National Collaborating Centre for Determinants of Health

Centre de collaboration nationale des déterminants de la santé

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PART OF THE
LEARNING FROM PRACTICE
SERIES

STILL SWIMMING AGAINST THE TIDE?

A FOLLOW-UP STUDY TO EXPLORE ONTARIO-BASED SOCIAL DETERMINANTS OF HEALTH PUBLIC HEALTH NURSES' EXPERIENCES IN ROLE ENACTMENT

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This resource follows the published work:

Swimming against the tide: A Canadian qualitative study examining the implementation of a province-wide public health initiative to address health equity (2016)

Learning to work differently: Implementing Ontario's social determinants of health public health nurse initiative (2015)

Learning to work differently: Summary

Learning to work differently: Key Messages

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Dear Public Health Professional: In your hands is a précis representing a much-appreciated period of time spent engaged with Ontario-based nurses who are practising or recently have practised in the role of the *social determinants of health public health nurse* — or SDH-PHN for short. The goal of our time together was to understand the status of this innovative role since 2015, when the role was first studied and documented,[1] and to update a subsequently published case study identifying the tide SDH-PHNs were swimming against.[2]

In listening to the voices and experiences of a cross-section of SDH-PHNs, as well as perspectives of public health unit chief nursing officers (CNOs), we can conclude that, while the role is much appreciated and considered something to be replicated across Canada, its future has some precarity.

Background

"It is my aspiration that health finally will be seen not as a blessing to be wished for, but as a human right to be fought for."

— Kofi Annan, United Nations Secretary-General (1997–2006)

Why are some people healthy and others not? Taking into account the systemic and structural aspects of health and health equity is a staple of the 2019 Canadian Community Health Nursing Standards of Practice.[3] The social and structural determinants of health enable an upstream and broad equity lens on a myriad of confluent aspects pertaining to health and quality of life. Using such a lens encourages public health professionals to focus and take action beyond so-called individual "choices" or "behaviours." Figure 1 includes some commonly understood social determinants of health (SDH) that Canada's public health nurses (PHNs) consider in their practice and their policy work.

In 2012, the Ontario Ministry of Health and Long-Term Care (MOHLTC) announced a strategy to enhance the capacity of public health units to address SDH and advance health equity for locally identified populations exposed to disadvantage. Through the 9,000 Nurses Commitment, the Ontario government's pledge to increase the nursing workforce, the MOHLTC's Public Health Division secured funding for all 36 public health units in Ontario to hire two new full-time (or equivalent) PHN positions to focus specifically on addressing the SDH.[2] With health equity as the umbrella goal of the initiative, registered nurses considered for these positions had to demonstrate knowledge and expertise in the SDH to further support the program and service needs of specific populations impacted most negatively by determinants of health.

FIGURE 1: Examples of social, economic and ecological conditions that influence health

Reproduced from National Collaborating Centre for Determinants of Health.[4(p6)]

In 2016, National Collaborating Centre for Determinants of Health (NCCDH) staff together with researchers from St. Francis Xavier University and the MOHLTC published a descriptive qualitative case study exploring the first province-wide initiative in Ontario to add SDH-PHNs to each public health unit.[2] This study was underpinned by specific assumptions, including that leadership at multiple levels was essential for successful implementation. Specifically, "public health leadership for health equity is context-specific and is highly relational in nature. Hence, public health leadership that considers context and relational factors is important for the SDH-PHN initiative."[2(p3)]

Their study was guided by the primary research question *What factors influenced the development and implementation of the SDH-PHN initiative in public health?* and the following context-grounded sub-questions:

- What key supports and barriers existed in developing and implementing the policy?
- Which key elements of public health leadership were crucial for developing and implementing the policy?
- What activities were undertaken by SDH-PHNs?[2]

The findings of the study indicated that, while all health units were provided with two SDH-PHNs and the nurses strove to collaboratively partner with communities to effect health equity change, ideological tensions within public health units created impediments to the enactment of the role. In some units, it was felt that addressing the SDH lay outside of public health, whereas SDH-PHNs understood them as the raison d'être of the role and indeed of public health nursing practice. Further, the role was inserted into organizational structures that were not ready for what was for some a seismic shift in perspective. The role of leadership factored large, with a collective call for improved supports for leadership to be able to champion innovative practice to address the SDH and advance health equity, such as the SDH-PHN role.

Follow-Up Project

With these findings in mind, a follow-up project to explore the continued status of the SDH-PHN role was undertaken. In this research, we built on the existing network of SDH-PHNs to reach out to PHNs who are or were in the role since 2015. We are indebted to that network and its leadership for the assistance and response we received.

