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Political Advocacy: Beliefs and Practices of Registered Nurses

By

Crystal D. Avolio

A Thesis

Submitted to the Faculty of Graduate Studies

through the Faculty of Nursing

in Partial Fulfillment of the Requirements for

the Degree of Master of Science at the

University of Windsor

Windsor, Ontario, Canada

2014

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Political Advocacy: Beliefs and Practices of Registered Nurses

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January 15, 2014

AUTHOR'S DECLARATION OF ORIGINALITY

I hereby certify that I am the sole author of this thesis and that no part of this thesis has been published or submitted for publication.

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ABSTRACT

Professional governing bodies of nursing have claimed that registered nurses have a responsibility to fulfill their social mandate of political advocacy. Little is known about how nurses can accomplish this task. An exploratory, descriptive study (N=201) was undertaken to examine registered nurse's beliefs and practices regarding the concepts of politics and advocacy and secondly, to explore if nurses believe political activism to be a function of their advocacy role. Results suggest that nurses believe it is important to be politically active and report an interest in learning more about politics. The majority of nurses agreed that politics is the concern of nurses and agreed with a statement suggesting that it was the duty of the nurse to be politically active. Despite these findings, nurses were only moderately active and just 30 % of respondents stated that they were motivated to become more involved. Implications for nursing include personal and professional commitments, educational preparation in political science, democracy, policy analysis and civic engagement, increased membership in professional organizations and workplace professional development in the political domain.

DEDICATION

I would like to dedicate this work to my husband Angelo who always reminds me that I have been a student for as long as we have known each other (over 20 years). Without his commitment to our children and family life, this study would not have been possible. I thank him for his support and encouragement. To my children, Dane, Vanessa and Andrew who have witnessed the efforts and have completed their own homework alongside Mom in order for us to spend time together. I appreciate your help while stamping, addressing and stuffing 1000 envelopes and reminders with me. It is my hope that you will always value education as a gift and embrace a life time of learning.

I would like to thank my father Richard who has always been my loudest and most devoted cheerleader in life. To my mother Rita who demonstrated to me since a young age a strong work ethic and dedication in providing for her children.

ACKNOWLEDGEMENT

I would like to acknowledge the support and patience of a wonderful advisory committee, Dr. D. Kane, Dr. D. Rajacich and Dr. K. Lafreniere. The entire thesis process has taken me much longer than I care to remember. My motivation has persisted as a result of Drs. Kane and Rajacich who have been a constant source of encouragement and support during this process. They were able to identify positives and recognized the value of the study at times when I was discouraged and unsure.

Dr. K. Lafreniere, I appreciate your participation on the advisory committee despite your overwhelming commitments within your own faculty. I thank you for your insight and knowledge on matters of process and statistics. I appreciate the challenges that you presented to me during the thesis proposal.

A special thanks to a colleague and new friend Christin Moeller who was kind in sharing both her time and research experience. Christin helped me to maintain my excitement for the project, provided clarity with new perspectives and provoked my confidence while working through the statistical analysis. You are an amazing scholar and researcher and I have learned a lot through you.

Last, thank you to my fellow University of Windsor students and colleagues who took the time to attend the oral thesis proposal. I appreciated your support and wish you the best in your own academic endeavours.

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Political Advocacy: Beliefs and Practices of Registered Nurses

Of all healthcare professionals, nurses are the closest to clients and consumers of health care (Ennen, 2001). Nurses bear witness to inadequacies in the health care delivery system and the negative effects that social issues have on health; however, "many nurses have not considered it their place to challenge the structure of the health care delivery system or the rules guiding that system" (Des Jardin, 2001, p. 614). Nurses work in environments that are driven by political decisions and are governed by health care policies that are political in nature (Des Jardin). It is unclear how many nurses thoroughly understand the processes of the health care system including problems such as access, quality and costs. Few do not understand the political processes that contribute to these system failures (Harrington, Crider, Benner & Malone, 2005). There is a need to explore the disconnect between nurses' awareness of health-system related issues and one's ability to perform the role of nurse activist to advocate for change.

Advocacy is a professional nursing value based on the nurse-client relationship that dates back many decades (Bu & Jezewski, 2006; Ballou, 2000). There are many examples of nurse activists throughout history including Florence Nightingale, Lillian Ward and more recently street nurse, Cathy Crowe. Today the concept of advocacy is dominant throughout the College of Nurses of Ontario (CNO) Standards of Practice, which guides and supports nursing practice throughout the province. International nursing organizations urge nurses to become more active to address population-level health issues on a global scale. Professional nursing associations such as the Registered Nurses Association of Ontario (RNAO) exist to represent the issues relative to the health of clients and the profession of nursing; however, membership totals represent less than

30% of all Ontario nurses. Nurses are disengaged from the political activities of the past and the mandate of our current leaders today. "What has happened to the legacy of early nurse leaders? Is it still not relevant in the 21st century? If it is not, when did socio-political activism slip outside of nursing's social mandate, as some have suggested?"(Falk-Rafael, 2005, p. 214).

Significance to Nursing

Nurses working in the acute hospital sector account for 61% of the nurses employed in Ontario (CNO Membership Statistics, 2012). Although nursing work performed at the bedside or "micro-level" activities serve the needs of clients and families, it does not address the larger "macro-level" or policy issues affecting the socio-political concerns of the greater public (Ballou, 2000; Falk-Rafael, 2005). According to professional regulatory bodies, registered nurses have an obligation to fulfill the profession's social mandate.

