others
- Patience, persistence, and participative
- Collaborative, facilitative, committed, and enabling
- Flexibility and adaptability
- Charisma

If leadership is action, what do leaders do? They:

- Coach, mentor, consult, and model
- Engage, include, enable and empower
- Forge new ground, innovate, collaborate
- Set an example, and act as role models,
- Embrace change, assume responsibility

- Listen, communicate, persuade, inspire, and facilitate
- Provide direction, support, opportunity and promote pride
- Speak up, leverage relationships, mobilize resources

Leaders have considerable knowledge and skill, although these were not mentioned as often in the data as the characteristics and actions of leaders. Leaders:

- Are able to see multiple perspectives
- Are able to learn from experience
- Are educators – they model, build capacity, coach and mentor
- Are communicators in many different forums
- Are knowledgeable about SDoH and health equity – are unafraid to name conditions and situations for what they are and use facts/evidence to support their position
- Use best evidence to offer solutions to issues
- Have the ability to persuade, negotiate, facilitate and influence

## Recommendations for developing PHN leadership

Some suggestions provided by survey participants and gleaned from the literature include:

- Create a Centre of Excellence that does short (3-6 week) residency programs for leadership development specific to public health nursing;
- Create a Community of Practice within a Centre of Excellence for public health nursing;
- Invite successful practitioners into academic faculties for writing sabbaticals to get more practice exemplars into the scholarly literature;
- Design nursing education programs around population health promotion principles and social action theory (CASN, 2006,2008, 2010);
- Focus program development on health equity (Gore & Kothari, 2013);
- Offer workshops, webinars, and conferences on social justice, equity and action on the determinants;
- Develop site-specific journal clubs focused on building the skills, knowledge and attitudes that support action on, and leadership for, health equity;
  - Discuss local health status and sociodemographic reports that link data to program planning;
  - Find ways to develop partnerships and teamwork to enhance individual PHN action;
- Build collaborative action/networks to influence social capital (Umble et al., 2013)

## Part III: Preconference Consultation

A preconference session was conducted at the 2013 7<sup>th</sup> Annual CHNC National Conference in Kelowna on June 17, 2013. Using an appreciative inquiry approach, approximately 30 participants were asked to contribute to the knowledge, foster knowledge use, and accelerate the development of networks in building public health leadership capacity for health equity (Schofield, 2013).

Through a process of consultation, data were collected that described a number of qualities or characteristics of good public health leaders:

- Vision
- Courageous, protecting PH, strategic agility
- Understanding of political climate – most important part is strategic agility, knowing who your allies are
- Ante up – having a moral core – knowing when you must ante up – get involved despite being very busy
- Create a safe place where mistakes can happen – nurses need to feel safe to make mistakes
- Not afraid to address problems or seek solutions
- Cultural competency needs to be embedded – Aboriginal medicine wheel as a public health focus
- Gentleness and assertiveness open to new ways of doing things but link with best practices
- Always presenting information that is current and true
- Strong link with primary care (especially in northern communities)
- Very knowledgeable

Participants also listed a number of actions that good public health nursing leaders do:

- Changing programs to client based needs
- The way programs are presented – high point of leadership
- Seeing strong leadership being exhibited in students – leaders
- Identifying upcoming leaders
- Getting to the core of matters
- Getting away from solution focus toward looking at root cause, challenging the status quo
- Strong leadership necessary by a small group in order to move others forward
- Rolling with resistance – negotiation and compromise
- Learning how to do it – how to put together the vision, courage, political knowledge etc. – they learn by making mistakes
- Not in formal leadership positions; initially more freedom but there can be more challenges as well
- Engaging leadership in the front line level – impact
- Promoting students in presenting and attending conferences
- Mentoring

- Advocacy – being able to advocate public health nursing
- Courage – honouring harm reduction strategies and perseverance
- Believes and has passion that is contagious– passion of practitioners/managers and professors
- Brings public health to the forefront
- Push to not have public health marginalized within nursing, health, and education
- Being able to cross-train nurses working in northern reserves (PH, Primary care, HH)
- Being able to fight for public health
- Reduce barriers to CHNs in politics
- Collaborative management model – shared power and decision-making

Participants identified the knowledge required of leaders in public health nursing:

- Mentorship is important to develop leadership ability
- Need time and mentorship skills
- Needs to have experience in public health
- Collaboration and commitment
- Leaders of public health nurses should be RN or NP /or need someone with strong leadership skills
- Leaders know the Blueprint for Action and take action

Overall, the preconference consultation underscored three important insights:

1. Community health nursing leaders are actively and effectively engaged in politics at all levels. The notion of Big P, little p is important. There is a strong leaning in the results towards political engagement and action in the consultation. Participants want leaders to engage politically – envision community health nurses as future politicians – and want help to get there.
2. The notion of organic knowledge was identified by participants, seen as important (particularly context and inclusive of diverse peoples/culture) and beginning to emerge in literature.
3. Visibility and identity is important; participants want leaders with skills to engage the media, and use emerging technologies to increase awareness (“Every Canadian should know their community health nurse”).

In short, PHN leaders have courage, vision, strategic agility, passion, and a moral core. They have substantial networks, keen understanding of issues and are solution-focused while seeking root causes of problems. They are assertive, tempered by gentleness and compassion. In terms of actions, they mentor, engage others, advocate for public health and nursing, succession plan, and persevere. Knowledge essential to PHN leadership includes experience in the field, how to collaborate and partner, and skills in mentorship. The full report of this consultation is available from [www.chnc.ca](http://www.chnc.ca).

## Appendix A: Summary of literature reviewed

<p>Algoma Public Health &amp; ANDSOOHA: Public Health Nursing Management. (2008). Orientation: Transition to public health nursing. Ottawa, ON: Author.</p>	<p>This orientation package introduces new hires to public health nursing in Ontario. Chief Nursing Officers in eleven public health units indicated in a recent survey, that there was a need for a broad orientation addressing public health nursing issues such as the <i>Core Competencies for Public Health in Canada and the Canadian Community Health Nursing Standards of Practice (CCHN Standards)</i>. The purpose of orientation is ensuring that employees are well prepared to perform their job function, to meet job expectations, and to have a high level of understanding of the business of public health (Halton Health Department, 2008). At Halton, orientation is considered to be a shared responsibility between employer and employee. The goal of orientation at the Chatham Kent Health Unit is to ease the adjustment of new staff by fostering their social integration into the organization and to facilitate and enhance the employee's ability to provide public health services to the community. Easing the adjustment of new staff is an important contributor to a successful orientation. This orientation package has two foci; learning about the business of public health through the content of the manual and developing relationships in the new workplace through interaction with others. To ease the adjustment of new staff, this orientation package is <i>guided</i>, in that there is an individual designated to oversee the new hires' orientation.</p>
<p>Armistead, C. (2011). Community health nurses of Canada (CHNC): Brief in response to the CNA national expert commission call for submissions. Community Health Nurses of Canada.</p>	<p><a href="http://www.chnc.ca">www.chnc.ca</a></p>
<p>Aston, M., Meagher-Stewart, D., Edwards, N., &amp; Young, L. (2009). Public health nurses' primary health care practice: strategies for fostering citizen participation. <i>Journal Of Community Health Nursing</i>, 26(1), 24-34.</p>	<p>Citizen participation is heralded as a critical element of community health programs that emphasize empowerment and health promotion strategies. Although there is a growing body of research on public health nurses' primary health care practice, few studies have described how public health nurses foster citizen participation. This article presents findings from an interpretive qualitative study of public health nurses' perceptions of their role in fostering citizen participation in an eastern Canadian province at a time of significant health care restructuring. The findings from this study clearly profile public health nurses as integral to the practice of fostering citizen participation.</p>



doi: <a href="http://dx.doi.org/10.1080/07370010802605762">http://dx.doi.org/10.1080/07370010802605762</a>	
Bakes-Martin, R., Corso, L., Landrum, L., Fisher, V., & Halverson, P. (2005). Developing national performance standards for local public health systems. <i>Journal Of Public Health Management &amp; Practice</i> , 11(5), 418-421.	Since the beginning of the 1990s, public health has struggled to measure its performance and capacity to carry out the core functions of public health practice, while facing increasing challenges within the everchanging landscape of healthcare delivery, bioterrorism response, emerging infections, and other threats to the public's health. The article describes the development of a set of national performance standards for measuring how effectively public health systems deliver the 10 Essential Public Health Services. The standards were developed through a practice-driven approach that incorporated comprehensive field testing and iterative revisions. The standards represent a national consensus framework for measuring important aspects of public health practice.
Bartee, RT, SD Winnail, SE Olsen, C Diaz, and J Blevens. 2003. "Assessing competencies of the public health workforce in a frontier state." <i>Journal Of Community Health</i> 28, no. 6: 459-469. CINAHL with Full Text, EBSCOhost (accessed February 20, 2013).	The purpose of this study was to determine the level of perceived proficiency of a public health workforce based on the Public Health Practice Core Competencies. The Public Health Profile and Training Needs Assessment questionnaire was mailed out to public health employees representing mostly public health nursing, environmental health, mental health, and public health management/administration (n = 696). Nearly three-quarters (74%) of participants were female and 96% reported being white. Eighty one percent of participants were currently employed full-time. The majority of participants were trained at the bachelor's level (54%). The response rate was 63.9%. Findings from this study show that all disciplines reported higher perceived proficiency in the Communication skills domain compared to the other seven skills domains. Perceived low skills domains included "financial planning and management skills" and "policy development/program planning skills" among public health nurses, mental health professionals, and environmental health specialists. Management/administration level staff reported their lowest perceived proficiency in Basic Public Health Science skills. Each group had different strengths and weaknesses and the necessary level of skill needed differs among discipline groups, thus future trainings on the Public Health Core Competencies should be discipline specific.
Betker, C., Bresnahan, A., & Clement, C. Fact sheet: What are the social determinants of health? National Collaborating Centres for Determinants of Health.	
Betker, C., & Ndumbe-Eyoh, S. (2013). A case study of a province-wide public health policy implementation: The Ontario social	Conference presentation

<p>determinants of health (SDOH) public health nurse positions. 7th National Community Health Nurses Conference, Kelowna, BC.</p>	
<p>Bleich, M., Hewlett, P., Miller, K., &amp; Bender, K. (2004). Beyond tradition: synergizing intellectual and material capital to forge the new academic-service partnership. <i>Journal Of Professional Nursing</i>, 20(5), 285-294.</p>	<p>Academic-service partnerships are being touted as a solution to workforce problems. "Traditional" approaches to these partnerships have been directed primarily at academic and hospital institutions for mutual benefit. An expanded model of partnership possibilities is presented through three detailed exemplars that include population health (with descriptors from an Institute of Medicine study addressing the public's health in the 21st century), public-private ventures (public institution with faith-based and community agencies), and nursing-corporate opportunities (academia and a proprietary information technology corporate supplier). The benefits of these expanded partnerships and the criteria for selecting a partnership sensitive to the scholarship of practice and the mission/purpose/goals of each partnering organization is highlighted.</p>
<p>Bigbee, J. L., Gehrke, P., &amp; Otterness, N. (2009). Public health nurses in rural/frontier one-nurse offices. <i>Rural &amp; Remote Health</i>, 9(4), 12p.</p>	<p>INTRODUCTION: Public health nursing is the foundation of the United States' (US) public health system, particularly in rural and remote areas. Recent increasing interest in public health in the USA has highlighted that there is limited information available about public health nursing in the most isolated areas, particularly in the US. The purposes of this study were to: (1) describe the characteristics, competency levels, and practice patterns of public health nurses (PHNs) working in remote one-nurse offices; and (2) compare PHNs working in one-nurse offices with nurses working in multi-nurse offices in Idaho, in relation to their demographic characteristics, practice patterns and competency levels. METHODS: Using a cross-sectional descriptive design, a statewide sample of 124 PHNs in Idaho, including 15 working in one-nurse satellite offices, were assessed in relation to their demographic characteristics, experience, educational background, job satisfaction, practice characteristics, and competency levels in March to May 2007. RESULTS: The solo (nurses working in one-nurse offices) PHNs were based in 15 different counties, 10 frontier (population density of less than 7 persons/1.6 km<sup>2</sup>; 7 persons/mile<sup>2</sup>) and 5 rural. The counties ranged in population from 2781 to 28 114 (mean = 11 013), with population densities ranging from 0.9 to 29.4 persons/1.6 km<sup>2</sup> (mean = 8.6; 0.9 to 29.4 persons/mile<sup>2</sup>). The distance from their offices to the district main office ranged from 25.8 to 241.4 km (mean = 104 km; 16 to 150 miles, mean = 64.6 miles). All the solo PHNs were Caucasian females, with a mean age of 46.9 years and a mean of 22.5 years' nursing experience. Educationally, 7 (47%) held a bachelor degree in nursing, 6 (40%) had associates degrees, 1 (7%) had a diploma in nursing, and 1 (7%) was a licensed practical nurse (LPN). These solo PHNs provided a wide array of services with</p>