Purpose of the research

This research project involved the following engagement activities and participants to reach our identified and shared aim:

The Still Swimming Against the Tide Project

3 focus groups

1 SDH-PHN survey

26 SDH-PHNs

4 CNOs

30 total participants

1 common goal:
To explore the enactment of the SDH-PHN role in Ontario since 2015 through the reported experiences and reflections of SDH-PHNs, and to provide the opportunity to share their insights and experiences regarding the innovative SDH-PHN role

Research questions

1. Since 2015, what activities and strategies have SDH-PHNs been engaged in?
2. What supports and challenges to the enactment of the SDH-PHN role are identified by SDH-PHNs?
3. What role do senior leadership, organizational culture and context play in the enactment of the SDH-PHN role and a public health unit's capacity to support the role?
4. Is there an impact of structurally embedded workplace inequities (e.g., devaluing of nurses' expertise and opinions, disempowerment, lack of structures through which to influence decision-making) on health inequity priorities and on the enactment of the SDH-PHN role?
5. From their perspective, to what degree do the activities of SDH-PHNs influence their respective organization's capacity to address health equity action?
6. In what ways has the global pandemic of COVID-19 affected the work of the SDH-PHN?

Engagement Feedback

The experiences of the participating SDH-PHNs are reflected throughout this summary and their voices heard directly in the many quotations highlighting their responses. Contributions from the CNOs who also took part are identified specifically.

How do the SDH-PHNs describe the role?

"Meaningful ... and timely."

"A nursing role that aims to decrease barriers to health."

Participants described their role in intricate yet connected ways. They characterized it as meaningful, timely and widely varied with a shared goal: reducing health inequities. Further, a key aspect of the role is to educate and strengthen organizational and community knowledge and capacity regarding health equity and the contributors to inequities. Theirs is a broad practice that includes numerous activities and services, wide consultations, community engagement, and the intentional and systematic development and/or review of key reports.

Many SDH-PHNs indicated, in fact, stressed that it is a nursing role. It is about finding and mitigating inequities, yes, but also about helping bring people along in their shared understandings of the upstream structural and social causes of health inequities. They view themselves as knowledge brokers, advocates, educators and capacity builders, and, above all else, believe that the role is about effecting change (see Figure 2).

FIGURE 2: Components of the SDH-PHN role

What is the goal of the SDH-PHN role?

"To advance health equity in public health promotion and practice."

In articulating the main goal of the SDH-PHN role, participant responses focused on advancing health equity. Whether it is through improving internal structures to take approaches more congruent with advancing health equity or through knowledge- or capacity-building efforts within one's health unit or community, participants indicated that the SDH-PHN role is meant to advance public health efforts

in health equity and to address the structural and SDH. They identified the advocacy and capacity-building role of the SDH-PHN as central to reducing inequities by ensuring that structural and SDH and health equity concepts and practices are embedded in public health programming and service delivery. One participant saw their role as holding expertise in their organization and championing health equity, while another indicated that the goal is to ensure a health equity lens is applied in all components of public health practice. PHNs emphasized their key goal of building organizational capacity to understand and then act on the contributors to health inequities, including projects related to specific groups and populations experiencing inequities.

Not satisfied with the role being relegated to internal capacity building, many participants expressed having a keen sense of wanting to contribute to the overall health and health equity of the communities they work with, and they named key approaches such as community engagement and development, policy influence and advocacy.

What is the most enjoyable part of the SDH-PHN role?

"Seeing impact at the community level."

Survey responses to this question ranged from enjoyment of the learning opportunities for both themselves and others to the ability to work closely with teams and staff across the public health unit as well as agencies working with those with lived experiences related to structural inequities. PHNs identified that outreach activities that come with an ability to effect changes "at the upstream or midstream levels" bring with them a sense of role efficacy and satisfaction. The SDH-PHN role provides them with the opportunity to "use their vast array of competencies" to "meet people and groups where they are at in a shared process of working towards sustainable and ever-increasing health equity." Interesting work, where change is visible, combined with the opportunity to "amplify the voices" of populations forced into marginalization also factored prominently in PHNs' responses to this question.

The ability to build relationships, the diversity of projects and the autonomy that comes with the role, along with dedicated resources and time allocated to the related work, provide opportunities for SDH-PHNs to read, consult, prepare, research and "stay on top of best practices." To be able to see impact at a community level and know that the PHN had a role in this change was a common reflection.

What is difficult about the SDH-PHN role?

"The role is seen as a nice to have, not a need to have."

The necessity of organizational buy-in and support was identified often by PHNs as a difficult and challenging component of the role. Uncertainty of the role factored prominently, with stories of cuts to funding directed previously towards the role, its cancellation during COVID and its subsequent precarity post-COVID. The predominance of a downstream focus created barriers to the sustained uptake of a structural and SDH focus and action for PHNs specifically and for health units more broadly. Even with wide-ranging efforts of the SDH-PHNs to identify key SDH issues, many indicated difficulties in getting the go-ahead for real and sustained action.