The College of Nurses of Ontario's (CNO) mandate is public protection through the regulation of nursing professionals. Nurses demonstrate accountability for the public through advocacy of individuals, the profession and the healthcare delivery system (CNO, Professional Standards, 2002). According to the Professional Standards, nurses at all practice levels can demonstrate leadership as a change agent for the patient, address workplace and nursing profession through conflict resolution, participate in nursing associations and guide and coach nursing projects (CNO, 2002). Political competence is our legacy and mandate, and needs to be stressed as a means to addressing the continuous health-related needs of society (Rains & Barton-Kriese, 2001).

The Canadian Nurses Association (CNA) is the national professional voice of registered nurses in Canada. The collective nursing associations from across Canada work collaboratively to advance the practice and profession of nursing to improve health outcomes and strengthen Canada's health care system (CNA, 2012). The CNA has dedicated five years to the development of the document titled "Social Justice…a means to an end, an end in itself" (2010). It elaborates on one of the seven values in the organization's Code of Ethics of promoting justice. Social justice is defined as, "the fair distribution of society's benefits, responsibilities and their consequences" (CNA, 2010, p. 10). The document further examines the concept of justice through comparison of social groups, examines root causes of disparities and explores possible resolutions. According to Smith, Baluch, Bernabei, Robhm & Sheehy (2003), individuals and members of professions are obliged to act responsibly to eliminate forms of inequality and oppression. What activities can nurses and the nursing profession take towards abolishing preventable disparities? Nurses are prompted to pursue roles of advocacy, collaboration, policy change and social responsiveness in order to advocate for change and human rights (CNA, 2010). The Canadian Nurses Association requests responsible action by nurses to lead by example. The determinants of health and the ill-healthcare system are societal in nature and should form the foundation of policy decisions (CNA, 2010).

The International Council of Nurses (ICN) and the World Health Organization (WHO) set the standards for health care communities across the world. Nurses are reminded of their "social and political responsibilities to focus on community, national

and global social policies in which nurses must strive to accomplish through external political action" (Des Jardin, 2001, p. 618).

Nurses need to be both seen and heard at debates that affect health. There is a role for nurses to contribute to health care policy (Des Jardin, 2001; Magnussen, Itano & McGuckin, 2005; Rains-Warner, 2003). Nurses have first- hand knowledge that can lend expertise to discussions that impact such issues as: quality of care, patient safety, cost containment, chronic disease management, equitable access to care and a sustainable healthcare delivery system. More broadly, nurses have an ethical-moral obligation to address the social determinants of health. Nurses continue to be ranked the highest trusted professionals among the public which make them suitable representatives to advocate for health (Ennen, 2001; Leavitt cited in Beu, 2005).

Little is known about how nurses can politically influence the social determinates of health. Acknowledgement alone will not change the "invisibility" of nurses in political settings (Antrobus, Masterson & Bailey, 2004; Boswell, Cannon & Miller, 2005; Spenceley, Reutter & Allen, 2006; West & Scott, 2000). Education and preparation to act politically and utilize skills of advocacy are needed.

The purpose of this research is to first, explore and describe the beliefs and practices of nurses regarding the concepts of advocacy and politics, and secondly, to explore if nurses believe political activism to be a function of their advocacy role. Through examining the advocacy and political experiences of nurses we will gain a greater understanding of the concept of political activism as a form of advocacy. The study will identify the learning needs of the profession which may guide the development

of curriculum and nursing education. This knowledge may assist in providing recommendations for professional organizations to formulate guidelines to better prepare nurses to fulfill their social mandate.

Research Questions

1. How do registered nurses participate in political activities?
2. What do nurses identify as facilitators and barriers for involvement in political activism?
3. What are registered nurses' beliefs regarding their role as a political advocate?

Definition of Terms

Definitions of advocacy vary from study to study in the literature which makes standardizing an acceptable definition difficult. Politics is more broadly defined below including the distribution of resources, influence, power and wealth.

Advocacy

Efforts intended to support and empower clients and/or to act on behalf of others who cannot act for themselves. "Downstream" refers to advocacy efforts on behalf of individuals, while "upstream" activities are social actions aimed at changing legislation, policies, practices, opportunities or attitudes. These advocacy efforts impact large groups of people such as a community or population.

Activism

The activities that nurses participate in to address areas of inequity and unfairness for clients, the profession or health care system, (i.e. voting, writing a letter to a MPP, campaigning, attending demonstrations, etc.)

Politics

"Politics refer to how decisions about the organization of society are made and how resources are distributed. Politics is about power and influence, attitudes and values, and the means of shaping society. Politics is an ongoing exercise in influencing policymakers to act in a certain way." (Raphael, 2007, p. 331).

Social Justice

Social justice examines the fair distribution of society's benefits by focusing on changing practices and social structures that benefit some and disadvantages others. Social justice is a responsibility to social action through partnership with others to address failures in health and social systems that challenge the health of populations (Bekemeier & Butterfield, 2005).

CHAPTER II

Review of the Literature

A review of the literature was conducted using the nursing databases CINAHL and EBSCO searching nursing and the following terms; political activism, political advocacy, political knowledge, political efficacy, political involvement, political competence, political analysis, political engagement, political astuteness, political expression, political socialization, participation and politics, social justice, community advocacy, civic engagement, civic participation, service learning, health policy, policy reform, health policy advocacy, health care restructuring and empowerment. It appears that there was an interest in this research topic between 1985 to the mid 2000s as indicated by the large number of articles revealed in the literature search. Approximately

55 % of the articles were from the United States, another 21 % originated in European countries, 18 % were Canadian content and another seven per cent of the articles were from Australia. The literature was further searched using the term critical social theory and nursing which resulted in 11 articles being selected for use of the theoretical framework.