	<p>support from other nurses in the district, including epidemiology, family planning/sexually transmitted disease clinics, immunization clinics, communicable disease surveillance, and school nursing. They expressed strong job satisfaction, citing the benefits of autonomy, variety, and close community ties, but also voiced some frustrations related to isolation. Their self-rated levels of competency were highest in the areas of communication, cultural competency, community dimensions of care, and leadership/systems thinking skills; and lowest in the areas of financial management, analytical assessment, policy development/program planning, and basic public health sciences skills. When the solo PHNs were compared with PHNs based in multi-nurse offices, there were no statistically significant differences between the solo and non-solo PHNs in demographics or competency levels, except in the competency area of community dimensions of practice skills. The mean self-rating for solo PHNs in relation to community dimensions of practice skills was significantly higher (3.9) than non-solo PHNs (3.2) (<math>t = 3.547, p = .002</math>). CONCLUSIONS: These findings suggest that US PHNs practicing in isolated one-nurse offices in rural and remote communities are comparable to PHNs working in less isolated settings; however, solo nurses may have stronger community dimensions of practice skills. Their practice is more generalized than other PHNs and they express high levels of job satisfaction. The study was limited in that it was conducted in only one state and data were collected only by self-report. Further research is indicated to describe this unique subset of PHNs, particularly in terms of factors promoting recruitment and retention. Additional study into the conceptual aspect of isolation is also indicated in relation to public health practice in rural and remote areas.</p>
<p>Bigbee, J., L., Otterness, N., &amp; Gehrke, P. (2010). Public health nursing competency in a Rural/Frontier state. <i>Public Health Nursing, 27</i>(3), 270-276.</p>	<p>Objectives: To assess the self-reported levels of competency among public health nurses (PHNs) in Idaho. Design and Sample: A cross-sectional descriptive design was used. The sample consisted of 124 PHNs, including 30 in leadership roles, currently practicing in Idaho's official public health agencies. Measures: Structured interviews were conducted with participants who provided self-ratings in the 8 domains of public health competency as developed by the Council on Linkages Between Academia and Public Health Practice and the Quad Council of Public Health Nursing Organizations. Results: The findings indicated that the overall level of competency was most strongly associated with the duration of professional experience. No major differences in the competency levels were found in relation to nurses' level of education or licensure. Nurses in leadership positions reported the highest levels of competency. Rurality, as measured by district population density, was not significantly correlated with competency levels, except in relation to community dimensions of practice skills. Conclusions: The findings suggest that PHNs' self-perceived levels of competence are most strongly influenced by their years of professional experience, particularly in leadership roles. Professional development efforts</p>

	should focus on the domains with the lowest perceived competency: policy development/program planning skills, analytic assessment skills, and financial planning/management skills.
<u>Boutain, D.M.</u> (2008). Social justice as a framework for undergraduate community health clinical experiences in the United States. <i>International Journal of Nursing Education Scholarship</i> , Volume 5: Article 35. doi: 10.2202/1548-923X.1419.	Educating future registered nurses for social justice is an urgent, yet complex undertaking in undergraduate education. Although the need for social justice education is often highlighted, few articles describe practical teaching strategies for ensuring that undertaking. The purpose of this article is to illustrate how a curricular focus on social justice framed and supported the development of a clinical evaluation tool for undergraduate community health clinical experiences. First, social justice is defined and its relationship to baccalaureate nursing education explained. Then a description is provided of how social justice was highlighted in the vision, curriculum, and community health clinical evaluation tool of a College of Nursing. The article subsequently showcases the content and evaluation of students' journal entries about social justice. The development of the social justice component presented in this article may be useful to nurse educators striving to match theory and practice in the evaluation of social justice in students' community health experience.
Braveman, P. (2013). What is health equity: And how does a life-course approach take us further toward it? <i>Maternal &amp; Child Health Journal</i> . Retrieved from <a href="http://link.springer.com">http://link.springer.com</a> doi:10.1007/s10995-013-1226-9	Abstract Although the terms “health equity” and “health disparities” have become increasingly familiar to health professionals in the United States over the past two decades, they are rarely defined. Federal agencies have often defined “health disparities” in ways that encompass all health differences between any groups. Lack of clarity about the concepts of health disparities and health equity can have serious consequences for how resources are allocated, by removing social justice as an explicit consideration from policy agendas. This paper aims to make explicit what these concepts mean and to discuss what a life-course perspective can contribute to efforts to achieve health equity and eliminate health disparities. Equity means justice. Health equity is the principle or goal that motivates efforts to eliminate disparities in health between groups of people who are economically or socially worse-off and their better-off counterparts—such as different racial/ethnic or socioeconomic groups or groups defined by disability status, sexual orientation, or gender identity—by making special efforts to improve the health of those who are economically or socially disadvantaged. Health disparities are the metric by which we measure progress toward health equity. The basis for these definitions in ethical and human rights principles is discussed, along with the relevance of a life-course perspective for moving toward greater health equity.
CASN Task Force on Public Health Education (2006). <i>Public Health Nursing Education at the</i>	In the fall of 2004, the Canadian Association of Schools of Nursing (CASN) created a Task Force on Public Health Education in Canada. The mandate of this Task Force was to assist CASN members in ensuring

<p>Baccalaureate Level in Canada today.</p>	<p>that all baccalaureate graduates of Canadian Schools of Nursing meet the expected Canadian entry-level competencies and be aware of the Canadian Community Health Nursing Standards of Practice.</p>
<p>CASN Public Health Education Sub-Committee (2008). Qualitative Data Analysis Findings from the CASN Focus Groups: “Characteristics of a Quality Community Health Nursing Clinical Placement for Baccalaureate Nursing Students”</p>	<p>The data from the focus group interviews has brought forward many important aspects that must be considered when determining community health nursing clinical placements for Baccalaureate students. To ensure quality clinical placements for students, these background and onsite characteristics need to be facilitated as much as possible. With the increased role that nursing in the community will likely take to provide health care to Canadians into the future (Vollman, Anderson &amp; McFarlane, 2004), quality clinical placements are even more essential to the development of competent community health nurses.</p>
<p>CASN Sub-Committee on Public Health (2010). Guidelines for quality community health nursing clinical placements for baccalaureate nursing students.</p>	<p>Nursing is a profession that requires a combination of theory and practice in order to adequately prepare individuals to meet the expected new graduate competencies. The successful acquisition of community health nursing knowledge and skills requires that nursing education programs have a strong community clinical practice component. Research in Canada has shown clinical placements to support community nursing education are decreasing, and numerous placement challenges exist. To overcome some of these challenges, Canadian schools of nursing have developed innovative clinical practice experiences including non-health sector placements. Variations in the content, process and outcomes of these experiences has led to calls for national dialogue to help standardize the educational quality of community health clinical placements. These guidelines were developed to ensure that all baccalaureate graduates of Canadian schools of nursing are prepared to meet the <i>Canadian Community Health Nursing Standards of Practice</i> at an entry-to-practice level.</p>
<p>Canadian Association for Rural and Remote Nursing. (2008). Rural and remote nursing practice parameters: Discussion document Canadian Association for Rural and Remote Nursing.</p>	<p>This document is a synthesis of the work of others nationally and internationally to assist Canadian nurses practicing in rural and remote areas to be able to discuss and validate their practice. A primary purpose of the document is to identify the contribution that this area of nursing makes to the health of Canadians and to celebrate the meaning and value of the uniqueness of this practice. It is intended that this document be a dynamic tool to percolate discussion and debate, to provide a framework for the practice expectations and practice setting characteristics and to highlight the essential and integral importance of rural and remote nursing.</p>
<p>Canadian Medical Association. (2013). Physicians and health equity: Opportunities in practice.</p>	<p>In the course of the interviews, participants suggested a number of areas for action. Interviewees saw a key role for CMA and other national medical groups in advocating for health equity issues. In addition, many felt that a national organization could take the lead in facilitating the development and dissemination of other key supports. They recommended actions in five main areas: clinical practice,</p>

	education, compensation, research, and advocacy and communications. A list of suggested actions is provided in a table. This is just a preliminary list and further refinement is required.
Carlson, M., Donahue, S., & Foster, S. (2011). Towards an understanding of health equity: Glossary methods Alberta Health Services.	The idea of developing a glossary was identified by two Units within Population & Public Health, Alberta Health Services (AHS) who agreed that a common understanding and standard use of terms was essential for collaborative work within the area of health disparities, health inequalities and/or health inequities. The purpose of the glossary is to provide a relevant collection of defined terms related to health disparities, health inequalities and health inequities that are meaningful and practical for AHS.
Cohen, B.E. & Gregory, D. (2009). Community health clinical education in Canada: Part 1--"state of the art". International Journal of Nursing Education Scholarship, Volume 6, Article1. doi: 10.2202/1548-923X.1637.	This paper presents the findings of a survey of community health clinical education in twenty-four Canadian pre-licensure baccalaureate nursing programs. A qualitative research design was used, involving a content analysis of Canadian course syllabi and supporting documents for community health courses. This study afforded a cross-sectional understanding of the "state of the art" of community health clinical education in Canadian schools of nursing. Clinical course conceptual approaches, course objectives, types of clinical sites, format and number of clinical hours, and methods of student evaluation are identified. The findings suggest the need for a national dialogue or consensus building exercise regarding curriculum content for community health nursing. Informing this dialogue are several strengths including the current focus on community health (as opposed to community-based) nursing education, and a solid socio-environmental perspective informing clinical learning and practice. The national data set generated by this study may have relevance to nursing programs globally.
Cohen B.E. & Gregory, D. (2009). Community health clinical education in Canada: Part 2--developing competencies to address social justice, equity, and the social determinants of health. International Journal of Nursing Education Scholarship, Volume 6: Article2. doi: 10.2202/1548-923X.1638.	Recently, several Canadian professional nursing associations have highlighted the expectations that community health nurses (CHNs) should address the social determinants of health and promote social justice and equity. These developments have important implications for (pre-licensure) CHN clinical education. This article reports the findings of a qualitative descriptive study that explored how baccalaureate nursing programs in Canada address the development of competencies related to social justice, equity, and the social determinants of health in their community health clinical courses. Focus group interviews were held with community health clinical course leaders in selected Canadian baccalaureate nursing programs. The findings foster understanding of key enablers and challenges when providing students with clinical opportunities to develop the CHN role related to social injustice, inequity, and the social determinants of health. The findings may also have implications for nursing programs internationally that are addressing these concepts in their community health clinical courses.

CHNC ad hoc committee (2012). Community health nurses of Canada: Center of excellence.	<a href="http://www.chnc.ca">www.chnc.ca</a>
Community Health Nurses of Canada. (2010). Community health nurses speak out! Key findings from and environmental scan about the future of community health nursing in Canada Community Health Nurses of Canada.	<a href="http://www.chnc.ca">www.chnc.ca</a>
Community Health Nurses of Canada Vision and Definition Project Team. (2009). CHNC vision statement, definition of community health nursing practice in Canada Community Health Nurses of Canada.	<a href="http://www.chnc.ca">www.chnc.ca</a>
Community Health Nurses of Canada. (2012). Public health nursing: Primary prevention of chronic diseases Community Health Nurses of Canada.	<a href="http://www.chnc.ca">www.chnc.ca</a>
Community Health Nurses of Canada. (2011). A blueprint for action for community health nursing in Canada.	<a href="http://www.chnc.ca">www.chnc.ca</a>
Cohen, B. (2006). Barriers to population-focused health promotion: the experience of public health nurses in the province of	There is growing evidence that population health is influenced by broad socio-environmental factors that require population-focused health promotion strategies. The author reports on a study of the perspectives of public health nurses (PHNs) on the nature of their health promotion practice in the Canadian province of Manitoba, highlighting their perceptions about barriers to population-focused health promotion. A descriptive, exploratory research design was used to conduct standardized open-

<p>Manitoba. Canadian Journal of Nursing Research, 38(3), 52-67.</p>	<p>ended interviews with 24 PHNs in 3 geographically and demographically diverse health authorities. There were remarkable similarities in PHNs' perceptions about their practice. Three categories of barrier to population-focused health promotion were identified: barriers at the level of individual PHNs; organizational barriers (culture, policies, processes); and extra-organizational barriers at the level of the community or province. The results point to a gap between the theory that population-focused health promotion is at the heart of PHN practice and the experience of PHNs at the 3 sites. A concerted effort to address the barriers is needed so that PHNs in Manitoba can play a leadership role in creating a health-care system that truly invests in population health.</p>
<p>Cohen, B. &amp; Reutter, L. (2007). Development of the role of public health nurses in addressing child and family poverty: a framework for action. Journal Of Advanced Nursing, 60(1), 96-107. doi:<a href="http://dx.doi.org/10.1111/j.1365-2648.2006.04154.x">http://dx.doi.org/10.1111/j.1365-2648.2006.04154.x</a></p>	<p>The purpose of this paper is to invite dialogue about how public health nurses could best address child and family poverty. Their current role is reviewed and a framework for expanding this role is presented. Background. The negative health consequences of poverty for children are well documented worldwide. The high levels of children living in poverty in wealthy industrialized countries such as Canada should be of concern to the health sector. What role(s) can public health nurses play in addressing child and family poverty? Method. A review of scholarly literature from Canada, the United States of America and the United Kingdom was conducted to ascertain support for public health nurses' roles in reducing poverty and its effects. We then reviewed professional standards and competencies for nursing practice in Canada. The data were collected between 2005 and 2006. Findings. Numerous nursing scholars have called for public health nurses to address the causes and consequences of poverty through policy advocacy. However, this role was less likely to be identified in professional standards and competencies, and we found little empirical evidence documenting Canadian public health nurses' efforts to engage in this role. Public health nurses' roles in relation to poverty focus primarily on assisting families living in poverty to access appropriate services rather than directing efforts at the policy level. Factors associated with this limited involvement are identified. We suggest that the conceptual framework developed by Blackburn in the United Kingdom offers direction for a more fully developed public health nursing role. Prerequisites to engaging in the strategies articulated in the framework are discussed. Conclusion. Given more organizational support and enhanced knowledge and skills, public health nurses could be playing a greater role in working with others to make child and family poverty history.</p>
<p>Core Public Health Functions Research Initiative, University of Victoria. Equity lens in public health (ELPH).<a href="http://www.uvic.ca/research">http://www.uvic.ca/research</a></p>	<p>The aim of the Equity Lens in Public Health (ELPH) is to produce new knowledge for reducing systemic health inequities related to mental health and substance use. This project is linked to the Core Public Health Functions Research Initiative (CPHFRI). We are located at the Centre for Addictions Research of British Columbia (CARBC) at the University of Victoria. We are working on four studies to explore the following questions:</p>