Despite having listed many positives associated with the role, and a key focus on public health unit capacity building, some PHNs identified not having their role necessarily respected by colleagues and needing to "try to convince [public health] people that we need to focus on health equity even though it is stated explicitly in our standards." Combined

with a lack of accountability for how the role was to be enacted, some respondents lamented how their public health unit used the role to fill other gaps in service that had nothing to do with the SDH or health equity. Some PHNs identified difficulties stemming from non-nurses leading programs coupled with a lack of public health experience or focus. Others identified challenges when they were heavily engaged in relationship building, taking a community development approach to their SDH efforts, only to be "pulled out of what we are doing only to the detriment of the relationship. We break trust over and over." Many identified the overarching role of the MOHLTC and the government's direction, and how these changes often did not reflect a commitment to health equity or to communities.

What activities and strategies are the SDH-PHNs involved in?

"It is a difficult position to always be fighting up."

Participants' rich and varied responses indicated that, as both a lens and a commitment, the role affords opportunities to respond to health unit, community and population-specific health equity issues. Many of the PHNs serve on equity-focused committees within their jurisdictions, with some leading the establishment of one within their health units. The following list provides examples of health equity and SDH activities and strategies the SDH-PHNs are engaged in — all of which involve leadership roles and community engagement:

- safe consumption, harm reduction
- poverty reduction, employment strategies
- Indigenous community partnerships, Truth and Reconciliation Commission-informed strategy
- partner-engaged health assessment
- workplace educational sessions, tool and resource development
- engagement with communities forced into marginalization
- anti-racism and equity, diversity and inclusion strategies
- housing strategies, partnering with shelters and community members
- food security
- youth mental health
- awareness building regarding SDH
- program evaluation regarding the infusion of SDH and health equity
- tobacco strategy with health equity lens
- 2SLGBTQI+ safer/positive space strategy
- health equity-informed access to health services strategy
- COVID-19 response with SDH lens

What are enablers and barriers to enacting the SDH-PHN role?

"It should have been nurse-led with less focus on research and policy only."

The SDH-PHNs identified senior and organizational leadership, support and buy-in as the most important enabling factors in their role enactment. Having a manager who "listens, helps strategize, and shares a similar vision" was noted often as an important enabler. Additionally, a manager who is open to the necessary time, creativity and patience it takes to enact the role is seen as a powerful enabler. Health equity guidelines[5] in the Ontario Public Health Standards and the Canadian Community Health Nursing Standards of Practice[3] provide the necessary "teeth" to rationalize the role and the layered approaches it necessitates. Finally, most participants indicated that having an SDH-PHN network is a key support — especially as it is supported externally, that is, not by any given public health unit but by the NCCDH.

PHNs identified that needing to secure senior and organizational support is an important barrier, describing how exhausting it is to advocate for the role when the role is poorly understood and often under threat. This lack of understanding of the role was identified as another powerful barrier. This could be the reason for some health units relegating the role to proxy capacity builders rather than supporting enactment of the full SDH-PHN role and scope of practice.

Other barriers experienced by the PHNs include a lack of decision-making power and inadequate time to engage and collaborate with communities and populations. Further obstacles are hierarchies within the organization, disconnection with upper leadership and thus decision-makers, too many levels of approval and communication, and being denied involvement in strategic and organizational planning.

What is the role of organizational culture in the SDH-PHN's ability to enact the role?

"While disagreements and differences of thought were shaping the health equity decision-making tables, we were not able to move forward in the role."

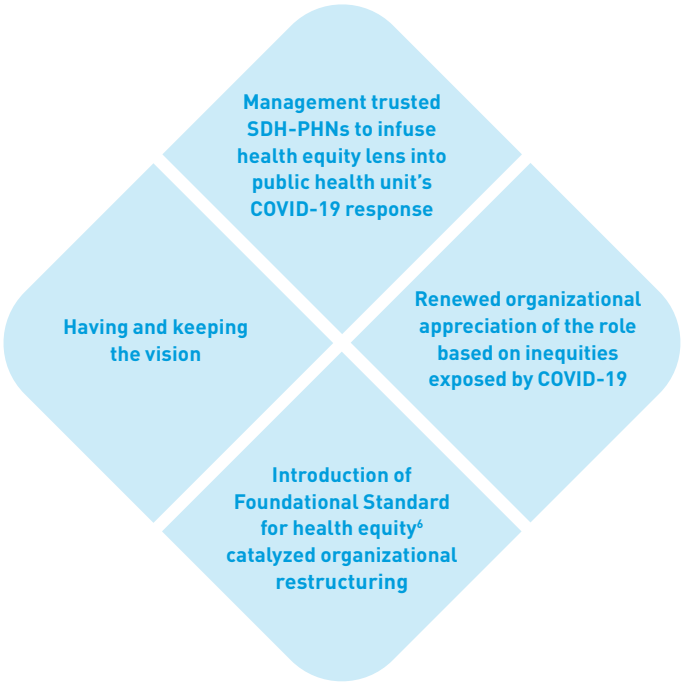
Survey respondents agreed that organizational culture plays a key role in their ability to fully enact their role. They need organizational support for their role, such as buy-in from senior leaders who could provide them with appropriate infrastructure and sufficient resources to plan and implement equity initiatives and meaningful engage with communities. Attributes of supportive organizational culture include trusting and valuing the work and expertise of all PHNs and their specialized skills and relationships. The responses suggested that support is uneven across departments or significantly lacking. Some respondents characterized organizations as top-down layers of management beset by leadership crises, slow decision-making and a risk-averse culture. Lack of leadership consensus on the SDH-PHN role, resistance to hearing from point-of-care and health equity staff, and a prevailing downstream focus contribute to challenging organizational cultures for role enactment.