Since the inception of nursing there have been many examples of nurses leading actions that are considered political in nature. The best known and considered the first nurse activist was Florence Nightingale in the 1800s. Nightingale is credited with assisting the nursing efforts in English military hospitals during the Crimean War and later she acted as an administrator and consultant to the British Army on issues related to health. (http://womenshistory.about.com/od/nightingale/Florence_Nightingale.htm, retrieved July 27, 2012). For over a century, her advocacy efforts have remained applicable on issues of infection control, public health education and disease prevention (Cowan-Novak, 1988). Further examples of nurse leaders include Lillian Ward, who first coined the term “public health nurse” in 1893 and recognized the need for “social betterment”. Ward established standardized policies and nursing skills while supporting the development of new roles for school and rural nurses (http://jwa.org/historymakers/wald/public-health-nursing, retrieved July 27, 2012). Dorothea Dix advocated for the mentally ill and championed actions to improve psychosocial healthcare for this population (O’Neill-Conger & Johnson, 2000). Nurse activist Cathy Crowe works to advocate for adequate housing for the homeless and delivers nursing care to the most vulnerable on the streets of Toronto. Nursing’s historic leaders possessed the wisdom to understand the relationship between economic, political,

social and cultural factors related to health (Fyffe, 2009). It was their legacy that paved the way for a nursing future that included political activism on behalf of the health of clients and communities. Although there are exceptions, activism is not a common function of the nursing role today.

O'Neill-Conger and Johnson (2000) propose that when nursing aligned itself with the medical model, it moved from a focus on population and prevention to the care and cure of individuals. Nurses working in the hospital sector, in which the focus is the individual as client, account for 61% of the 117, 322 nurses who work in Ontario (CNO Membership Statistics, 2012). Gehrke (2008) suggests that nurses need to shift their attention from the acutely ill phase, to one of assisting large groups of people to become healthier. Nurses have an obligation to act dutifully as both nurses and citizens for the betterment of community (Ballou, 2000; Des Jardin, 2001; Ennen, 2001; Gehrke, 2008; O'Neill-Conger & Johnson, 2000; Primomo, 2007; Redman & Clark, 2002; Wold, Brown, Chastain, Griffis & Wingate, 2008). Advocacy at the policy level is regarded as a "logical extension" of the nurse-client relationship (Spenceley, Reutter & Allen, 2006).

Advocacy

The College of Nurses of Ontario includes advocacy as a function of the nursing role throughout the Standards of Practice. Practices or interpretations of advocacy may vary based on a nurse's area of practice. For example in a hospital setting,"calling a physician, requesting a medication order or providing information" may be considered advocating for a patient (Kubsch, Sternard, Hovarter & Matzke, 2004, p. 37). However, telephoning physicians for orders and providing for patient's needs are mere "doing for"

tasks (Spenceley, Reutter & Allen, 2006). The role of patient advocate is much more considerable than performing the task of "runner" for individual patients. Nurses must "advocate, educate and set an example for the public", not simply care for them (Des Jardin, 2001, p. 617). Limited interpretations of advocacy reduce the importance of the role and relegates the advocate to nothing more that a "go between" (Kubsch et al. 2004, p. 37).

The history of advocacy as a modern nursing ideal began in the 1970s, and had its philosophical foundations grounded in the nurse-patient relationship (Ballou, 2000). Between the late 1970s and early 1980s, nursing literature cued nurses to speak out and get involved in the socio-political issues that addressed health, or risk being left out of important decisions affecting nursing (Cohen et al. 1996). Other themes, such as feminism and power, emerged in the nursing literature discussing the importance to obtain power within political circles. Next, manuals and "how to" guides were published encouraging nurses to demystify politics to increase the number of nurses engaged in political activity, and to include political content in curriculum (Cohen et al. 1996). A broader meaning of advocacy developed over the next two decades, focusing on issues of access and allocation of resources. Current interpretations of advocacy hold nurses morally responsible to issues of social justice (Ballou, 2000; Bekemeier & Butterfield 2005; Kagan, Smith, Cowling & Chinn, 2010). Social justice is a responsibility to social action through partnership with others to address failures in health and social systems that challenge the health of populations (Bekemeier & Butterfield, 2005). Social justice goals in research, education and practice are focused on changing practices and social

structures that sustain advantages for some and disadvantages for others (Kagan et al. 2009).

Patient advocacy practices are aimed at the protection of patients from harm, particularly those who are vulnerable such as the elderly and children. MacDonald (2006) adds that the patient's role in self-advocacy must be recognized and valued through providing choice, autonomy and self-determination. The Merriam-Webster Dictionary (1999) defines an advocate as "one who pleads another's cause". A broader definition of advocacy pertains to both clinical situations on behalf of patients and social circumstances on behalf of communities (Beu, 2005). Advocacy has further been described as, "a process or actions intended to bring about change in the attitudes, behaviours, policies, programs, practices, or laws of individuals, groups, institutions or governments" (Alberta Association of Registered Nurses, 2004). Bu and Jezewski (2006) conclude that current literature lacks a clear image of nurse's analysis of the meaning and application of advocacy. This variation in definitions of advocacy may contribute to the difficulty for nurses to interpret its meaning and expand on its potential.

Politics and policy

In order for nurses to meet the challenge of being politically active, one must first understand the relationship between health and policy. "Differences in social determinants of health such as income and its distribution, quality of early childhood, employment and working conditions, explain much of the differences in health among citizens of Canada" (Raphael, Bryant & Rioux, 2006, p. 120). Poverty is identified as the key indicator of the accumulation of social determinants and the effects they have on health (Raphael, Bryant & Rioux). Over 15 % of Canadians are reported as living below

the low income cut-off levels (Statistics Canada, 2006 Census). “Ontarians who live in poverty and are socially excluded experience a greater burden of disease and die prematurely compared to those who have better access to economic, social, and political resources” (RNAO, 2009).