<p>/groups/cphfri/projects/currentprojects/elph/index.php</p>	<ul style="list-style-type: none"> <li>• What promotes or restricts the implementation of health equity as a priority in BC health authorities?</li> <li>• What mechanisms of collaboration exist between public health and other sectors to take action on health inequities?</li> <li>• What tools and resources can be developed to support health equity oriented policies and programs?</li> <li>• How do public health providers address the ethical challenges as they work to reduce health inequities?</li> </ul> <p>Please visit the ELPH website for details.</p>
<p>CPHA 2010 Public health /Community health practice in Canada, Roles and Activities</p>	<p><a href="http://www.chnc.ca">www.chnc.ca</a></p>
<p>Cusack, C. (2012). <i>Public Health Nurse service delivery: Development of a new model using Participatory Action Research. Unpublished doctoral thesis proposal, Winnipeg, MB. Retrieved from email correspondence with Cheryl Cusack" &lt;ccusack@wrha.mb.ca&gt;</i></p>	
<p>Danaher, A. (2010). A synthesis of Canadian community health nursing reports: A report submitted to community health nurses of Canada. Unpublished manuscript.</p>	<p>While community health nurses may report to nurses in leadership roles, leadership remains a critical issue (Underwood et al., 2009, No.14). Leadership is reflected not only through positions of authority within an organization but also through the ability to influence others in bringing about change. It is exercised within an organization through the work of community health nurses at the local, provincial, and national levels and also by those who champion community health such as government decision makers and policy makers. Community health nurses are seen as demonstrating leadership at all levels where they work to influence change and to strengthen the health system.</p> <p>As described in the reports, leadership:</p> <ul style="list-style-type: none"> <li>• Is facilitated by a vision for community health nursing;</li> <li>• Is exercised at multiple levels within organizations;</li> <li>• Is exercised at multiple levels within the health care system;</li> <li>• Is a key organizational support for nursing practice;</li> <li>• Involves identifying and monitoring trends in health and health care;</li> <li>• Advocates for change to strengthen the health care system;</li> <li>• Requires training at all levels;</li> <li>• Supports recruitment and retention.</li> </ul>

<p>Deschaine, J., &amp; Schaffer, M. (2003). Strengthening the role of public health nurse leaders in policy development. <i>Policy, Politics &amp; Nursing Practice</i>, 4(4), 266-274.</p>	<p>The purpose of this study is to identify and analyze factors that affect the ability of public health nurse (PHN) leaders to influence public health policy development. Longest's model of public policymaking provided the theoretical framework. Eight PHN leaders representing rural, suburban, and urban population areas participated in semi-structured interviews. Findings suggested factors that affect the PHN leaders' abilities to influence public health policy development: existing barriers such as political factors, gender issues, a lack of public understanding, financial issues, and resource limitations; skills training in policy development; academic preparation; political competency; political power associated with policy development responsibilities; leadership competency; and the ability to use research to influence policy making. Recommendations include strengthening academic preparation in policy development and creating support for growth in leadership competency, political competency, and research skills for current PHN leaders.</p>
<p>Dilworth, K., Tao, M., Shapiro, S., &amp; Timmings, C. (2013). Making Health Promotion Evidenced-Informed: An Organizational Priority. <i>Health Promotion Practice</i>, 14(1), 139-145. doi:<a href="http://dx.doi.org/10.1177/1524839912461274">http://dx.doi.org/10.1177/1524839912461274</a></p>	<p>This large urban health unit identified a need for explicit, strategic, long-term organizational priority toward practical application of evidence in health promotion practice. Becoming a Best Practice Spotlight Organization (BPSO®) candidate provided an opportunity to systematically implement this commitment. The primary goals were to support incorporation of evidence-informed practice throughout the organization, increase interprofessional collaboration, and provide opportunities for knowledge exchange for staff. A mixed-methods evaluation consisting of three phases, including an analysis of previous evaluations, a survey of Champions, and an online focus group with the Steering Committee, demonstrated very positive outcomes. Staff reported increased incorporation of evidence in practice and program delivery. Collaboration and consultation amongst interdisciplinary staff across program areas also increased and staff responded very positively to increased opportunities for knowledge exchange. BPSO® candidacy opportunities should be used by health organizations to increase evidence-informed practice and inspire excellence in health promotion practice.</p>
<p>Diem, A., &amp; Moyer, A. Canadian community health nursing standards of practice (CCHN standards) toolkit Community Health Nurses Association of Canada and Public Health Agency of Canada.</p>	<p><a href="http://www.chnc.ca">www.chnc.ca</a></p>
<p>Diem, E., Moyer, A., &amp; MacDonald, M. (2009). Final report and resource</p>	<p><a href="http://www.chnc.ca">www.chnc.ca</a></p>

<p>package: Model of communities of practice for advancing practice in community health nursing.</p>	
<p>Drevdahl, D. J. (2013). Injustice, suffering, difference: How can community health nursing address the suffering of others? <i>Journal of Community Health Nursing</i>, 30(1), 49-58. doi: 10.1080/07370016.2013.750212</p>	<p>Social justice brings to life the purpose of public health—improving a population’s overall health and well-being. Critiques of the concept demonstrate that social justice is inconsistently defined and rarely is acted upon, and continuation of these injustices constitutes a form of suffering. Seeing one’s self as disconnected from others makes their suffering normal. Viewing others from an ethical, moral, and human rights perspective helps one understand that the well-being of the self and the individual rests on the well-being of the collective other; this obligates each person to ameliorate and, if possible, prevent the suffering of others.</p>
<p>Edwards, L. (1994). Commentary on One hundred years of powerful women: a conversation with Myrtis J. Snowden; a conversation with Sylvia R. Peabody [original article by Cary A et al appears in <i>PUBLIC HEALTH NURS</i> 1993;10(3):141-50]. <i>AONE's Leadership Prospectives</i>, 2(2), 16.</p>	<p>These interviews continue a series of conversations with key public health nursing leaders, highlighting factors in their leadership development. Purpose: The discussions focused on significant mentors and life events that influenced the choice of nursing as a career and their innovative contributions to the profession. Source: Interviews with Myrtis Snowden, coordinator of the graduate program in community health nursing at the Louisiana State University Medical Center School of Nursing in New Orleans, and Sylvia Peabody, former executive director of the Visiting Nurse Association of Metropolitan Detroit or 15 years. Conclusions: Both of these outstanding leaders cited the teaching and shaping of fledgling nurses as one of their major accomplishments. Both took risks that helped in the development of the nursing profession.</p>
<p>Exploring a centre of excellence for public health nursing: Discussion questions, summary of responses. (May 2008). Second National Community Health Nurses Conference, Toronto, ON.</p>	<p>Summary forum discussion:  Through the comments and responses to the questions several themes emerged. There was support for a Centre of Excellence for Public Health Nursing but also some concern expressed in separating out PHN and HHN issues (potentially could jeopardize the Standards and certification process). There is a need for:</p> <ul style="list-style-type: none"> <li>• Advocacy and a strong voice for public/community health nursing issues</li> <li>• Exercising leadership and leadership development.</li> <li>• A clearinghouse for public health resources, best practices, etc.</li> <li>• A Centre that is inclusive and far reaching</li> <li>• Strong relationships with other organizations</li> <li>• Coordination of policy, education, research, and practice to support the vision</li> <li>• Better integration of theory, practice and research</li> </ul>

	<ul style="list-style-type: none"> <li>• Partnerships with other organizations</li> <li>• A clear definition of public health nursing – articulating nursing practice</li> <li>• Raising the bar- supporting excellence in all domains.</li> <li>• Influencing for system change. Enabling nurses to control their own practice.</li> <li>• Creating and supporting the opportunity for dialogue and debate.</li> </ul>
<p>Falk- Rafael, A. (2005). Speaking truth to power: Nursing’s legacy and moral imperative. <i>Advances in Nursing Science</i>, 28(3), 212–223.</p>	<p>Critical caring has been proposed as a mid-range theory to guide public health nursing. One of its carative health promoting processes, contributing to the creation of supportive and sustainable physical, social, political, and economic environments, is particularly suited to enacting Nightingale's legacy of political action as an expression of caring. Increasing evidence supports the link between broad societal influences on health inequities. Relative and absolute poverty are significant influences on health and contribute significantly to differential health statuses of populations within and between countries. Nurses, who practice at the intersection of public policy and personal lives, are, therefore, ideally situated and morally obligated to include political advocacy and efforts to influence health public policy in their practice. The health of the public and the future of the profession may depend on it.</p>
<p>Freudenberg, N., &amp; Kotelchuck, D. (2001). Political competencies and public health leadership. <i>Am J Public Health</i>. 2001;91(3),468..</p>	<p>Review of Wright et al.</p>
<p>Ganann, R., Underwood, J., Matthews, S., Goodyear, R., Stamler, L., Meagher-Stewart, D., &amp; Munroe, V. (2010). Leadership attributes: a key to optimal utilization of the community health nursing workforce. <i>Canadian Journal Of Nursing Leadership</i>, 23(2), 60-71.</p>	<p>This research examined leadership attributes that support the optimal utilization and practice of community health nurses (CHNs). Community health nursing is facing challenges in workforce capacity and sustainability. To meet current and future demands on the community sector, it is essential to understand workplace attributes that facilitate effective utilization of existing human resources and recruitment of new nurses. This pan-Canadian, mixed-methods study included a demographic analysis of CHNs in Canada, a survey involving responses from approximately 6,700 CHNs to identify enablers and barriers to community health nursing practice and 23 focus groups to examine organizational attributes that "best" support optimal practice within the public health nursing subsector. Nursing leadership was identified as an important attribute in organizations' utilization and support of CHNs working to work effectively. This effectiveness, in turn, will enhance community health programs and overall healthcare system efficiency. This paper highlights findings related to the role of nursing leadership and leadership development in optimizing community health nursing practice.</p>

<p>Gilson, L., Doherty, J., Loewenson, R., &amp; Francis, V. (June 2007). Challenging Inequity Through Health Systems. Final Report, Knowledge Network on Health Systems. WHO Commission on Social Determinants of Health. On-line at: <a href="http://www.who.int/social_determinants/resources/csdh_media/hskn_final_2007_en.pdf">http://www.who.int/social_determinants/resources/csdh_media/hskn_final_2007_en.pdf</a>.</p>	<p>This briefing note presents key messages of the final report of the <i>Health Systems Knowledge Network</i> established by the World Health Organization's Commission on the Social Determinants of Health. The messages have been formulated for the political executive, particularly Ministers of Health, and their senior advisors. They have been generated by Network members and are based on review of evidence and experience (members were drawn from a range of policy, civil society and academic bases across the world). In the report, health systems are seen to include all activities whose primary purpose is to improve health. The report discusses important health system features and actions that can address health inequity. While it focuses on low- and middle-income countries, many of the recommendations may be appropriate to high-income countries.</p>
<p>Gore, D. M., &amp; Kothari, A. R. (2013). Getting to the root of the problem: Health promotion strategies to address the social determinants of health. <i>Canadian Journal of Public Health</i>, 104(1), e52-e54.</p>	<p>Although extensive research shows that the social determinants of health influence the distribution and course of chronic diseases, there is little programming in public health that addresses the social determinants as a disease prevention strategy. This paper discusses different types of health promotion initiatives and differentiates them based on whether they attempt to impact intermediate (environmental) determinants of health or structural determinants of health. We argue for the importance of programming targeted at the structural determinants as opposed to programming targeted solely at the immediate environment. Specifically, the former has more potential to create significant improvements in health, contribute to long-term social change and increase health equity. We urge public health leaders to take this distinction into consideration during public health program planning, and to build capacity in the public health workforce to tackle structural mechanisms that lead to poor health and health inequities.</p>
<p>Gottlieb, L. N., Gottlieb, B., &amp; Shamian, J. (2012). Principles of Strengths-Based Nursing Leadership for Strengths-Based Nursing Care: A New Paradigm for Nursing and Healthcare for the 21st Century. <i>Canadian Journal Of Nursing Leadership</i>, 25(2), 38-50.</p>	<p>The current healthcare system is slowly evolving into a new system built on a vision of health promotion, primary care and community-based home care, with hospitals still being a core pillar of the healthcare system but not its primary service. This transformation requires a new approach to practice, namely, Strengths-Based Nursing Care (SBC). SBC is about mobilizing, capitalizing and developing a person's strengths to promote health and facilitate healing. For nurses to practise SBNC requires strong nursing leadership that creates conditions to enable them to do so. Strengths-Based Nursing Leadership complements and acts in synergy with, SBNC. This paper describes eight principles of Strengths-Based Nursing Leadership to support SBNC.</p>
<p>Halseth, R. (2013). Aboriginal women in Canada: Gender, socio-</p>	<p>The circumstances in which people are born, grow, live, work and age are responsible for most of the health inequities that have persisted and widened within and between countries. These circumstances</p>