For other respondents, support for health equity in the whole organization as an "entrenched value" is so strong that not just SDH-PHNs but also PHN colleagues are undertaking health equity-focused initiatives. However, even where there is strong overall support for the role, there are challenges, such as devaluing of SDH-PHN leadership contributions as reflected in lack of integration of their role in planning and organizational structures and ambiguous reporting processes.

"If management and decision-makers do not support an initiative, do not see the importance or value in it (even with evidence), then I will not be able to use this role to its full potential."

Still, 75% of the SDH-PHNs who were in the role at some point after the onset of COVID described various examples of facilitative organizational culture that support the continuation of the SDH-PHN roles and the use of a health equity lens. Trust emerged as a concept in many SDH-PHN responses, especially related to the need for management to trust the SDH-PHN to infuse health equity into their approaches, which then enable their focus on populations exposed to disadvantage and on community engagement. Figure 3 depicts some ways that support for the SDH-PHN role was fostered within organizational culture.

FIGURE 3: Examples of organizational support for the SDH-PHN role



Conversely, PHNs faced organizational dynamics post-COVID that reflected a lack of vision among leadership to see the potential within the SDH-PHN role. Combined with leadership turnover, this contributed to cultures that, in effect, curtailed their ability to move forward with meaningful health equity strategies that are within their scope of practice. Even with widespread knowledge that the pandemic had exacerbated health inequities for populations living in adverse conditions, once the acute focus on COVID passed, several SDH-PHNs characterized their public health unit focus as on recovery and renewal. They explained that competing public health unit priorities included the need to prioritize internal staff wellness, given burnout and exhaustion, before focusing on SDH and health equity in program planning. SDH-PHNs working in smaller public health units stressed that resources would be moved from SDH-PHN support to addressing gaps in primary health care infrastructure. Others were told to expect more downstream focus and approaches in public health units, exacerbating uncertainties about the future of the SDH-PHN role, especially in light of the disruption to community partnerships that had been forged previously. Survey respondents reported that in some public health units, SDH-PHNs had not been moved back into the role. Given these uncertainties, some respondents anticipated challenges ahead in their attempts to re-establish their community partnerships and their SDH-PHN role in the organization and communities, where at times their partnership role had been replaced by others in the community and their role in projects had been replaced by a consultant.

How might the activities of the SDH-PHN influence an organization's capacity to take action on health equity?

"The SDH-PHNs can be the eyes and ears of the community members served, assuming there is support from management, and bring back the stories, needs and sights to decision-making tables at the [health unit]. With SDH-PHN knowledge of primary health care, SDH-PHNs can envision, together with communities, better outcomes ... and then make real, tangible efforts to get there."

The survey respondents shared several strategies that characterize how SDH-PHNs perceive that their activities could influence their organization's capacity to take action on health equity and SDH. For instance, PHNs provide evidence-informed information on best practices regarding health equity and SDH and planning tools that embed health equity and health equity impact assessment in development of programs to help enable a cultural

shift towards addressing health equity and SDH in communities. Given that the SDH-PHN role has been primarily used towards internal capacity building, PHNs described their involvement and leadership in developing equitable planning tools and processes that facilitate action, oversight for equity-facing committees and projects, and staff support for development of program logic models that embed equity-related frameworks and concepts.

SDH-PHNs use varied communication strategies to motivate colleagues to engage with health equity work with populations exposed to disadvantage and to build public awareness of SDH and health equity. Examples include SDH-PHN knowledge exchange activities and leadership that showcase the impact of the SDH work within the organization, and the development of communication products to raise awareness of the importance of SDH and health equity with communities and the public. Some respondents identified strengths and principles that SDH-PHNs bring to their practice and to these activities that are aligned with a relational focus, prioritizing community voice and partnerships to inform action.