Politics is the term often used to refer to the activities that are performed by the government, whereas policy is defined as actions intended to guide and determine present and future decisions (Merriam-Webster Dictionary, 1999). According to Ham (2004), policy is the allocation of resources and making decisions, which reflect a set of values and beliefs. Reutter and Duncan further add that “policy is the course of action or inaction taken by government or by those in authority” (2002, p. 295). Activities aimed at addressing broad policy and political issues that impact communities and populations are known as “upstream or macro-level” actions. Meso or intermediate level activities occur at the organization or institution level, while decisions made at the point of delivery or at the level of patient care are referred to as “downstream and micro-level” activities (Ballou, 2000; Bekemeier & Butterfield, 2008; Hewison 2007; O’Mahony Paquin, 2011; Spenceley, Reutter & Allen, 2006). There are opportunities for socio-political activity at all levels.

Policy analysis refers to inquiries of health care policy that impact health care services, personnel and costs (Fawcett & Russell, 2001). Analysis of policy is a “structured approach to problem identification, problem solving and decision making” (Ennen, 2001, p. 565). Any public policy that has direct or indirect effects on people’s health is a health policy and therefore should be of interest to nursing (Fawcett & Russell,

2001, p. 113). Policies change and differ over time based on the current values or ideals of the government of the day.

Despite the call from professional nursing organizations such as RNAO to react politically, first a critical appraisal of the nursing role is needed to determine whether public policy reform is a legitimate role of the practice of nursing (Ballou, 2000; Reutter & Duncan, 2002, p. 303). Public health is one branch of nursing that practices at the population level and is concerned with the provision of effective health services, inequalities, injustices and the denial of human rights (Bennett, Perry & Lawrence, 2009). The work of a public health nurse may include providing the community with education, surveillance, vaccination and rehabilitation programs. Whereas the majority of nurses practice at the individual level, the nursing specialty of public health addresses the underlying causes of illness from political, social, environmental, biological and psychological perspectives (Bennett, Perry & Lawrence, 2009).

The College of Nurses of Ontario annually collects self reported membership data from all nurses renewing their registration to practice. The public health nursing role can be used as an indicator of trends in nursing positions related to working with populations. In 2012, 3.9% of Ontario nurses reported working in this area of practice (CNO Membership Statistics, 2012). This number represents a small fraction of the total number of nurses in Ontario who currently fulfill formal roles related to politics and/or population health. The need for nurses to be concerned with politics is best described by Crowe, “I am not a politician, an economist, or an urban planner. I’m a nurse, a street nurse, and what I see “downstream” in society necessitates that I look “upstream” to find the root of the problem” (2007, p. 6).

Governing bodies of nursing have claimed that the profession has a responsibility to act, and has called upon nurses to take action; however, the nursing profession has been described as being "invisible" in relation to contributions towards health, political action and power (Falk-Rafael, 2005; Rains & Barton-Kriese, 2001). Despite a long history of activism, most nurses today do not feel compelled or skilled to act politically (Magnussen, Itano & McGuckin, 2005).

Challenges to Political Action

Nursing: A Caring Profession

A question that arises when one examines the political beliefs and behaviours of nurses is whether caring is advantageous in politics and whether the caring profession of nursing is too soft a science for political involvement. Caring is a common theme linked to the concept of advocacy in the literature (Ballou, 2000; Bu & Jezewski, 2006; Ennen, 2001; Falk-Rafael, 2005; Sumner, 2004; Sumner 2010; Sumner & Danielson, 2007). Several well known nurse theorists have described advocacy in regards to their models of nursing including Watson's concepts of caring, Newman's expanding consciousness and mutuality, and Leninger's culturally congruent care (Kubsch et al. 2004). The nursing profession is synonymous with caring and has an image of "trust and goodness" to uphold (Des Jardin, 2001, p. 614; Ennen, 2001). According to Sumner (2004), nursing values hinder our advancements in the political arena. Historically, caring images of nurses have included subordinate, dutiful, obligated and obedient servants (Sumner, 2004; Sumner & Danielson, 2007). Additionally, past nursing images include repression, fear of power and a lack of knowledge. According to Rains-Warner (2003) nursing

contributions in politics are value added and improve the decision-making process. Nurses have “the power to define needs and problems, the power to allocate resources, power to control their own work and the power over people” (Wilding, as cited in West & Scott, 2000, p. 818). Although the profession of nursing may possess power in theory, the profession is viewed as not being influential. Nurses have the potential to be influential by becoming more active to address health policy that can improve quality patient care. At the core of the nursing profession are values, beliefs and practices that align nurses well in the political arena as change agents for health policy. Ongoing health care reform initiatives provide an opportune time for nursing to get involved in discussions where their values are constructive. Nursing knowledge is based on the foundation of the systematic use of the nursing process to assess, plan, implement and evaluate problems. Nurses possess the skills required to analyze, think critically and decipher health policy information; Falk-Rafael (2005, p. 213) implore that “political action is an expression of caring”.

Social Consciousness

Expanding social consciousness requires engagement in advocacy activities, in which the focus is an intentional response to address the root causes of issues such as homelessness and poverty that are located in societal structures and policies (Reimer Kirkham & Browne, 2006; Reutter & Duncan, 2002). Carnegie and Kiger propose that an advocacy role which includes building relationships with local governments and citizen’s councils may assist nurses to discover how health inequalities originated and how best to respond (2009, p. 1979). Nurses have the responsibility as members of a community to promote its wellness (Ennen, 2001) and can use these opportunities to form

alliances with community members and leaders in order to raise awareness of health care issues impacting the community. Ballou (2000) states that due to the size and focus on the whole human health experience, nurses are the greatest potential resource for the health of the public. Prior to nurses being able to answer the call for greater involvement in political processes they must first develop meaningful understanding of policy, politics and the social determinants of health.