<p>economic determinants of health, and initiatives to close the wellness gap. Prince George, BC: National Collaborating Center for Aboriginal Health.</p>	<p>are commonly referred to as determinants of health. While a number of agencies and organizations have identified different determinants as contributing to ill health and inequities, they typically include: early child development, education, income, employment and the nature of employment, social and physical environments, personal health practices and coping skills, access to health services, racism, and gender. Within the context of Aboriginal peoples in Canada, these determinants have worked in concert with Aboriginal-specific determinants such as culture, self-determination, and colonialism to produce significant health disparities compared to non-Aboriginal Canadians. These disparities are felt by many Aboriginal women who may experience accumulated disadvantage from the interaction of gender with other determinants. This paper explores the role that gender plays, alone and in concert with other determinants, to affect the health status of Aboriginal women across Canada, and highlights some initiatives aimed at improving their health and well-being.</p>
<p>Hogan, M. (2008). Public health nursing practice in Canada: A review of the literature Community Health Nurses Association of Canada (CHNAC).</p>	<p><a href="http://www.chnc.ca">www.chnc.ca</a></p>
<p>Isaacs Lowe, J. (2010). A new way to talk about the social determinants of health - vulnerable populations portfolio. New York, NY: Robert Wood Johnson Foundation.</p>	<p>When the Robert Wood Johnson Foundation went through a restructuring in 2003, it organized all the programs that worked at the community level to advance health into a new programming group called the Vulnerable Populations Portfolio. The newly created portfolio included a vast array of programs focused on areas as disparate as long-term care, school-based health and chronic homelessness. The members of the team struggled to find a meaningful connection among the programs that could help them discern a strategy for managing the current groups of programs and making future funding decisions.</p>
<p>Kalb, K., Cherry, N., Kauzloric, J., Brender, A., Green, K., Miyagawa, L., &amp; Shinoda-Mettler, A. (2006). A competency-based approach to public health nursing performance appraisal. <i>Public Health Nursing</i>, 23(2), 115-138.</p>	<p><b>OBJECTIVES:</b> To integrate public health nursing (PHN) competencies into a comprehensive performance review instrument for nurses at multiple practice levels in an urban public health department. <b>DESIGN:</b> Based on thorough review of PHN competency literature, the tool evaluates performance for 5 nursing practice classifications (Staff RN, Public Health Nurse, Nurse Practitioner, Clinical Nurse Specialist, Nursing Supervisor) in eight PHN domains (assessment, policy development/program planning, evaluation, communication, cultural competency, partnership/collaboration, disease prevention/health promotion, leadership/systems thinking). <b>SAMPLE:</b> Tool was piloted with over 50 nurses from PHN workforce (n&gt;400) of Public Health-Seattle &amp; King County (Washington). <b>METHOD:</b> Pilot testing includes</p>

	<p>all components of the performance appraisal system: Public Health Competency Grid, statement of general workplace expectations, Nursing Performance Appraisal Tool, and supporting documents defining performance elements by job classification. RESULTS: Supervisors find the tool easy to use and report that it provides opportunity for real communication between employee and supervisor. Nurses at all practice levels report that it effectively describes/evaluates their practice. CONCLUSIONS: This tool is an efficient performance appraisal instrument providing meaningful feedback to nursing employees within a framework of PHN competencies. Adopting such tools in PHN practice can help nurses to better understand their role in population-based public health efforts.</p>
<p>Keller, L., Strohschein, S., Lia-Hoagberg, B., &amp; Schaffer, M. (2004). Population-based public health interventions: practice-based and evidence-supported. Part I. Public Health Nursing, 21(5), 453-468.</p>	<p>The Intervention Wheel is a population-based practice model that encompasses three levels of practice (community, systems, and individual/family) and 17 public health interventions. Each intervention and practice level contributes to improving population health. The Intervention Wheel, previously known as the Public Health Intervention Model, was originally introduced in 1998 by the Minnesota Department of Health, Section of Public Health Nursing. The model has been widely disseminated and used throughout the United States since that time. The evidence supporting the Intervention Wheel was recently subjected to a rigorous critique by regional and national experts. This critical process, which involved hundreds of public health nurses, resulted in a more robust Intervention Wheel and established the validity of the model. The critique also produced basic steps and best practices for each of the 17 interventions. Part I describes the Intervention Wheel, defines population-based practice, and details the recommended modifications and validation process. Part II provides examples of the innovative ways that the Intervention Wheel is being used in public health/public health nursing practice, education, and administration. The two articles provide a foundation and vision for population-based public health nursing practice and direction for improving population health.</p>
<p>Keller, L., Strohschein, S., Schaffer, M., &amp; Lia-Hoagberg, B. (2004). Population-based public health interventions: innovations in practice, teaching, and management. Part II. Public Health Nursing, 21(5), 469-487.</p>	<p>The Intervention Wheel is a population-based practice model that encompasses three levels of practice (community, systems, and individual/family) and 17 public health interventions. Each intervention and practice level contributes to improving population health. The Intervention Wheel, previously known as the Public Health Intervention Model, was originally introduced in 1998 by the Minnesota Department of Health, Section of Public Health Nursing (PHN). The model has been widely disseminated and used throughout the United States since that time. The evidence supporting the Intervention Wheel was recently subjected to a rigorous critique by regional and national experts. This critical process, which involved hundreds of public health nurses, resulted in a more robust Intervention Wheel and established the validity of the model. The critique also produced basic steps and best practices for each of the 17 interventions. Part I describes the Intervention Wheel, defines population-based practice, and</p>

	<p>details the recommended modifications and validation process. Part II provides examples of the innovative ways that the Intervention Wheel is being used in public health/PHN practice, education, and administration. The two articles provide a foundation and vision for population-based PHN practice and direction for improving population health.</p>
<p>Kenrick, M., &amp; Luker, K. (1996). An exploration of the influence of managerial factors on research utilization in district nursing practice. <i>Journal Of Advanced Nursing</i>, 23(4), 697-704. doi:<a href="http://dx.doi.org/10.1111/j.1365-2648.1996.tb00040.x">http://dx.doi.org/10.1111/j.1365-2648.1996.tb00040.x</a></p>	<p>This paper reports a small study which explored the management arrangements of the providers of community services in five health districts and the influence these had on the way research findings were utilized by nurses in their clinical practice Insights were sought into the nature of the organizations in which district nurses worked With the co-operation of the service managers, all the nurses had previously been involved in testing a model of dissemination of research information The study reported here arose from that original research and explored the links between management arrangements and research utilization in clinical practice Interviews using a semi-structured schedule are reported from 22 service managers in the five health districts Data on managers' professional roles and backgrounds, the organizational structures and processes and external social and political factors were collected and analysed A selection of findings is discussed in relation to influence on research utilization in clinical practice.</p>
<p>Kleinman, C. (2004). Leadership: a key strategy in staff nurse retention. <i>Journal Of Continuing Education In Nursing</i>, 35(3), 128-132.</p>	<p>Nursing administrators are challenged to recruit and retain staff nurses in the midst of increasing job vacancies and staff nurse turnover rates averaging 21%. The prevailing issues related to staff nurse recruitment and retention in the current healthcare environment are briefly reviewed as introductory content. The article outlines the case from nursing administration literature that effective leadership styles of nurse managers and nurse administrators enhance staff nurse retention. As nurse administrators continue to struggle with staff nurse recruitment and retention, evidenced-based strategies are discussed that address leader preparation and organizational leadership structure including advanced education, leadership training, and shared leadership models.</p>
<p>Knibbs, K., Underwood, J., MacDonald, M., Schoenfeld, B., Lavoie-Tremblay, M., Crea-Arsenio, M., &amp; ... Ehrlich, A. (2012). Appreciative inquiry: a strength-based research approach to building Canadian public health nursing capacity. <i>Journal Of Research In</i></p>	<p>In this paper we evaluate the use of appreciative inquiry in focus groups with public health nurses, managers and policy makers across Canada as part of our project to generate policy recommendations for building public health nursing capacity. The focus group protocol successfully involved participants in data collection and analysis through a unique combination of appreciative inquiry and nominal group process. This approach resulted in credible data for analysis, and the final analysis met scientific research standards. The evaluation revealed that our process was effective in engaging participants when their time available was limited, no matter what their position or public health setting, and in eliciting solution-focused results. By focusing on what works well in an organisation, appreciative</p>



<p><i>Nursing</i>, 17(5), 484-494. doi:<a href="http://dx.doi.org/10.1177/17449871110387472">http://dx.doi.org/10.1177/17449871110387472</a></p>	<p>inquiry enabled us to identify the positive attributes of organisations that best support public health nursing practice and to develop practical policy recommendations because they were based on participants' experience. Further, appreciative inquiry was especially effective with public health policy makers and nurses as it is consistent with the strength-based, capacity building approaches inherent in public health nursing practice.</p>
<p>Kalb, KA, O'Conner-Von, SK, Schipper, LM, Watkins, AK, Yetter, DM (2012). Educating leaders in nursing: Faculty perspectives. <i>International Journal of Nursing Education Scholarship</i>, Volume 9, Issue 1, Pages 1–13, ISSN (Online) 1548-923X, DOI: 10.1515/1548-923X.2215</p>	<p>Recent changes in health care legislation have presented an unprecedented opportunity for nurses to engage as full partners in transforming health care (Institute of Medicine, 2010). According to diverse opinion leaders from insurance, corporate, health services, government, and higher education, nurses should have more influence than they do now on health policy, planning, and management (Robert Wood Johnson Foundation, 2010). More than ever before, nursing needs leaders, and nursing faculty are in a pivotal position to educate leaders in nursing. This article describes the findings of a descriptive study that surveyed nursing faculty teaching in all degree levels to ascertain how they prepare students to be leaders in nursing. Data were analyzed using qualitative methods. Findings demonstrate that faculty engage in self-development as leaders, promote student role development as leaders, and use multiple teaching-learning strategies to educate students to be leaders in nursing.</p>
<p>Kouzes, J. &amp; Posner, B. (2010). <i>The truth about leadership: The no-fad, health of the matter facts you need to know</i>. CA: Jossey-Bass.</p>	<p>Kouzes and Posner evaluated decades of research to understand the changes in economies, technologies, and workplaces only to find the essential fundamentals – the systems, actions, and attitudes – of leadership remain intact. One continuous unifying element that runs through Kouzes and Posner's leadership theory is ten commitments within five practices that threads their leadership model and brings it to life.</p>
<p>Leaders for Life. (n.d.). <i>Health leadership capabilities framework</i>. Victoria, BC: Leaders for Life.</p>	<p>The LEADS Leadership Capabilities Framework represents the key skills, abilities and knowledge required to lead at all levels of the health system. It aligns and consolidates the competency frameworks of individual health employers, professional associations and other progressive organizations into a common strategy.</p>
<p>MacDonald, M., &amp; Schoenfeld, B. (2003). Expanding roles for public health nursing. <i>Canadian Nurse</i>, 99(7), 19–22.</p>	<p>Numerous guidelines have been published in recent years as frameworks for public health, but are the concepts being translated into practice? Are front-line nurses supported as their roles expand?</p>
<p>Macdonald, S. E., Newburn-Cook, C. V., Allen, M., &amp; Reutter, L. (2013). <i>Embracing the population health</i></p>	<p>Individuals' health outcomes are influenced not only by their knowledge and behavior, but also by complex social, political and economic forces. Attention to these multi-level factors is necessary to accurately and comprehensively understand and intervene to improve human health. The population</p>