Further examples provided by PHNs include how through "partnerships created between the SDH nurse and external partners, they can [collectively] determine what initiatives the health unit can be part of" and a "strong ability to complete research (e.g., literature review) can help the health unit determine how to complete equity and [SDH] work." As one PHN stressed, "There is always someone at the table with health equity considerations top of mind no matter what program, service, policy or procedure is being developed or reviewed." This reflects an example of how "the SDH-PHNs' activities have potential to bridge people's health needs in the community and the health unit's ability to take action and [effect] such change."

How did the SDH-PHN role change with the global pandemic?

"I was not able to focus on any true [SDH] and equity initiatives or work."

"I was pulled out and placed into various roles even though I advocated the importance of the role in this pandemic situation. What did happen though, is the equity lens was brought with me into all of the roles I was placed."

Numerous participants described how their role was diverted away from equity work in order to support pandemic public health activities, including information lines, vaccine clinics, case and contact management, and others. The language they used was being "pulled out" of their role. While many indicated that the pandemic prevented a continued focus on any true SDH and equity work, others noted that the lens they had on SDH and health equity did not change. Despite redeployment, some SDH-PHNs appeared to seamlessly practice from a health equity lens from one situation to the next.

Some participants described how advancing health equity was a core role regardless of context — but they added this was of their own doing rather than an administrative directive. Others, though rare, were able to continue in the SDH-PHN role, including, for some, completing a health equity impact assessment on how the pandemic impacted certain populations exposed to disadvantage. For those able to continue in the role, their own self-advocacy and leadership skills were central to rationalizing the role's ongoing necessity.

What has the global pandemic demonstrated for the SDH-PHN role going forward?

"It has highlighted the major inequities that exist on a global level. This is the first time we (humans) have tried to tackle a wicked problem on this scale. We failed."

Many participants articulated a root-cause understanding of the overall role of the SDH-PHN role and identified the ways in which the pandemic exposed existing inequities, the inadequacy of many structures and systems, and the political context within which the pandemic unfolded. Many also highlighted that the pandemic was a proof of concept for the necessity of health equity approaches to public health, with some lamenting that the SDH-PHN role was not seen as central in a pandemic. Some PHNs noted that the populations identified as "at risk" before COVID were the same populations who had inequitable access to health services during the pandemic.

"It's really too bad we do not leverage the skills and abilities of staff. We are good at cutting wings."

Further, respondents identified that the importance of community engagement was even more prominent during the pandemic — and how it is a key ingredient of the SDH-PHN role in order to best understand the experiences of populations and then shift approaches based on the priorities and needs of the population itself.

"[The pandemic] showed how the structural determinants of health are cement and withstood a global pandemic and remained unchanged."

The PHNs found that movements such as Black Lives Matters, #MeToo and others, once global, helped health units and decision-makers accept the need to infuse the SDH into the collective work. Participants consistently maintained that the SDH-PHN role should not have stopped during the pandemic, and they are concerned about lost community relationships and the need, in some instances, to start over.

As the pandemic shifts to an endemic, how do SDH-PHNs see the role and what are they now doing? What supports exist now for the role?

Fifteen respondents had returned to their role, whereas others indicated the future of the role is unknown. Of those who had returned to the role, seven said their role had diminished, five returned to their role with a focus on equity, one said their role was maintained, one said their role was expanded, and one said they returned but the future focus is unknown. The participant for whom the SDH-PHN role had been expanded within the health unit explained this was a result of "new leadership ... more tuned in to the realities of [health equity] and the needs exacerbated by COVID." The one participant who returned with future focus unknown said, "I have returned to the role, but how the organization values the role is TBD."

Half of the respondents indicated there is no support, they are not sure about any support or they do not know of any support for their SDH-PHN role. Of those PHNs who said there is support for the role, two indicated that that support is themselves — they have the ear of people who can influence decision-makers and it is up to them to demonstrate the value of the role. Some PHNs indicated they think there is

support from their leadership, and several named the self-organized SDH-PHN community of practice as a key support for the role. Other participants named external support for the role including this research, the NCCDH, the Ontario Public Health Association, key legislation, and other equity leaders and organizations.

What hopes and concerns do SDH-PHNs have regarding the role?

"I don't believe we have utilized the role to the extent we can."

The SDH-PHNs all hope that the role can continue and will be protected. They want the focus of the role to be on health equity, versus it being an add-on behind more traditional foci of public health. They hope that the role will be valued, funded and recognized by decision-makers. They also hope they do not need to continue focusing on capacity building within their organizations so they can get out into their respective communities. Many wish that the role might serve as an inspiration for other jurisdictions and be augmented with stronger support for equity work in the Ontario Public Health Standards.[6]

Participants are worried about the role being diminished due to funding cuts and redirection of funding to other priorities. Several noted concern that those currently in the role are not being replaced when they leave or retire. Another concern is the shifting focus of the role, in particular, being directed to focus their work on organizational needs and not being able to sustain their engagement with communities. With almost constant reorganization or threat of amalgamation, there is unease that there is not the vision and energy to keep the role alive and growing.