There is concern that nurses are becoming more apathetic about political advocacy (Boswell, Cannon & Miller, 2005; Falk-Rafael, 2005; Reutter & Duncan, 2002). Des Jardin suggests that perceived moral-ethical conflicts, a lack of an approach for political action and negative images of politics are causes for nurse's political apathy (2001). This trend is apparent in the general population in which 58.8 % of Canadians voted in the last federal election. This result represents a decline from the 2006 election in which voter turnout represented 64.7 % of the population. (http://www40.statcan.gc.ca/101/cst01/govt09c-eng.htm, retrieved June 16, 2012). Similarly, the province of Ontario experienced like results of 58.6 % voter turnout, down nearly eight percent from the previous election. (http://www40.statcan.gc.ca/101/cst01/govt09c-eng.htm, retrieved June 16, 2012).

Barriers to Political Involvement

Personally, nurses often experience work-life balance struggles that include the demands of home, family and career (Boswell, Cannon & Miller, 2005). This is further complicated by long work hours and the mental and physical challenges of the work they perform. Time restraints and the fear of infringement on family time have been identified

as barriers to nurse's political involvement (Boswell, Cannon & Miller, 2005). Gender issues such as the predominance of females in the nursing profession have been cited as a barrier to political action (Fyffe, 2009; Sumner & Danielson, 2007). "The foundational assumptions of nursing are embedded in the traditional role of women and medical paternalism which has historically been devalued" (Allen, 1995, p. 176). Gender issues are likely to continue based on the current membership trends in which 90 % of new registered nurses of the CNO are female, while only 10 % are male (CNO, New Membership Trends, 2012). Historically, women have been assumed to have less concern with public interests and it has been argued that this identity may still be relevant today (West & Scott, 2000). A frequent finding in the literature includes the challenge of the fear of public speaking as a common insecurity for nurses and creates difficulty when strong arguments are needed during political debates (Antrobus, Masterson & Bailey, 2004; Byrd, Costello, Shelton, Thomas & Petrarca, 2004; Des Jardin, 2001).

Professional barriers faced by nurses include heavy workloads, feelings of powerlessness, time constraints, gender issues, lack of resources, frustration, burnout, apathy and a lack of understanding of the complex processes of politics (Des Jardin, 2001; Boswell, Cannon & Miller, 2005). Access to policy makers and political networks, lack of educational preparedness and a lack of ambiguity have been identified as further barriers to political action (Antrobus, Masterson & Bailey, 2004; Boswell et al. 2005; Des Jardin, 2001; Primomo, 2007). Des Jardin (2001) adds oppressive images, understaffing, management approachability and the fear of retaliation as additional hindrances to political involvement. According to Antrobus et al. (2004) nurses fear conflict, which is contradictory to the environment of political debate. The lack of

support provided by administrators, colleagues, and institutions to support nurses has been described as an obstacle to nurse's political activity (Bu & Jezewski, 2006). These authors further explain that staff nurses often fear negative consequences for advocating, especially from people in authority.

Borthwick and Galbally (2001) refer to nurses as having low self concepts and therefore experience no political clout. They argue that this combination creates a political barrier and presents a challenge for nurse leaders to equip nurses as advocates for themselves and others. According to Beu, (2005); Fyffe, (2009); and West & Scott, (2000), some nurses may be reluctant and unable to participate in the political process. Experienced nurse activists recommend a need for nurses to be visible to the public and in the media as a strategy for political success (Rains-Warner, 2003). Nurses had been largely ignored in the media prior to 1997 until a publication regarding this lack of nursing visibility was released. After this study was published, many nursing organizations made it a goal to strengthen their relationship with the media. Recognizing the power of the media, nurses can become more visible by engaging with the press on television and radio, being published in journals, and joining internet-based networks to address health care issues in the public eye (Fyffe, 2009).

Issues of power struggles in nursing are not new, dating back over a century to the early days of nurse training that was influenced by gender issues, the physician-nurse relationship and the biomedical model (Carnegie & Kiger, 2009; Falk-Rafael, 2005; Kagan et al. 2009; Mooney & Nolan, 2005). Historically nurses have been oppressed in issues of power; however, today nurses possess their own power such as knowledge which may be used constructively to take action towards change (Manias & Street, 2000).

Staff nurses have been accused of neglecting to view health policy issues as nursing issues and therefore avoid engagement in health policy debates (Toofany, 2005). It has been suggested by Cloke (2002) that a move towards a political future includes an ethical approach, including consideration of one's behaviours and responses to the needs of disadvantaged groups. The author further explains a need to consider the consequences of one's own actions and lastly the societal norms to which we adhere. Through observance of Cloke's suggestions, nurses could then act politically within a moral framework (Carnegie & Kiger, 2009).

Education and Preparedness for Activism

One of the most prevalent barriers impacting nurse's involvement in public policy is the "lack of know how". Nurses require education, scholarship and research activities to support their efforts (O'Mahony Paquin, 2011). Bu & Jezewski (2006) report that the lack of research development in this area is a hindrance to nurse's political activism. Primomo (2007) claims that in order to be politically astute, awareness and understanding of health policy and legislation is needed, otherwise known as political competence. Political competence includes three areas of focus, understanding, responding and shaping policy environments (Longest (2004). Political competence has been described as the "knowledge of policies and the processes through which they are made, leadership to respond to the challenges and opportunities of issues arising from the policy environment, and the ability to persuade policy makers to make decisions" (Hewison, 2007, p. 695). Rains and Carroll (2000) further define political competence to include the availability of resources and the need for effective lobbying strategies. The authors

suggest that the skills required for political competence consist of communication, policy analysis and media expertise.