<p>framework in nursing research. Nursing Inquiry, 20(1), 30-41.</p>	<p>health framework is a valuable conceptual framework to guide nurse researchers in identifying and targeting the broad range of determinants of health. However, attention to the intermediate processes linking multi-level factors and use of appropriate multi-level theory and research methodology is critical to utilizing the framework effectively. Nurse researchers are well equipped to undertake such investigations but need to consider a number of political, societal, professional and organizational barriers to do so. By fully embracing the population health framework, nurse researchers have the opportunity to explore the multi-level influences on health and to develop, implement and evaluate interventions that target immediate needs, more distal factors and the intermediate processes that connect them.</p>
<p>MacLeod, M., Misener, R. M., Banks, K., Morton, A. M., Vogt, C., &amp; Bentham, D. (2008). "I'm a different kind of nurse": Advice from nurses in rural and remote Canada. Canadian Journal of Nursing Leadership, 21(3), 40-53.</p>	<p>The sustainability of the rural and remote nursing workforce in Canada is increasingly at issue as the country becomes more urbanized and the nursing workforce ages. In order to support the retention of nurses in rural and remote communities and the recruitment of nurses to these communities, we require a better understanding of what is important to rural and remote nurses themselves. As part of the in-depth interviews conducted within The Nature of Nursing Practice in Rural and Remote Canada, a national research project, registered nurses (RNs) were asked what advice they would have for new nurses, educators, administrators and policy makers. This is the first of two papers describing that advice. It focuses on RNs in acute care, long-term care, home care, community health/public health and primary care roles in rural and remote communities across the country. The RNs were generous with their advice and gave many rich examples. While they were enthusiastic about their nursing practice and encouraging of other nurses to work in rural settings, they were intent that improvements be made in several key areas: education available to new practitioners and themselves, working conditions for rural and remote nurses, leadership, organizational supports and policies that better support rural and remote practice and communities.</p>
<p>MacLeod, M., Kulig, J., Stewart, N., &amp; Pitblado, R. (2004). Nursing practice in rural and remote Canada: Final report to Canadian health research foundation Nursing Practice in Rural and Remote Canada.</p>	<p>Nursing practice in rural and remote Canada is characterized by its variability, and complexity and by the need for a wide range of knowledge and skills in situations of minimal support and few resources. This study describes the rural and remote registered nursing workforce and the nature of their practice. It gives voice to the nurses in these regions.</p> <ul style="list-style-type: none"> <li>• Managers and policy-makers need to better understand the realities of rural and remote practice. Creation of a “rural lens” can assist in the development of relevant policies and practices. This may be a useful component of a national rural and remote nursing strategy.</li> </ul>

	<ul style="list-style-type: none"> <li>• In small communities, nurses’ personal and professional roles are inseparable. The intertwining of nurses’ everyday practice and their personal lives needs to be taken into account in developing policies and services.</li> <li>• Because many rural and remote nurses work alone or with little backup in their everyday practice, there are pressing needs for providing professional supports at a distance, both in person and using information technology.</li> <li>• Recruitment and retention of nurses can be more successful when undertaken with an understanding of the perceptions of nurses in rural and remote communities and in partnership with the communities themselves.</li> <li>• New models of interprofessional practice can be developed that are supportive of the varied strengths and resources in rural and remote communities.</li> <li>• Special attention needs to be paid to the recruitment, retention, and support of nurses in Aboriginal communities, as well as to ways in which continuity of care and culturally appropriate care can be provided.</li> <li>• There is a pressing need for undergraduate and postgraduate education programs to prepare nurses for the realities of rural and remote nursing practice. Targeted funding is needed for university nursing programs that focus on preparing rural and/or remote nurses, in order to address the additional design and implementation costs.</li> <li>• New ways are needed to systematically design and provide relevant continuing education for rural and remote nurses, including providing education on site, supporting nurses to travel for further and continuing education, and using information technology.</li> <li>• A larger issue for some rural and remote communities than retirement may be the issue of migration – when nurses leave communities for education or alternate employment and do not return. Counting on overseas recruitment to fill these gaps is not a good option as only a fraction of foreign-educated nurses work in rural Canada.</li> <li>• The distinctiveness of rural and remote settings and rural nursing practice will not be adequately captured until nursing databases are improved through the development of unique personal identifiers, as well as relevant rural/urban indicators.</li> </ul>
<p>MacPhee, M., &amp; Bouthillette, F. (2008). Developing leadership in nurse managers: The British Columbia nursing leadership</p>	<p>The British Columbia Nursing Administrative Leadership Institute for First Line Nurse Leaders (BC NLI) is a collaborative partnership among British Columbia's Chief Nursing Officers, the Ministry of Health Nursing Directorate and the University of British Columbia School of Nursing. This initiative consists of a four-day residential program and a year-long leadership project between BC NLI participants and their</p>

<p>institute. Canadian Journal of Nursing Leadership, 21(3), 64-75.</p>	<p>organizational mentors. The evidence-based curriculum covers universal leadership and management concepts, but it also addresses leadership issues of relevance to nurse leaders in today's complex healthcare environments. The BC NLI is part of a provincial health human resources endeavour to ensure sufficient nursing leaders - for now and in the future. This paper will discuss the development, implementation and evaluation of the BC NLI. Unique aspects of the program, such as its online networking component, will be described, and its role in nursing leadership research will be briefly examined.</p>
<p>Mahan, C. (2000). How can performance standards strengthen accountability for public health? Journal Of Public Health Management &amp; Practice, 6(5), 85-87.</p>	<p>Performance standards with both process and outcome measures can lead to greatly increased accountability for public health and a major leadership position in U.S. health care. Accreditation of health departments should become part of the accountability process. (C) Aspen Publishers, Inc.</p>
<p>Manitoba Public Health Managers Network. (2011). Core competencies for managers who work in public health. Manitoba: Manitoba Public Health Managers Network.</p>	<p>In March 2008, the Manitoba Public Health Mangers Network and the Public Health Agency of Canada collaborated to bring together 30 public health managers from across Manitoba to look at the core competencies for Public Health in Canada (2008) and to begin to identify the core competencies of managers who work in public health.</p> <p>It is anticipated this list of competencies will be used to assist public health organizations to:</p> <ul style="list-style-type: none"> <li>• Articulate the knowledge, skills and attitudes required of managers who work in public health management and leadership positions.</li> <li>• Identify professional development and training needs.</li> <li>• Develop competency based job descriptions, interview questions, and frameworks for evaluation and quality assurance.</li> <li>• Facilitate collaboration, shared goals and interdisciplinary work.</li> </ul> <p>The Competencies: 1. Public Health Science and Knowledge, 2. Assessment and Analysis, 3. Policy, Program Planning and Evaluation, 4. Partnerships, Collaboration and Advocacy, 5. Diversity and Inclusiveness, 6. Communication, 7. Leadership, 7.1 System and Organizational Results, 7.2 Build Capacity and Improving Performance, 7.3 Team Building and Conflict Management, 7.4 Problem Solving and Decision Making, 7.5 Administration and Resource Management, 8. Professional Responsibility and Accountability</p>

<p>Meagher-Stewart, D., Solberg, S. M., Warner, G., MacDonald, J., McPherson, C., &amp; Seaman, P. (2012). Understanding the Role of Communities of Practice in Evidence-Informed Decision Making in Public Health. <i>Qualitative Health Research</i>, 22(6), 723-739. doi:http://dx.doi.org/10.1177/1049732312438967</p>	<p>In this article we report on qualitative findings that describe public health practitioners' practice-based definitions of evidence-informed decision making (EIDM) and communities of practice (CoP), and how CoP could be a mechanism to enhance their capacity to practice EIDM. Our findings emerged from a qualitative descriptive analysis of group discussions and participant concept maps from two consensus-building workshops that were conducted with public health practitioners (N = 90) in two provinces in eastern Canada. Participants recognized the importance of EIDM and the significance of integrating explicit and tacit evidence in the EIDM process, which was enhanced by CoP. Tacit knowledge, particularly from peers and personal experience, was the preferred source of knowledge, with informal peer interactions being the favored form of CoP to support EIDM. CoP helped practitioners build relationships and community capacity, share and create knowledge, and build professional confidence and critical inquiry. Participants described individual and organizational attributes that were needed to enable CoP and EIDM.</p>
<p>Meagher-Stewart, D., Underwood, J., MacDonald, M., Schoenfeld, B., Blythe, J., Knibbs, K., &amp; ... Crea, M. (2010). Organizational Attributes That Assure Optimal Utilization of Public Health Nurses. <i>Public Health Nursing</i>, 27(5), 433-441. doi:http://dx.doi.org/10.1111/j.1525-1446.2010.00876.x</p>	<p>Optimal utilization of public health nurses (PHNs) is important for strengthening public health capacity and sustaining interest in public health nursing in the face of a global nursing shortage. To gain an insight into the organizational attributes that support PHNs to work effectively, 23 focus groups were held with PHNs, managers, and policymakers in diverse regions and urban and rural/remote settings across Canada. Participants identified attributes at all levels of the public health system: government and system-level action, local organizational culture of their employers, and supportive management practices. Effective leadership emerged as a strong message throughout all levels. Other organizational attributes included valuing and promoting public health nursing; having a shared vision, goals, and planning; building partnerships and collaboration; demonstrating flexibility and creativity; and supporting ongoing learning and knowledge sharing. The results of this study highlight opportunities for fostering organizational development and leadership in public health, influencing policies and programs to optimize public health nursing services and resources, and supporting PHNs to realize the full scope of their competencies.</p>
<p>Mechanic, D. (2003). Who shall lead: is there a future for population health?. <i>Journal Of Health Politics, Policy &amp; Law</i>, 28(2/3), 421-442.</p>	<p>There is renewed interest in population health concerns, elevation of this field in policy considerations faces many challenges. At present there is much concern about disparities and meeting improved population health objectives, but interest waxes and wanes with scientific developments and especially with dominant political alignments and ideologies. If the field of population health is to have sustained policy influence, it requires a persistent constituency, a strong organizational base both within and outside government, and academic respectability. Population health faces many issues in seeking to become legitimized as both a unique field of study and as a significant force in public policy. Among</p>

	these are clear definitions of the boundaries of the field. A continuing flow of resource for development, and attractive career structures for new recruits and future leaders.
Mikkonen, J., & Raphael, D. (2010). Social determinants of health: The Canadian facts. Toronto, ON: York University School of Health Policy and Management.	Social Determinants of Health: The Canadian Facts provides Canadians with an introduction to the social determinants of our health. We first explain how living conditions “get under the skin” to either promote health or cause disease. We then explain, for each of 14 key social determinants of health: 1) Why it is important to health; 2) How we compare on the social determinant of health to other wealthy developed nations; 3) How the quality of the specific social determinant can be improved.
Mildon, B., Betker, C., & Underwood, J. (2010, updated March 2011). Standards of practice in community health nursing: A literature review undertaken to inform revisions to the Canadian community health nursing standards of practice Community Health Nurses of Canada.	This literature review was undertaken to inform a review and revisions to the Canadian Community Health Nursing Standards of Practice (hereafter referred to as the Standards). The Standards were first published by the Community Health Nurses Association of Canada (CHNAC) in 2003 and were edited and re-printed in 2008. The specific purpose of this literature review was to determine the degree to which the Standards remain comprehensive, current and relevant for contemporary community health nursing practice. This document reports the process and results of the literature review in the context of the standards. The description of community health nursing in the Standards (CHNAC, 2008, p. 9) notes that the various characteristics of the organizations that employ community health nurses (CHNs) act as enablers or barriers for their practice. Accordingly, because nurses enact standards of practice within the context of their work environments, this document reflects the assumption that a quality setting is a requirement for nurses to be able to practice according to standards (Mackay and Risk, 2001; Underwood et al., 2009).
Mills, L., Wong, S. T., Bhagat, R., Quail, D., Triolet, K., & Weber, T. (2012). Developing and sustaining leadership in public health nursing: Findings from one British Columbia health authority. Nursing Research, 25(4), 63-75.	Objective: To develop clinical leadership among front-line public health nurses (PHNs). Methods: This paper describes a quality improvement process to develop clinical leadership among front-line PHNs. Three activities were undertaken by a working group consisting mainly of front-line staff: engaging PHNs in an online change-readiness questionnaire, administering a survey to clients who had ever used public health services delivered by one Vancouver Community Infant, Child and Youth (ICY) program team and conducting three group interviews with public health providers. The group interviews asked about PHN practice. They were analyzed using thematic content analysis. Results: This quality improvement project suggests that PHNs ( n=70) strongly believed in opportunities for system improvement. Client surveys ( n=429) and community partner surveys ( n=79) revealed the importance of the PHN role. Group interview data yielded three themes: PHNs were the “hub” of community care; PHNs lacked a common language to describe their work; PHNs envisioned their future practice encompassing their full scope of