Many participants spoke about the notion of action or lack of action at a local level that is evident, pointing to a valuable but limited internal focus on capacity building where organizations are seemingly "stuck in an endless loop of just prioritizing awareness strategies" rather than then being able to move into action mode. Participants envisioned needed actions as those undertaken in collaboration with communities and other partners that aim to foster meaningful and tangible change to meet community needs. A participant expressed concern "that denial, deflection, tokenism and gaslighting will continue." Other participants said they are concerned about the equity focus of their work. They stated that health equity work takes time and that the MOHLTC mandate is "very vague and does not provide a health equity lens," thus impacting and diluting the work of SDH-PHNs.

Participants are also concerned that some people believe health equity is firmly enough established within health units that funding can be redirected, and that other competing priorities will replace this work. SDH-PHNs find themselves "working against the hand that feeds us" when the political party in power is not knowledgeable or supportive of SDH and making changes to improve the health of the people. One participant raised concern about a societal world view that "those who do without will never be accepted or recognized as being important or feel deserving."

What suggestions do SDH-PHNs have for other Canadian PHNs considering this innovative role for their own organizations?

In contrast to SDH-PHNs' feedback about their concerns and the uncertain support for the role, they responded to this question with pride in their work and the belief that they have made a difference. Their advice to other nurses is to embrace this type of role as it is worthwhile and rewarding, even though for some it is the most difficult and challenging work in public health nursing they have undertaken.

Many participants noted the opportunity the role provides them and their organizations to advance health equity by addressing the SDH. One PHN advised others starting off in the role to "be quick ... to build relationships with as many community partners as you can [and] help your nonprofits and charities as much as possible." Another advised that this role is an "opportunity to promote social justice [and] influence upstream policies which ... promotes health equity at the population level." The role provides an opportunity to do "so much good to address health inequities." Others stated that the role of the SDH-PHN is that of a trailblazer and that it "is a great role to have at any health unit as it helps setting the foundation of all the work done within the health unit — be it with internal program or external partners." "Overall this has been the most rewarding role in public health I have experienced!"

"In my years of practice, this role has had the ability to create the most change for the various populations while keeping them central to their wanted outcomes."

The SDH-PHN role was further described as one "that can actualize change when it comes to health equity." One participant affirmed that the role is "an excellent way to embed health equity into ... [health unit] programs and services therefore enhancing the overall health of the community." Respondents urged that "we can make this role standard and expected part of PHN practice nationally" and "this role can be an exemplar for the rest of the world!" They encouraged other Canadian PHNs to reach out to the Ontario SDH-PHN community of practice for support in developing this role.

SDH-PHNs also cautioned that the role is not an easy role, it requires hard work, and at times it is very lonely. They further advised that relying on their "inner strength and believing" became vitally important. Several participants identified this role as the best and hardest role they have undertaken and stressed the need to continually seek to increase their knowledge.

Participants talked about the need for support and understanding of the role at an organizational level, clarity in the role description and responsibilities, MOHLTC support, and a "provincial network for those in the role to facilitate support and collaboration." Several advised that supportive leadership is critical to the success of this unique role, along with trust and respect of others and the organization. SDH-PHNs need to be supported as valued members of the health unit with institutional power to use their strengths.

"Having a core group of professional SDH-PHNs funded to focus on this work and build their own and the organization's knowledge and experience, and who can initiate and maintain trusting and effective relationships with community partners and other organizations, increases an organization's capacity to maintain a focus on addressing health equity for clients in coordination with partners."

What we learned from CNOs

"The fact that [the role] exists is a really good thing."

— CNO participant

The CNOs who took part in the focus group affirmed the value and importance of the SDH-PHN role, with each participant keenly aware of its scope within their own health unit and the ways in which it changed during the global pandemic. Four key themes emerged from our consultation with these wise leaders:

1
The CNOs unanimously see this role as highly valuable and are actively seeking ways to augment or reinstitute the role in their health units.

2
Role balancing and role precarity factored largely in the reflections of the CNOs.

3
SDH-PHNs having to serve as proxy organizational capacity builders inhibited the full enactment of the role.

4
System (macro/structural) change is needed to support CNOs to support SDH-PHNs.

As key public health leaders in Ontario, CNOs shared that numerous daily pressures impeded their own capacity to participate in focus groups. Tasked with leading reorganization efforts, many were unable to participate in this study despite unanimous expressed desire to reflect on the SDH-PHN role. However, for those who did, their input and reflections were rich. These CNOs noted the importance of the focus on the SDH for public health nursing and the potential for expanding the PHNs' scope, highlighting their strategic leadership skills and voice. They identified role tension and precarity and need for system change so that the role, which they all value deeply, could continue to be enacted and enacted strongly. CNO participants talked about the challenges and difficulties of continuously needing to balance roles (back and forth from urgent and ongoing on-the-ground health equity practice with families and communities, on the one hand, and supporting competency education on health equity across the health unit on the other) — also referred to as "role tension" where SDH-PHNs are expected to train others as well as do front-line work.