Nurses use a language based on patient care needs; however, in order to influence policy makers a language that recognizes “policy priorities for both policy and practice” is necessary (Antrobus, Masterson & Bailey, 2004, p. 24). The authors state that nurses require the skill of “constructing strong arguments that communicate patient perspectives and clinical realities to political debate” (p. 24). Inactivity by nurses is further blemished by the intricate nature of the “abstract and intangible” legislative process (Borthwick & Galbally, 2001; Byrd, Costello, Shelton, Thomas & Petrarca, 2004; Des Jardin, 2001). There is frustration with the legislative process that is both slow and tedious, taking months to years for motions to pass into law (Des Jardin, 2001).

According to the literature, nurses require preparation in order to gain confidence and knowledge to advocate politically on behalf of their communities (Harrington, et al. 2005; Primomo, 2007; West & Scott, 2000). Nursing curriculum is frequently cited as an avenue to groom nurses to act as nurse citizens (Cohen & Milone-Nuzzo, 2001; Primomo, 2007; Rains & Carroll, 2000). An internet search of six Ontario Universities offering undergraduate nursing programs revealed that courses in political science are not requirements of the program. Nursing education has been accused of not adequately preparing nurses for policy advocacy, legislation analysis or in providing the instructions on how to do so (Boswell, Cannon & Miller 2005; Fyffe, 2009; Gebbie,Wakefield & Kerfoot, 2000; O’Neill-Conger & Johnson, 2000). Nurses have called for educational preparation in policy advocacy and beginning research suggests that educational preparation enhances competencies in political advocacy (Reutter & Duncan, 2002).

Students must learn how to advocate for, interpret and understand social systems that play a part in the inequalities within society and their workplaces (Carnegie & Kiger, 2009). Magnussen, Itano and McGuckin (2005) explain that nursing students are introduced to community health; however, they lack quality opportunities to observe how needed resources are allocated. Cohen et al. (1996) suggested that in order to develop leadership abilities, a political “mentorship” program would be of benefit, in which nurses and students could learn at the side of nurse political leaders. Gehrke (2008) agrees that students require experiences and specific educational preparation in civic engagement. Although there is little debate that nursing education includes content on health policy, there remains an unanswered call as to how this will be accomplished and at which level of nursing education it will be introduced (O’Neill-Conger & Johnson, 2000).

In a study by Primomo (2007) graduate nursing students were given a pre-post test during a health systems and policy course. Results showed that following the course, the students had improved their level of political astuteness. Students reported greater knowledge of the legislative process and knew how to contact their government representatives, could state two current issues of importance to the nursing profession being reviewed at the government level and were able to recite the names of the elected officials. The researcher concluded that “nursing curriculum that includes health policy may enhance nurses’ ability to set political agendas and advocate successfully for healthy public policy” (Primomo, 2007, p. 264). Graduate nursing studies should move beyond the prologue of understanding health policy introduced in a baccalaureate program to include preparation for the role of leader to address healthcare delivery system

inadequacies, cost-effective healthcare and policy reform (O'Neill-Conger & Johnson, 2000).

In a study of baccalaureate nursing students by Rains & Barton-Kriese (2001), students voiced a desire to empower others to speak, act and to advocate for those unable to do so for themselves. However these same students reported a knowledge deficit about public policy and did not see the connections between the personal, professional and political self. Students found it difficult to discuss their own political perspectives and did not see their roles as volunteers in health care settings as a function of activism. Research conducted by Byrd, et al. (2004) suggested that following an active learning course, baccalaureate level nursing students reported having gained knowledge about public policy change, legislation and the relation of bills to the needs of society. It is suggested that involvement of students at the baccalaureate level would benefit their knowledge, confidence and assist in the formulation of their own political opinions through critical thinking (O'Neill-Conger & Johnson, 2000). There is criticism that nursing education has lingered too long to adapt policy and political skills into curriculum (Boswell, Cannon & Miller, 2005; O'Neill-Conger & Johnson, 2000). A "political awakening" is needed in nursing education (Cohen et al.,1996, p. 260) and efforts must be made to reinstate mandatory courses related to political science, democracy and civic engagement (Gehrke, 2008). "All nurses have political dimensions to their roles and need to be politically aware, but not every nurse wishes or needs to be a political leader" (Antrobus, Masterson & Bailey, 2004, p. 25). Byrd et al. (2004) agree that it is unrealistic to think that each nursing student will become politically active the

moment of graduation; however, engaging students early in their education is a first step in preparing them to become politically active professionals.

Experienced nurses are gaining access to leadership positions in schools of nursing, research, legislative bodies, government agencies, health care and advocacy organizations. In a recent study, these nurses reported having had a lack of formal health policy education and claimed to have learned their skills on the job (Harrington et al. 2005).

Facilitators of Political Action

Understanding factors that promote nurses' political involvement is a first step in enhancing their ability to be a policy advocate. In a study of 118 American nurses, it was reported that the belief that the participant's actions would make a difference and the availability of free time were positive influences on political development (Primomo, 2007). Family experiences with political activism, mentoring from positive political role models, parental influence, participation in professional organizations, and previous exposure to political activities have lead nurses and others to a greater likelihood of political involvement (Des Jardin, 2001; Gebbie, Wakefield & Kerfoot, 2000; Primomo, 2007).