	competencies. PHNs developed the “ICY Public Health Nursing Model,” which articulates 14 public health interventions and identifies the scope of their work. Conclusion: Developing and sustaining clinical leadership in front-line PHNs was accomplished through these various quality assurance activities.
Mills, T., & Schneider, A. (2007). The Office of the National Nurse: leadership for a new era of prevention. <i>Policy, Politics &amp; Nursing Practice</i> , 8(1), 64-70.	The American health care system is in a crisis of soaring costs and epidemics of preventable diseases; poor health literacy contributes to these problems. In spite of the need for change, the system is resistant. Efforts to address the crisis must focus on new ways of educating the public to understand their health and how to prevent illness. Nurses calling for leadership, innovation, and inspiration are uniting behind the proposal for an Office of the National Nurse to serve as the vehicle for the delivery of accurate and accessible health information to all Americans to reduce the incidence of preventable diseases.
Ministry of Health and Long Term Care & Ministry of Health Promotion and Sport. (2011). <i>Ontario Public Health Organizational Standards</i> . (2011). Toronto, ON: Queen's Printer for Ontario.	The Ontario Public Health Organizational Standards (Organizational Standards) establish the management and governance requirements for all boards of health and public health units. Similar to the Ontario Public Health Standards (OPHS) 2008 (or as current), <sup>1</sup> which outline the expectations for providing public health programs and services, the Organizational Standards outline the expectations for the effective governance of boards of health and effective management of public health units. Organizational Standards help promote organizational excellence, establish the foundation for effective and efficient program and service delivery and contribute to a public health sector with a greater focus on performance, accountability and sustainability
Misener, R. M., MacLeod, M., Banks, K., Morton, A. M., Vogt, C., & Bentham, D. (2008). "There's rural, and then there's rural": Advice from nurses providing primary healthcare in northern remote communities. <i>Canadian Journal of Nursing Leadership</i> , 21(3), 54-63.	Nursing practice in remote northern communities is highly complex, with unique challenges created by isolation, geography and cultural dynamics. This paper, the second of two focusing on the advice offered by nurses interviewed in the national study, <i>The Nature of Nursing Practice in Rural and Remote Canada</i> , considers suggestions from outpost nurses. Their advice to new nurses was: know what you are getting into; consider whether your personal qualities are suited for northern practice; learn to listen and listen to learn; expect a steep learning curve, even if you are experienced; and take action to prevent burnout. Recommendations for educators were to offer programs that prepare nurses for the realities of outpost nursing and provide opportunities for accessible, flexible, relevant continuing education. The outpost nurses in this study counselled administrators to stay in contact with and listen to the perspectives of nurses at the "grassroots," and not merely to fill positions but instead to recruit outpost nurses effectively and remunerate them fairly. The study findings highlighted the multiple

	interrelated strategies that nurses, educators and administrators can use to optimize practice in remote northern communities.
Misener, T.R., Alexander, J., Blaha, A., Clarke, P., Cover, C., Felton, G., & ... Sharp, H. (1997). National Delphi study to determine competencies for nursing leadership in public health. <i>Image: Journal Of Nursing Scholarship</i> , 29(1), 47-51.	Purpose: To identify competencies needed by nurse leaders in public health programs. Design: Five-round national Delphi. Sample: Convenience sample of members of major public health nursing associations and nurse and non-nurse public health leaders in the USA. Methods: Mailed survey in 1994-1995 using a modified snowball technique based on a modification of the Pew Foundation health professions' competencies for Round 1. Four additional rounds produced consensus. Findings: Initially, 62 competencies were identified. Factor analysis resulted in four factors: political competencies, business acumen, program leadership, and management capabilities; 57 competencies were clustered in the four groupings and accounted for 91.4% of the variance. Conclusions: Graduate schools in nursing and public health must prepare students with broad-based competencies from a variety of disciplines. Findings of this national survey provide a database for curriculum development and evaluation of programs to prepare nurse leaders for roles in public health based delivery systems.
Mitchell, G.J., Ferguson-Pare, M., & Richards, J. (2003). Exploring an alternative metaphor for nursing: Relinquishing military images and language. <i>Nursing Leadership</i> , 16(1):48-58; discussion 58-60	The language used to describe nursing practice and nursing leadership has a profound influence on how nurses think about themselves, their work relationships, and indeed the very essence of their reason for being. Language often includes metaphor in order to help capture the complexities and layers of meaning that establish contexts for action. Nurses and others have relied on various metaphors to describe nursing work. However, there is one metaphor that, more than any other, has shaped the context of nursing work and formed the images and the meanings that nurses have of themselves and their purposes in practice. The privileged one is the military metaphor. This article explores the notion of metaphor, and its usefulness and potential to help nurses change their work patterns. The traditions and history of the military metaphor are examined and an alternative notion of the "frontier" is proposed in order to enhance understanding of the potential for change.
Moloughney, B. (2010). Integrating social determinants of health and health equity into Canadian public health practice: Environmental scan 2010. Antigonish, NS: National Collaboration Centre for	The NCCDH has requested this environmental scan to inform its future direction, priorities and activities through an analysis of the key challenges, needs, gaps, and opportunities in the determinants of health for public health. Overall, there appear to be four key roles for public health action on health determinants to reduce health inequities: <ul style="list-style-type: none"> <li>• assess and report on the health of populations describing the existence and impact of health inequalities and inequities and, effective strategies to address those inequalities/inequities.</li> </ul>



<p>Determinants of Health, St. Francis Xavier University.</p>	<ul style="list-style-type: none"> <li>• modify/orient public health interventions to reduce inequities including the consideration of the unique needs and capacities of priority populations (i.e., do planning and implementation of existing programs considering inequities).</li> <li>• engage in community and multisectoral collaboration in addressing the health needs of these populations through services and programs (i.e., when looking at the collectivity of our programming for ‘x’, where are the gaps?).</li> <li>• lead/participate and support other stakeholders in policy analysis, development and advocacy for improvements in health determinant/inequities.</li> </ul>
<p>OHPE. (2003). A leadership framework for management in public health. Ontario Health Promotion E-Bulletin, 2003(334)</p>	<p>Since 1997, public health in Ontario has undergone many changes. Management needs to consider ways to provide leadership and support staff in their changing roles. Kouzes and Posner believe that leadership is the process of ordinary people engaged in extracting the best from themselves and others. In their 2002 book, <i>The Leadership Challenge</i>, they identified five key practices for leaders:</p> <ol style="list-style-type: none"> <li>1. Model the way;</li> <li>2. Inspire a shared vision;</li> <li>3. Challenge the process;</li> <li>4. Enable others to act; and</li> <li>5. Encourage the heart</li> </ol>
<p>Ouzts, K., Brown, J., &amp; Swearingen, C. (2006). Developing public health competence among RN-to-BSN students in a rural community. <i>Public Health Nursing</i>, 23(2), 178-182.</p>	<p>A new RN/BSN nursing program offers rural students in a western state the opportunity to address significant health care needs on a local level by developing public health leadership competencies in their home communities. The innovative program, funded by a grant from the Health Resources and Services Administration, makes it possible for RNs to complete their BSN degrees without travel, as they position themselves to provide critically needed health care leadership in their local areas. Partnerships between the university, community colleges, and local health agencies allow students in the RN-to-BSN program to benefit from a streamlined BSN admission process, onsite mentoring, and newly developed courses that lead students to reflect on health needs in their home communities. On the basis of Public Health Nursing Competencies as defined by the Nursing Quad Council (2004), the re-designed curriculum prepares students for public health leadership by encouraging application of competencies while participating in the delivery of essential public health services in their communities. Initial response to this new opportunity indicates that students can develop as leaders by developing public health competencies, and facets of the program may encourage more students to commit to completing the BSN while increasing capacity among PHNs.</p>
<p>Patychuk, D. (2009). Health equity: Promising practices inventory for central LHIN. Steps to Equity.</p>	<p>For the purposes of this inventory, “promising practices” in health equity are strategies, actions, initiatives, approaches, policies or resources that can assist organizations to integrate a health equity approach into their leadership, governance, operations, services, partnerships and community</p>

	<p>engagement in order to reduce health disparities. A practice or strategy is considered “promising” if it is equitable, transferable, empowering and is or may be effective.</p> <p>Table of Contents:</p> <p>INTRODUCTION</p> <p>1. LEADERSHIP AND GOVERNANCE</p> <p>1.1 Setting vision, commitment, goals and objectives for health equity</p> <p>1.2. Meeting legal, ethical, and human rights requirements</p> <p>1.3. Making our health organizations reflective of our communities</p> <p>1.4. Using health equity lenses , audits and impact assessments</p> <p>1.5. Monitoring, measuring, researching g and reporting health disparities</p> <p>2. CLIENT/COMMUNITY CENTERED CARE</p> <p>2.1 Reducing barriers to access to services, information and participation</p> <p>2.2 Language Access Strategies</p> <p>2.3 Cultural competency</p> <p>3. OPERATIONS AND HUMAN RESOURCES</p> <p>4. COMMUNITY PARTNERSHIPS</p> <p>5. EMPOWERED COMMUNITIES</p> <p>6. INFLUENCING PUBLIC POLICY</p> <p>7. RESOURCES, WEBSITES, GLOSSARIES</p>
<p>Pauly, B. M. (2013). Challenging health inequities: enacting social justice in nursing practice. In Janet L. Storch, Patricia Rodney &amp; Rosalie Starzomski (Eds.), <i>Toward a Moral Horizon: Nursing Ethics for Leadership and Practice</i> (2nd ed., pp. 430-447). Toronto: Pearson.</p>	
<p>Peroff-Johnston, N., &amp; Chan, I. (2012). Evaluation of the social determinants of health nursing initiative among health units in Ontario 6th National Community Health Nursing Conference.</p>	<p>CHNC SDoH presentation</p>
<p>Population Health Improvement Research Network, University of Ottawa What does it take to be a leader for health equity?</p>	<p>Webinar March 14, 2013. <a href="http://www.chnet-works.ca">www.chnet-works.ca</a></p>

<p>Potter, MA, CL Pistella, CI Fertman, and VM Dato. 2000. "Needs assessment and a model agenda for training the public health workforce." American Journal Of Public Health 90, no. 8: 1294-1296. CINAHL with Full Text, EBSCOhost (accessed February 20, 2013).</p>	<p>OBJECTIVES: A training needs assessment project tested the use of "universal" competencies for establishing a model training agenda for the public health workforce. METHODS: Agency supervisors selected competencies for training priorities. Regional and national public health leaders used these selections to design the model training agenda. RESULTS: The competencies given high priority by supervisors varied among state and local agencies and included some not within the universal set. The model training agenda reflected supervisors' priorities as well as leaders' perspectives. CONCLUSIONS: The universal competencies provide a useful starting point, but not necessarily an exclusive framework, for assessing and meeting the training needs of the public health workforce.</p>
<p>Poulton, B., Lyons, A., &amp; O'Callaghan, A. (2008). A comparative study of self-perceived public health competencies: practice teachers and qualifying SCPHNs. Community Practitioner, 81(9), 31-34.</p>	<p>There is evidence to suggest that population-focused public health nursing is more rhetoric than reality. This quantitative study compares the self-perceived public health competence of qualifying student specialist community public health nurses (SCPHNs) (n=35) with those of the practice teachers (PTs) facilitating their practice learning (n=31). Findings suggest that PTs felt more competent than qualifying students on leadership and management for public health, working with communities, and communication skills. However, the qualifying students self-rated higher than the PTs on principles and practice of public health, suggesting that the PTs in this study felt less competent than their qualifying students in key public health skills, such as epidemiology, population health needs assessment, research and evidence-based decision-making. It is recommended that the triennial review of PTs should address not only educational skills but knowledge and skills in contemporary public health practice, a continuing professional development framework for SCPHNs should be developed and funded, providers should assist PTs in keeping up with contemporary public health, and the role of the PT should be recognised and given appropriate support and remuneration.</p>
<p>Public Health Agency of Canada, &amp; World Health Organization. (2008). Health equity through intersectoral action: An analysis of 18 country case studies. Ottawa, ON: Queen's Printer.</p>	<p>This synthesis is part of a joint initiative between the World Health Organization (WHO) and the Public Health Agency of Canada (PHAC), to increase knowledge and application of effective intersectoral approaches. The report provides an analysis of key learnings about intersectoral action for health and health equity from the 18 country case studies (commissioned under this initiative). Some of the key themes and learnings identified in the report include:</p> <ul style="list-style-type: none"> <li>• building a strong case for intersectoral action is vital;</li> <li>• building trust among players is key to developing and maintaining intersectoral action;</li> <li>• models and structures to organize intersectoral action need to take a variety of forms depending on the context and conditions;</li> <li>• monitoring the on-going processes and outcomes of intersectoral work is critical; and</li> <li>• the role of the health sector needs to be flexible.</li> </ul>

<p>Public Health Agency of Canada. (2011). Reducing health inequalities: A challenge for our times. Ottawa, ON: Public Health Agency of Canada.</p>	<p>Reducing Health Inequalities: A Challenge for our Times explains what health inequalities are and includes a glossary of relevant terms. It discusses what causes health inequalities and how they interact with the personal, social, economic and environmental determinants of health. It presents ‘snapshots’ of the five most vulnerable groups in Canada, and concludes with details about the Public Health Agency of Canada’s actions to reduce health inequalities.</p> <p>Use this resource to:</p> <ul style="list-style-type: none"> <li>Gain greater understanding about health inequalities and how they affect vulnerable groups in Canada</li> <li>Identify opportunities to support public health action to reduce health inequalities</li> <li>Access a glossary of terms relevant to the social determinants of health</li> </ul>
<p>Public Health Chief Nursing Officer (PHCNO) Working Group (2011). Public Health Chief Nursing Officer Working Group Report. Ontario.</p>	<p>Powerpoint presentation.</p>
<p>Raphael, D. (2012). Latest OECD figures confirm Canada as a public health laggard. Canadian Journal of Public Health, 103(6), e425-e427.</p>	<p>Despite the Canadian public health community’s commitments to promoting public policy that supports health, evidence indicates that Canada’s public health picture continues to decline. This may be due in part to the failure of public health agencies and local public Health Units to engage in public policy advocacy and public education about the social determinants of health. Examples of such activities by local public health h units are now available and provide a model for such activity</p>
<p>Registered Nurses' Association of Ontario. (2006). Healthy work environments best practice guidelines: Developing and sustaining nursing leadership [Healthy Work Environments Best Practice Guidelines: Developing and Sustaining Nursing Leadership]. Toronto, ON: Registered Nurses’ Association of Ontario.</p>	<p>Achievement of healthy work environments for nurses requires transformational change, with “interventions that target underlying workplace and organizational factors”. It is with this intention that we have developed these guidelines. We believe that full implementation will make a difference for nurses, their patients/clients and the organizations and communities in which they practice. It is anticipated that a focus on creating healthy work environments will benefit not only nurses but other members of the health care team. We also believe that best practice guidelines can be successfully implemented only where there are adequate planning processes, resources, organizational and administrative supports, and appropriate facilitation. There is evidence that demonstrates that the nurses’ relationship with the immediate supervisor is an important predictor of job satisfaction and intent to stay (Blegen, 1993; Irvine &amp; Evans, 1992; Thomson et al., 2002). Thomson et al. (2002) noted that, “at a time when nurses need leadership most the cadre is shrinking, leaving nurses with little day-to-day support and diminished access to those who are positioned within the hierarchy to advocate on their behalf” p. 26). Although Patrick and White (2005) argue that it is difficult to operationalize</p>