The CNOs provided numerous examples of the fluid nature of SDH-PHNs' capacity to move between community-based nursing practice and roles that involve actions such as education and strategic planning. They described how the SDH-PHNs are often proxy organizational capacity builders (organizational capacity building in action), taking on an overall organizational role of integrating health equity into organizational staffing tools, environmental scans and so on.

Several CNOs described how, initially, there was no apparent overall or identifiable organizational capacity frame for implementing the role. CNOs also described how the SDH-PHN role itself was consistently under threat of being eliminated and/or redeployed to existing PHN roles due to the urgency of COVID-19 impacts on their communities. Despite role precarity, role stoppage and redeployment, CNO respondents remarked on SDH-PHNs' willingness and initiative for reintegrating the role after the initial pandemic crisis had lessened. The lessons afforded by the pandemic —

lessons reinforcing the structural awareness and competency associated with the role's goals and objectives — serve as rationale for CNO efforts to reinvigorate the role. CNOs also described the need for an organizational evaluation of the effectiveness of the SDH-PHN role in terms of potentially strengthening its success. Finally, and perhaps most importantly, the CNOs collectively urged that meaningful role integration and expansion will need structural support and resourcing to demonstrate that SDH-PHNs are indeed valued by the organization.

"Health equity has been mentioned a few times in our strategic planning piece. My hope is that the role will be able to be to be brought up in a in a more — what's the word I'm looking for — not enhanced but in a more prominent way, as is built into our ... strategic planning as well to that health equity lens [now that] we do have a job description for it."

— CNO participant

Confirming what we already knew

"While understood as having value, the SDH-PHN role continues to be precarious."

What we discovered is not new, nor a shock. The SDH-PHN role is valued by many and understood to effect change. However, its presence is precarious, with its scope dependent on organizational support and the ever-shifting external factors considered more important or pressing. While there has been some depletion in personnel serving in this role since 2015, for PHNs whose roles continued, the activities and strategies have shifted slightly to those more associated with community development. What has remained the same is the relegation to in-house training of public health personnel. For some PHNs, it is seen as an effort to continually convince people that this is an important lens.

"Patient and unwavering organizational buy-in is a key enabler of the role."

Organizational buy-in for the SDH-PHN role continues to be needed, and in many health units, CNOs also face barriers in being heard regarding the role's importance and requisite scope. There continues to be a lack of infrastructure where the voice of the SDH-PHN might influence role enactment. For some PHNs, this felt like a structural devaluation of their views and expertise. While it was important for any and all public health units to pivot during a global pandemic, there were only a handful, at best, of SDH-PHNs who were explicitly empowered to continue in their role in order to integrate an important health equity approach into their workplace's COVID response. For all the participants we engaged with, this was a visceral missed opportunity.

"Unless the nurses are out in the community, listening, bearing witness and building relationships, the role will stagnate to an ideology versus an action."

A key barrier to the enactment of the SDH-PHN role is the lack of recognition and permission for the PHNs to take the time needed to immerse themselves in communities and spend time listening in order to understand a community's strengths and self-defined priorities. Almost 75% of the SDH-PHNs surveyed reported occasionally, rarely or never spending time immersed in building capacity with populations experiencing disadvantage. Without this engagement, the role becomes one in name only. Further, the trust necessary to allow the PHNs to voice what they witness and understand remains precarious itself as public health units grapple with doing equity work while ensuring not to ruffle feathers. For PHNs to be able to advocate for the "conditions that influence a healthy and dignified life,"[4(p6)] their relationship with their communities must be better respected. They need time to immerse, bear witness and then act. With mixed messages about valuing the role on the one hand but tethering the SDH-PHNs to in-house capacity building on the other, the SDH-PHN role will remain precarious at best and tokenistic at worst.

Still Swimming Against the Tide — But the Currents are Different and Stronger

Ideological tensions as a key reason for the need to swim against the tide appear to have lessened since 2015. The understanding of the importance of an SDH lens on health and health equity appears to have firm footing within public health, despite the continued in-service training of employees on health equity. But there now are other aspects that continue to impede the role, further necessitating a balance between treading water and swimming against a tide. These include seeing the SDH as a nice-to-use lens versus a requisite lens despite the evident lessons provided by the COVID-19 pandemic. Below, we comment on a few causes of the tide, followed by some recommendations and key takeaways.