Self-Interest and Motivation

Nurses need to acquire self-interest and enthusiasm for political involvement (Boswell, Cannon & Miller, 2005). Nurses are encouraged to look inward at their personal philosophies, beliefs, values, worldviews, citizenship and motivations to identify their individual perceptions of politics (Carnegie & Kiger, 2009; Boswell, Cannon &

Miller, 2005). Characteristics such as self-confidence, assertiveness and maturity were found to support political advocacy (Kubsch et al., 2004). Having dissatisfaction in the health-care system seemed to positively impact nurse's political involvement to speak out (Drew, 1997). Cohen, et al.(1996) describe a four stage process of nurse's political development. The first stage of political activism or "buy in" includes an increased awareness of nursing issues, learning political language and occasional participation in political activities. Self-interest is the focus of stage two in which the nurse moves from awareness to activism. During this stage, nursing begins to develop a "sense of uniqueness", fostering self-understanding which can work to improve the well-being of others (Cohen, et al., 1996, p. 261). In stage two a new sense of identity emerges in response to nursing coalitions and the building of nursing's political foundation (p. 261). Stage three describes more complex and sophisticated political action than present in previous stages. Nurses become skilled in activities such as campaigning, financing, laws, election strategies and public relations. In the fourth stage of political development, nurses lead the way through initiation of health policy ideas that benefit the larger public good. "The public will benefit from nursing's expertise and the advocacy that nurses can provide on behalf of the public" the further they integrate into stage four (p. 263)

According to Crowe, there are no actions, without difficulty. She equates this to a formula, "witness + honesty + speaking out = the right thing to do" (2007, p. 10). Crowe's involvement as an advocate for the homeless has involved countless struggles involving the legal system, the need for action-based research, and the frustration of being silenced. She claims politics are about resources that are limited; they do not come without a fight and are never given freely. Although difficult, Crowe stays positive by

"celebrating wins every day", such as new shelter standards, homelessness being declared a national disaster, and a national homeless strategy which created hundreds of millions of dollars for emergency assistance to the homeless (p. 11).

Affiliation with Professional Nursing Organizations

Membership in a professional nursing organization encourages nurses to vote, get to know their policy makers, use their communication skills, organize and mobilize resources in the community, write letters to policy makers or newspapers, campaign for candidates, and develop and analyze policies, all of which have been identified as facilitators for nursing activism in the literature (Boswell, Cannon & Miller, 2005; Cohen & Milone-Nuzzo, 2001; Rains & Barton-Kriese, 2001; Reutter & Duncan, 2002). "Individually we make a difference; collectively we make a bigger difference" (Rains-Warner, 2003, p. 140). There are currently 117, 322 registered nurses eligible to work in Ontario, accounting for a significant delegation of voters within the nursing profession (CNO, Membership Statistics, 2012). If Ontario nurses worked collectively they may be able to move health related political issues forward (Ennen, 2001; Leavitt as cited in Beu, 2005).

The Registered Nurses Association of Ontario (RNAO) is the professional organization for nurses and the voice that speaks for nurses on health related issues (RNAO, 2012). The mandate of the RNAO is advocacy for healthy public policy and to promote the full participation of registered nurses in shaping and delivering health services now and in the future (RNAO, 2012). The RNAO strategic plan includes:

- influencing public policy to strengthen Medicare and the impact on the determinants of health
- speaking out on emerging issues that impact health, healthcare and nursing
- advancing nursing as a vital, significant and critical contributor to health
- influencing the public to achieve greater engagement in health care
- inspiring every RN and undergraduate basic nursing student to be a member

Not all nurses have made the connection between our numbers and our ability to lobby for improved health policy. Current membership in RNAO is greater than 33,000; however, it is unknown how many of these members are actively involved in their individual chapters (RNAO, 2012). If nurses were to participate politically to their full potential, nursing would have an attentive ear of the legislators who make the decisions that impact nursing practice systems, healthcare delivery systems, geopolitical communities and lastly humankind (Fawcett & Russell, 2001). Boswell, Cannon & Miller (2005) state that with minimal numbers affiliated with our professional organizations, the nursing image in the political arena is weakened and the ability to act politically is jeopardized. Collaboration can occur within the discipline of nursing, between other healthcare practitioners, with community leaders and the government. "Collaboration is a moral imperative-good patient care requires it. Nurses collaborate in three ways in the creation of new and improved delivery systems with individuals in the process of care; with communities in the creation of health, and with their health care colleagues in the development and implementation of service" (Sigma Theta Tau

International as cited in Rains-Warner, 2003, p. 136). Collaboration reinforces commitment to a common goal and reaffirms the message that patient welfare is the goal (Hamric, Spross & Hanson, 2009, p. 296).

West & Scott (2000) hold an opposing view that there is insufficient evidence regarding nurses' contributions to policy making in relation to the size of the profession. Although nurses possess several means of power, they lack the influence necessary to contribute to the political agenda. Robinson (1992, p. 7) adds that "nurses are virtually never involved in concrete policy decision-making processes; what may pass for a nursing decision is in reality acquiescence to others' prior formulations". Maslin-Prothero & Masterson (1998) support the opinion that nurses have been inadequate in addressing public policy agendas.

Learning from Example-Successful Leaders

A facilitator to political involvement is awareness of strategies identified by successful nurses in leadership roles. Nursing's historic leaders possessed many common traits including having a vision, taking risks, contacting and collaboration with people in power and positions of authority, and a drive to influence government to achieve their goals (Leavitt as cited in Beu, 2005).

The five C's of political influence include communication, credibility, collective action, collaboration and cash (Leavitt as cited in Beu, 2005). These five attributes have been credited as traits of professional nurses who have experienced political success. In a phenomenology study of six nurse activists, the major themes that emerged from the data were nursing expertise, networking, persuasion, collective action, a broad perspective and perseverance as facilitators to success in politics (Rains-Warner, 2003). According to

Boswell, Cannon & Miller (2005) the political role of the nurse includes three levels of commitment: survival, success and significance. Nurses can involve themselves in community, address social injustices and are significant by maintaining a focus on the goal of improving health care for all.