	<p>leadership theories, they concede that educational interventions can increase leadership behaviours. Tourangeau et al. (2003) found that a concentrated residential leadership program can strengthen leadership behaviours in both established and developing nurse leaders. In a meta-analysis of research examining the effects of managerial leadership development programs, Collins and Holton (2004) found that there was an emerging trend of transformational leadership but found little in terms of reporting on training or results. Further, they found few empirical studies to assess the outcomes of interventions such as coaching, mentoring or feedback. These authors recommend the need to track the return on investment of leadership development programs. Research in this area needs to further address the supports and barriers to interest and success in leadership roles, along with evaluation tools that address nursing leadership and performance.</p> <p>Blegen, M. (1993). Nurses' job satisfaction: meta-analysis of related variables. <i>Nursing Research</i>, 42(1), 36-41.</p> <p>Collins, D., &amp; Holton, E. (2004). The Effectiveness of managerial leadership development programs: A meta-analysis of studies from 1982 to 2001. <i>Human Resources Development Quarterly</i>. 15(2), 217-248.</p> <p>Irvine, D., &amp; Evans, M. (1992). Job satisfaction and turnover among nurses: A review and meta-analysis. <i>Quality of Nursing Worklife Research Unit Monograph Series</i>. University of Toronto.</p> <p>Patrick, A., &amp; White, P. (2005). Scope of nursing leadership. In L. McGillis Hall (Ed.), <i>Quality work environments for nurse and patient safety</i>. Sudbury, MA: Jones and Bartlett Publishers.</p> <p>Thomson, D. Dunleavy, J., &amp; Bruce, S. (2002). <i>Nurse Job Satisfaction – Factors Relating to Nurse Satisfaction in the Workplace</i>. Report commissioned for the Canadian Nursing Advisory Committee, Ottawa, ON.</p> <p>Tourangeau, A., Lemonde, M., Luba, M., Dakers, D., &amp; Alksnis, C. (2003). Evaluation of a leadership development intervention. <i>Canadian Journal of Nursing Leadership</i>, 16(3), 91-104.</p>
Registered Nurses' Association of Ontario. (2012). Resolution 13: The Role of Public Health Nurses in schools: A Research and policy analysis.	
Reutter, L., & Duncan, S. (2002). Preparing nurses to promote health-enhancing public policies. <i>Policy, Politics &amp; Nursing Practice</i> , 3(4), 294-305.	<p>Nursing leadership in policy development continues to be acknowledged as an important aspect of professional practice. The past decade of health services restructuring has led to a renewed emphasis on nursing's role in health care policy; however, there is also a need to focus more broadly on policies outside the health care sector that influence health. A critical question is how to prepare nurses to influence the development of "healthy public policy." This article describes shifts in thinking about policy in health and what this portends for nursing education. The authors argue that comprehensive</p>

	<p>preparation in public policy for nurses is an essential element of graduate education. The article describes faculty and student perspectives and experiences in the first offerings of the nursing graduate course, Promoting Health-Enhancing Public Polity. The article concludes with recommendations that may assist students to acquire knowledge regarding the policy process and approaches to policy advocacy.</p>
<p>Reutter, L., &amp; Ford, J. (1996). Perceptions of public health nursing: views from the field. <i>Journal Of Advanced Nursing</i>, 24(1), 7-15. doi:<a href="http://dx.doi.org/10.1046/j.1365-2648.1996.01681.x">http://dx.doi.org/10.1046/j.1365-2648.1996.01681.x</a></p>	<p>While there has been considerable debate about future roles for public health nurses, there is little research that explores public health nursing from the practitioner's perspective. The findings reported in this paper are part of a larger study that explored public health nurses' perspectives and experiences of their practice: what they do and how they feel about what they do. Qualitative data were gathered through in-depth individual and focus group interviews with 28 female public health nurses (PHNs) in Alberta, Canada. This paper describes how PHNs feel about their work. The analysis revealed that public health nurses perceived that their work was valuable and worthwhile, enjoyable, demanding, and not well understood by others. These perceptions are discussed in terms of their implications for the future role of public health nursing in a reformed health care system and for the quality of nursing worklife.</p>
<p>Reutter, L., &amp; Kushner, K. (2010). 'Health equity through action on the social determinants of health': taking up the challenge in nursing. <i>Nursing Inquiry</i>, 17(3), 269-280. doi:<a href="http://dx.doi.org/10.1111/j.1440-1800.2010.00500.x">http://dx.doi.org/10.1111/j.1440-1800.2010.00500.x</a></p>	<p>'Health equity through action on the social determinants of health': taking up the challenge in nursing Reducing health inequities is a priority issue in Canada and worldwide. In this paper, we argue that nursing has a clear mandate to ensure access to health and health-care by providing sensitive empowering care to those experiencing inequities and working to change underlying social conditions that result in and perpetuate health inequities. We identify key dimensions of the concept of health (in)equities and identify recommendations to reduce inequities advanced in key global and Canadian documents. Using these documents as context, we advocate a 'critical caring approach' that will assist nurses to understand the social, political, economic and historical context of health inequities and to tackle these inequities through policy advocacy. Numerous societal barriers as well as constraints within the nursing profession must be acknowledged and addressed. We offer recommendations related to nursing practice, education and research to move forward the agenda of reducing health inequities through action on the social determinants of health.</p>
<p>Robert Wood Johnson Foundation. (2013). Finding answers, disparities research for change. <a href="http://www.solvingdisparities.org/about">http://www.solvingdisparities.org/about</a></p>	<p>In 2005, the Robert Wood Johnson Foundation launched Finding Answers: Disparities Research for Change to seek and evaluate projects aimed at reducing racial and ethnic health care disparities. Finding Answers manages an \$8 million grant portfolio that funds program evaluations in 33 health care organizations across the country. We are evaluating a variety of intervention strategies in different health care settings to find out what works—and what does not—to improve care. As results come in,</p>

	<p>the program will disseminate information to health care systems so they can incorporate successful strategies into their quality improvement efforts. Finding Answers focuses our research on interventions targeting diabetes, cardiovascular disease, and depression. We focus on reducing disparities in these three conditions because the evidence of racial and ethnic disparities is strong and the recommended standards of care are clear.</p>
<p>Schim, S. (1997). Leadership experiences of elder community health nurse leaders in Michigan.</p>	<p>Community health nursing (CHN) provides models for leadership during periods of rapid transition in social and health care systems. CHN elders offer a unique perspective on leadership, career experiences, and the profession which needs to be recorded and examined. The purpose of this oral life history study was discovery about leadership among elder CHN leaders in Michigan. Five women between the ages of 60 and 90 were identified as nurse leaders by CHNs through a purposeful sampling/snowball technique. A "leader" was defined as one who guided or directed one or more CHNs in practice and/or education. The study was limited to leaders who experienced at least part of their careers in Michigan. Informant careers spanned from 1926 to 1996 and practice areas included school nursing, home care, public health, nursing education, and international public health. Oral life history interviews were audio recorded. Tapes were transcribed verbatim and entered into a qualitative analysis software program for coding and analysis. Data analysis and data collection were concurrent and recursive. A modified ethnographic approach was used to code, categorize, and identify patterns and themes. Credibility, transferability, dependability, and confirmability were addressed through repeated contacts, rapport building with informants, member checking, provision of thick description, reflexive journaling, field notation, and audit. Patterns identified included the use of humor, pathos, intimacy/surprise, and engaging narrative styles. Themes that emerged were (1) nursing as uniform garments and expectations, (2) leader as unorthodox, and (3) respect. Leaders were articulate, value driven, and committed and led by managing resources, mentoring/nurturing, and exhibiting social graces. A variety of life experiences including elements of choices, chances, and circumstances contributed to leadership development. Models for administrative practice are linked to transformation and stewardship. Identity stories, articulation of vision, and social skills are important. The need for social skills and respect in CHN practice is highlighted. Nursing education implications include tolerance for idiosyncrasy and respect coupled with the need to teach critical thinking and social skills. This study is a foundation for further work on nursing leadership. The analysis method developed for this study can be applied to other oral life history projects.</p>
<p>Schofield, R., Ganann, R., Brooks, S., McGugan, J., Dalla Bona, Betker, C.,</p>	<p>As health care is shifting from hospital to community, community health nurses (CHNs) are directly affected. This descriptive qualitative study sought to understand priority issues currently facing CHNs,</p>

<p>&amp; ... Watson, C. (2011). Community Health Nursing Vision for 2020: Shaping the Future. <i>Western Journal Of Nursing Research</i>, 33(8), 1047-1068. doi:<a href="http://dx.doi.org/10.1177/0193945910375819">http://dx.doi.org/10.1177/0193945910375819</a></p>	<p>explore development of a national vision for community health nursing, and develop recommendations to shape the future of the profession moving toward the year 2020. Focus groups and key informant interviews were conducted across Canada. Five key themes were identified: community health nursing in crisis now, a flawed health care system, responding to the public, vision for the future, and CHNs as solution makers. Key recommendations include developing a common definition and vision of community health nursing, collaborating on an aggressive plan to shift to a primary health care system, developing a comprehensive social marketing strategy, refocusing basic baccalaureate education, enhancing the capacity of community health researchers and knowledge in community health nursing, and establishing a community health nursing center of excellence.</p>
<p>Shapiro, M., Miller, J., &amp; White, K. (2006). Community transformation through culturally competent nursing leadership: application of theory of culture care diversity and universality and tri-dimensional leader effectiveness model. <i>Journal Of Transcultural Nursing</i>, 17(2), 113-118.</p>	<p>Transcultural knowledge and competency have become a critical need for nurses to accommodate the global trends in cultural diversity and health care disparities. Today, nurses are increasingly taking on leadership roles in community settings. This article addresses the application of Leininger's culture care theory with the sunrise model and Hersey and Blanchard's tri-dimensional leader effectiveness model as potential collaborating theories for capacity building and community transformation from a global, transcultural nursing perspective. The two theories, used in collaboration, view the provision of competent leadership as the delivery of effective, culturally congruent nursing care in promoting health and health equity at the community level.</p>
<p>Shookner, M. (2002). An inclusion lens: Workbook for looking at social and economic exclusion and inclusion. Halifax, NS: Population and Public Health Branch Atlantic Region.</p>	<p>By using this Inclusion Lens, readers have analyzed the sources of exclusion of a population or community of concern, identified solutions leading toward inclusion, and developed a plan to get started.</p>
<p>Smith, G. (2007). Health disparities: what can nursing do? <i>Policy, Politics &amp; Nursing Practice</i>, 8(4), 285-291.</p>	<p>Health disparities result from lack of caring within the society. Central to nursing, caring makes the profession best suited for leadership in reducing disparities. Nursing is losing its capacity for caring. Nursing's progress in gaining status has alienated it from the needs of other oppressed groups. It has also been seduced by the scientific model and does not always use its best judgment of truths about human suffering. Research has identified unequal treatment, discrimination, workplace and social status, income inequality, and policy decisions to deplete resources as social and economic determinants of health. All involve relationships. Nursing is the profession for which relationships are</p>