Continued relegation to internal capacity building prevents the full enactment of the role

A new strategy is needed to teach new and continuing staff about health equity and the structural and SDH. Modules could be developed and folded into in-servicing roles of other health unit employees. The SDH-PHNs' expertise must be tapped based on their community engagement efforts — from their very real boots-on-the-ground efforts rather than their abilities to explain the concepts alone. They must be afforded the space to enact the full scope of their SDH-PHN role.

CNOs support the role but face their own systemic barriers

"There's absolutely no reason why these nurses can't have a much stronger voice and really lead this work much more strategically."

— CNO participant

All of the CNOs expressed support for the role, and while buy-in from the CNO is key, so too is buy-in from the SDH-PHN's direct manager. Organizational support coupled with an infrastructure that facilitates the enactment of a health equity lens is critical in order for this role to thrive.

Community voices must be prioritized

Central to public health nursing practice is listening. In order to witness, advocate, mobilize and effect meaningful change in the well-being of individuals, families and communities, public health units must facilitate the immersion of PHNs in communities again. The SDH-PHN must be untethered from their office and their desk. They have to be afforded the time it takes to earn trust, link with key informants and partners, and have countless conversations that cumulatively afford us the privilege of understanding the real answer to the question "Why are some people healthy and others not?" To prioritize community voices means community-based efforts must be undertaken to hear them.

It is about trust

Nurses in general and PHNs more specifically situate relationship building at the centre of their practice. Indeed, relationships with their communities is folded into the social mandate of Canada's PHNs. The SDH-PHNs told us that it takes time to earn the trust of a community in order to bear witness to their lives and the structural determinants of their health and well-being. They longed to be provided the time needed to earn that trust. However, what was missing for them was organizational trust in them to be away from the office and their desk in order to immerse themselves in communities, one interaction at a time.

The external context of the tide calls for moral courage over fear

PHNs and public health units are affected by external contexts by virtue of where they are situated provincially. Various provincial landscapes have recently shown a reluctance to support health equity directions, leading to a reluctance among public health units to be seen as "too political." When public health unit funding is contingent upon the political party in power's lens on public health work — this may be the biggest tide that the SDH-PHN, CNO and public health unit writ large have to overcome. Similar to the social mandate of PHNs, public health units' social mandate is equally important, and speaking up and taking action on issues of health equity must be deemed a part of public health's social mandate.

Key Takeaways

"The role is necessary and needs internal support!"

- SDH-PHNs enjoy their role but experience a constant uphill battle — they are still swimming against the tide.
- For the most part, the SDH-PHN role remains a nice-to-do versus a must-do for public health units.
- The enormous and varied value of the role and significant possibilities for health equity impact are demonstrated in this study.
- Role precarity intensifies SDH-PHN dissatisfaction with the role.
- Lack of a consistent role definition also brings opportunity for nurses to "run-with-it!"
- The SDH-PHN role fully aligns with the Canadian Community Health Nursing Standards of Practice.[3]
- The SDH-PHN role is largely dependent on overall organizational capacity to support health equity.
- The creative expertise and leadership enacted by the SDH-PHNs validates the capacity of public health and public health nursing to effect upstream and structural change associated with health equity.
- The health of individuals, families, communities and populations is the work of Canada's PHNs and best addressed through an applied SDH lens.

Recommendations

An important message from SDH-PHNs can be summed up as: This role represents a compelling opportunity for public health units across Canada to enable PHNs to live our scope of practice according to our standards: To witness, advocate, capacity build, effect change.

- Ensure that SDH and health equity are central tenets of each health unit's strategic plan, and measure the impacts of the SDH-PHN role according to this strategic priority.
- Equip decision-makers with a comprehensive educational foundation in SDH, health equity and the wide scope of the PHN.
- Prioritize and support community engagement to advance equity practice and policy development grounded in SDH.
- Ensure organizational supports for PHNs so they can engage with communities for prolonged and intentional community mobilization efforts.
- Incorporate health equity as a foundational value of public health organizational structures, and formally link the SDH-PHN role to this value and strategic priority.
- Prepare PHNs to lead health equity work at strategic points in health and social system structures.
- Demonstrate specific and measurable support of an equity lens in evidence-informed decision-making at all levels of health systems and related organizations.
- Evaluate the impacts of reliance on SDH-PHNs for in-house SDH training and professional development in terms of diversion from community-engaged health equity practice.
- Reprioritize community engagement as a core professional practice imperative for all PHNs.
- Promote understanding of the Canadian PHN role by revising the (2010) *Public health~community health nursing practice in Canada: Roles and activities*[7] document to reflect the (2019) Canadian Community Health Nursing Standards of Practice,[3] and disseminate it widely.

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