	<p>primary. Nursing can rebuild the capacity for caring and social and relational practice through transforming nursing education on the principle of mutuality. Nursing can also promote nurse-managed primary care and focus on changing local, state, and national policies to increase access, equity, and health protection.</p>
<p>Spence Laschinger, H., Wilk, P., Cho, J., &amp; Greco, P. (2009). Empowerment, engagement and perceived effectiveness in nursing work environments: does experience matter? <i>Journal Of Nursing Management</i>, 17(5), 636-646. doi:<a href="http://dx.doi.org/10.1111/j.1365-2834.2008.00907.x">http://dx.doi.org/10.1111/j.1365-2834.2008.00907.x</a></p>	<p>Aims: We examined the impact of empowering work conditions on nurses' work engagement and effectiveness, and compared differences among these relationships in new graduates and experienced nurses. Background: As many nurses near retirement, every effort is needed to retain nurses and to ensure that work environments are attractive to new nurses. Experience in the profession and generational differences may affect how important work factors interact to affect work behaviours. Methods We conducted a secondary analysis of survey data from two studies and compared the pattern of relationships among study variables in two groups: 185 nurses 2 years post-graduation and 294 nurses with more than 2 years of experience. Results A multi-group SEM analysis indicated a good fit of the hypothesized model. Work engagement significantly mediated the empowerment/effectiveness relationship in both groups, although the impact of engagement on work effectiveness was significantly stronger for experienced nurses. Conclusions Engagement is an important mechanism by which empowerment affects nurses feelings of effectiveness but less important to new graduates' feelings of work effectiveness than empowerment. Implications for nursing management: Managers must be aware of the role of empowerment in promoting work engagement and effectiveness and differential effects on new graduates and more seasoned nurses.</p>
<p>Spence Laschinger, H.K., Wong, C. A., Grau, A. L., Read, E. A., &amp; M. (2012). The influence of leadership practices and empowerment on Canadian nurse manager outcomes. <i>Journal Of Nursing Management</i>, 20(7), 877-888. doi:<a href="http://dx.doi.org/10.1111/j.1365-2834.2011.01307.x">http://dx.doi.org/10.1111/j.1365-2834.2011.01307.x</a></p>	<p>Aim To examine the influence of senior nurse leadership practices on middle and first-line nurse managers' experiences of empowerment and organizational support and ultimately on their perceptions of patient care quality and turnover intentions. Background Empowering leadership has played an important role in staff nurse retention but there is limited research to explain the mechanisms by which leadership influences nurse managers' turnover intentions. Methods This study was a secondary analysis of data collected using non-experimental, predictive mailed survey design. Data from 231 middle and 788 first-line Canadian acute care managers was used to test the hypothesized model using path analysis in each group. Results The results showed an adequate fit of the hypothesized model in both groups but with an added path between leadership practices and support in the middle line group. Conclusions Transformational leadership practices of senior nurses empower middle- and first-line nurse managers, leading to increased perceptions of organizational support, quality care and decreased intent to leave. Implications for Nursing Management Empowered nurse managers at all levels who feel supported by their organizations are more likely to stay in their</p>

	roles, remain committed to achieving quality patient care and act as influential role models for potential future leaders.
Stamler, L., & Yiu, L. (2012). Community health nursing: A Canadian perspective. (Second ed.). Toronto, ON: Pearson Canada.	
Summary of discussion from OHPA workshop. (November 2009). Unpublished document.	
Tomey, A. (2009). Nursing leadership and management effects work environments. <i>Journal Of Nursing Management</i> , 17(1), 15-25. doi: <a href="http://dx.doi.org/10.1111/j.1365-2834.2008.00963.x">http://dx.doi.org/10.1111/j.1365-2834.2008.00963.x</a>	The aim of this literature search was to identify recent research related to nursing leadership and management effects on work environment using the 14 forces of magnetism. This article gives some historical perspective from the original 1983 American Academy of Nursing study through to the 2002 McClure & Hinshaw update to 2009 publications. Evaluation Research publications were given a priority for references. Key issues The 14 forces of magnetism as identified by Unden & Monarch were: 1. Quality of leadership, 2. organizational structure, 3. Management style, 4. Personnel policies and programs, 5. Professional models of care, 6. Quality of care, 7 Quality improvement, 8. Consultation and resources, 9. Autonomy, 10. Community and the hospital, 11. Nurse as teacher, 12. Image of nursing, 13. Interdisciplinary relationships and 14. Professional development. Correlations have been found among positive workplace management initiatives, style of transformational leadership and participative management; patient-to-nurse ratios; education levels of nurses; quality of patient care, patient satisfaction, employee health and well-being programmes; nurse satisfaction and retention of nurses; healthy workplace environments and healthy patients and personnel. Implications for nursing management This article identifies some of the research that provides evidence for evidence-based nursing management and leadership practice.
Umble, K., Steffen, D., Porter, J., Miller, D., Hummer-McLaughlin, K., Lowman, A., et al. (2005). The national public health leadership institute: Evaluation of a team-based approach to developing collaborative public health leaders. <i>American Journal of Public Health</i> , 95(4), 641-644.	Recent public health literature contains calls for collaborative public health interventions and for leaders capable of guiding them. The National Public Health Leadership Institute aims to develop collaborative leaders and to strengthen networks of leaders who share knowledge and jointly address public health problems. Evaluation results show that completing the institute training increases collaborative leadership and builds knowledge-sharing and problem-solving networks. These practices and networks strengthen interorganizational relationships, coalitions, services, programs, and policies. Intensive team-and project-based learning are key to the program's impact Read More: <a href="http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2004.047993">http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2004.047993</a>
Underwood, J. (2012). What contributes to successful health leadership for health equity? Embargoed Confidential Draft: National Collaborating Centre for Determinants of Health.	

<p>Underwood, J., Mowat, D., Meagher-Stewart, D., Deber, R., Baumann, A., MacDonald, M., &amp; ... Munroe, V. (2009). Building community and public health nursing capacity: a synthesis report of the National Community Health Nursing Study. <i>Canadian Journal Of Public Health</i>, 100(5), 11-11.</p>	<p>OBJECTIVES: 1) To describe the community health nursing workforce in Canada; 2) To compare, across political jurisdictions and community health sectors, what helps and hinders community nurses to work effectively; 3) To identify organizational attributes that support one community subsector--public health nurses--to practise the full scope of their competencies. METHODS: Our study included an analysis of the Canadian Institute for Health Information nursing databases (1996-2007), a survey of over 13,000 community health nurses across Canada and 23 focus groups of public health policy-makers and front-line public health nurses. RESULTS: Over 53,000 registered and licensed practical nurses worked in community health in Canada in 2007, about 16% of the nursing workforce. Community nurses were older on average than the rest of their profession. Typical practice settings for community nurses included community health centres, home care and public health units/departments. To practise effectively, community nurses need professional confidence, good team relationships, supportive workplaces and community support. Most community nurses felt confident in their practice and relationships with other nurses and professionals, though less often with physicians. Their feelings about salary and job security were mixed, and most community nurses would like more learning opportunities, policy and practice information and chances to debrief about work. They needed their communities to do more to address social determinants of health and provide good quality resources. Public health nursing needs a combination of factors to succeed: sound government policy, supportive organizational culture and good management practices. Organizational attributes identified as supports for optimal practice include: flexibility in funding, program design and job descriptions; clear organizational vision driven by shared values and community needs; coordinated public health planning across jurisdictions; and strong leadership that openly promotes public health, values their staff's work and invests in education and training. CONCLUSION: The interchangeable and inconsistent use of titles used by community nurses and their employers makes it difficult to discern differences within this sector such as home care, public health, etc. Our studies also revealed that community nurses: thrive in workplaces where they share the vision and goals of their organization and work collaboratively in an atmosphere that supports creative, autonomous practice; work well together, but need time, flexible funding and management support to develop relationships with the community and their clients, and to build teams with other professionals; could sustain their competencies and confidence in their professional abilities with more access to continuing education, policies, evidence and debriefing sessions.</p>
<p>Valaitis RK, Rajsic CJ, Cohen B, Leeseberg Stamler L, Meagher-</p>	<p>The Canadian Schools of Nursing (CASN) task force on public health was mandated to facilitate Schools of Nursing to provide students with the foundation required to meet the Canadian Community Health</p>

<p>Stewart D, Froude SA. (2008). Preparing the community health nursing workforce: Internal and external enablers and challenges influencing undergraduate nursing programs in Canada. <i>International Journal of Nursing Education Scholarship</i>, Volume 5: Article22. doi: 10.2202/1548-923X.1518.</p>	<p>Nursing Standards of Practice. This paper reports on an environmental scan that explored barriers and enablers influencing the integration of community health nursing content in baccalaureate education in Canada. Data was collected over three phases including: 1) a pan-Canadian survey of nursing schools, 2) completion of open-ended workbook questions by educators, policy makers, administrators, and community health nursing managers attending a pan-Canadian symposium on community health nursing, and 3) recorded notes from the symposium. The response rate for the survey was 72.5% (n = 61 schools) and approximately 125 stakeholders participated in symposium activities. Internal and external enablers and challenges as well as recommendations for practice and education are presented.</p>
<p>VanderPlaat, M., &amp; Teles, N. (2005). Mainstreaming social justice: Human rights and public health. <i>Canadian Journal of Public Health</i>, 96, 34-36</p>	<p>Our interest in a human rights and health discourse emerges from our efforts as social scientists to bring a meaningful social justice perspective to the realm of public health. In Canada, as in many countries, "health" is still firmly within the domain of the biomedical and the clinical. While considerable effort has been made to include more social, economic, and cultural perspectives, efforts to frame these issues as political phenomena have tended to be polarized into either a rich body of theoretical literature or case studies of interventions which have in varying degrees incorporated a social justice approach. What is still missing is a framework of discourse that allows various concepts of social justice to inform policy, intervention strategies, evaluation and evidence-based measures of effectiveness. This commentary examines the human rights discourse as conceptual space from which to build this framework.</p>
<p>Williams, P. (2011). The life and times of the boundary spanner. <i>Journal of Integrated Care</i>, 19(3), 26-33.</p>	<p>The purpose of this paper is to explore, in some depth, the role and nature of boundary spanners a dedicated cadre of people who operate within collaborative arenas; to identify the particular skills and competencies that they exhibit; and to reflect on the tensions and ambiguities that they face in their everyday work. Design/methodology/approach The author presents an analysis of the recent history of UK health and social care in relation to the role "boundary spanners" a valuable and distinctive class of "actor", operating within intra- and inter-sectoral collaborative environments, including partnerships, alliances, networks, consortia and forms of integration. Findings Boundary spanners have a distinct role to play in managing the highly interdependent and collaborative arenas that are designed to manage health and social care, and they undertake this by deploying a range of competencies, supported by relevant knowledge, experience and personal attributes. The valuable role that boundary spanners play must be reflected in appropriate investment in their training and development. Originality/value</p>

	Reflections are directed towards the training and development of boundary spanners as an important role in health and social care.
Winnipeg Regional Health Authority. (2012). Community team manager competencies. Winnipeg, MB: Winnipeg Regional Health Authority.	<ol style="list-style-type: none"> <li>1. Health and Social Science Knowledge</li> <li>2. Assessment and Analysis</li> <li>3. Policy, Program Planning, Implementation and Evaluation</li> <li>4. Partnerships, Collaboration and Advocacy</li> <li>5. Diversity and Inclusiveness</li> <li>6. Communication</li> <li>7. Leadership <ol style="list-style-type: none"> <li>7.1 System and Organizational Results</li> <li>7.2 Build Capacity and Improve Performance</li> <li>7.3 Team Building and Conflict Management</li> <li>7.4 Problem Solving and Decision Making</li> <li>7.5 Administration and Resource Management</li> </ol> </li> <li>8. Professional Responsibility and Accountability</li> </ol>
Wong, M. (2007). Transformational leadership and job satisfaction of advanced practice nurses in public health setting.	<p>The United States faces a nursing shortage that may cause nationwide vacancies, potentially jeopardizing the population's health. Advanced practice nurses (APNs) in public health settings are key players in promoting and maintaining health for the community, and APNs' leadership skills may bring real changes to society. This non-experimental correlational quantitative study explored the relationships among transformational leadership, organizational commitment, job satisfaction, and intent to leave the nursing profession. One hundred twenty-one APNs in public health settings in a southwestern state of the United States were surveyed. The data demonstrated leadership was the primary factor contributing to the promotion of organizational commitment, increased job satisfaction, and the employee retention. The statistical technique of structural equation modeling was used to determine the degree to which the factors transformational leadership, organizational commitment, and job satisfaction were related to nurses' intent to leave their employment. The APNs, the respondents of this study, scored high in their leadership skills and were intent to stay in their jobs. Furthermore, job satisfaction was positively correlated to commitment to the organization and leadership behaviors. These findings may allow educators, researchers, administrators, and policy makers to develop strategies to retain nurses in order to sustain the health care system. This study provided insight into the relationships among leadership skills, job satisfaction, and retention of staff</p>

	<p>nurses. The implication of this study may be useful in nursing education, health care policy making, and organizational research to promote patient care and nurse retention.</p>
<p>Wright, K., Rowitz, L., Merkle, A., Reid, W. M., Robinson, G., Herzog, B., et al. (2000). Competency development in public health leadership. <i>American Journal of Public Health</i>, 90(8), 1202-1207.</p>	<p>The professional development of public health leaders requires competency-based instruction to increase their ability to address complex and changing demands for critical services. This article reviews the development of the Leadership Competency Framework by the National Public Health Leadership Development Network and discusses its significance. After reviewing pertinent literature and existing practice-based competency frameworks, network members developed the framework through sequential use of workgroup assignments and nominal group process. The framework is being used by network members to develop and refine program competency lists and content; to compare programs; to develop needs assessments, baseline measures, and performance standards; and to evaluate educational outcomes. It is a working document, to be continually refined and evaluated to ensure its continued relevance to performance in practice. Understanding both the applications and the limits of competency frameworks is important in individual, program, and organizational assessment. Benefits of using defined competencies in designing leadership programs include the integrated and sustained development of leadership capacity and the use of technology for increased access and quality control Read More: <a href="http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.90.8.1202">http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.90.8.1202</a></p>