Theoretical Framework

Critical Social Theory

Max Horkheimer, of the Frankfurt School of Sociology in 1937, first coined the term critical social theory (CST). Horkheimer's work observed society with a critical eye directed towards change. He held an emacipatory-Marxist perspective and understood society to be under social domination. His perspective was conceived through his observation of capitalism and the fair distribution of goods (Browne, 2000; Fulton, 1997; Manias & Street, 2000).

In the 1960s, Jurgen Habermas and fellow scholars of the same school expanded the critical social theory to include issues of power, freedom and self-reflection (Fulton, 1997). He asserted that transformation is possible by challenging the confinements of traditional social norms. "Central to this theory is that society is structured by rules, habits, convictions and meanings to which all social beings adhere" (Cody, 2006, p. 187). Critical theorists believe consciousness of power imbalances in society are required to create rational societies (Falk-Rafael, 2005). The term enlightenment in CST is described as the "raising of the consciousness of the oppressed" in order to rationalize the disparities in their lives (Manias & Street, 2000, p.51). The authors describe that enlightenment alone can not change one's situation; however, through working with individuals and assisting them to consider alternatives to their personal and societal

circumstances, they are empowered. It is the goal of CST that society is changed to a system in which all persons will fare equally in a genuine democratic environment (Carnegie & Kiger, 2009). The authors assert that this can be achieved by "exploring underlying interests and the legitimacy of these interest groups to identify if they serve equality and democracy"

(p. 1977).

Critical social theory can not be discussed without including the concept of social justice. As described previously, professional organizations urge nurses to respond to an ethical and moral calling to address social disparities affecting the health of individuals and communities. Social justice is the amount of fairness and equality for health that is made possible through political, social, and economic structures and values of a society (Smith, Jacobson & Yiu, 2008). Bekemeier and Butterfield (2005) explain that social justice analysis provides an indication of the causalities and beneficiaries of "inequities, environmental exploitation, discrimination and oppression" within society (p. 154). If issues such as poverty, systematic diminishment of life opportunities and health disparities are not critically examined, acceptance or adaptation of current unjust social structures will continue to exist (Reimer Kirkham & Browne, 2006, p. 337). Therefore, the nurse is the ideal social activist to examine the appropriate distribution of resources and power, address health issues, education and the welfare needs of all people in institutions, communities or society (Bu & Jezewski, 2007).

According to Sumner (2004) critical social theory is an ideal tool to explore issues of power and justice which are applicable in the delivery of modern day health care. Nurses are in a unique role to address issues of poor nutrition, lack of the ability to afford

medications and depression as signs and symptoms of broader socio-political issues. Understanding critical social theory may guide nurses towards taking action to improve the health of communities by addressing global and local policy (Carnegie & Kiger, 2009). Critical social theory has been applied to nursing through research exploring professional issues of power imbalances, dominance and oppression (Browne, 2000; Manias & Street, 2000; Wilson-Thomas, 1995). According to Wilson-Thomas (1995) further use of the theory is needed in practice.

It is argued that nurses are an oppressed group themselves, and therefore are not capable of raising unconscious awareness personally or for those in their care (Borthwick & Galbally, 2001; Mooney & Nolan, 2006; Sumner, 2004). Nurses must first self-reflect on their own values and prejudices, exposing ideals that are not congruent with principles and standards of health, wellness, fairness and equality (Betts 2008; Browne, 2000). Nursing images of being traditional and reactive need to be reinvented to one of leaders who contribute to broad health service policy development and management (Borthwick & Galbally, 2001, p. 77).

Critical social theory emphasizes that all persons have a responsibility to create social change. Nurses are additionally challenged by being a member of a profession; one of which holds the value of caring (Browne, 2000; Wilson-Thomas, 1995). Critical social theory has been linked to concepts of holism which are considered central to the practice of nursing (Browne, 2000; Fulton, 1997; Manias & Street, 2000). Nurses must render the power imbalances of the workplace, health care systems and government that prohibit individuals and groups to reach their full health potential (Cody, 2006, p. 187). Knowledge of critical social theory will prepare the nurse with unique insight into the

conditions that propagate current societal practices and beliefs that repress groups and individuals (Allen, 1995).

In conclusion, advocacy is an important part of the nurse's role; however, nursing efforts on behalf of clients are mostly focused on the individual. The nursing profession has been challenged by their professional organizations to meet their social mandate through expanding their acts of advocacy to the broader public. Addressing public health issues includes examining the socio-political causes of illness known as the social determinants of health. Barriers to political activism include time and family restraints, lack of knowledge and educational preparedness, apathy, feelings of powerlessness, and a lack of support from colleagues and management. Facilitators of political activism include having had positive political role models, parental influences, prior exposure to political activities, a personal interest, self-confidence and professional nursing organization affiliation.

There is a gap between the nurse recognizing the influence of socio-political issues on health, and what nursing actions are necessary to address these problems. The purpose of this research is to explore and describe the beliefs and practices of nurses, regarding the concepts of advocacy and politics. Previous research has examined the barriers and facilitators of political involvement, examined the effects of policy and political curriculum on knowledge development (Borthwick & Galbally, 2001; Des Jardin, 2001; Boswell, Cannon & Miller, 2005). The current study will add to the body of knowledge through describing the political activities, experiences and beliefs of Ontario registered nurses. This population has not previously been studied in regards to the concept of political advocacy. Findings may provide information on how best to

understand the concept of political activism as a form of advocacy. Study findings may identify the learning needs of the profession through assisting schools of nursing and professional nursing organizations to formulate guidelines to better prepare nurses to fulfill their social mandate.

CHAPTER III

Method

Chapter three explains the research methods and design that was used to conduct the study.

Research Design

Little is known about the beliefs and values of Ontario nurses related to politics and their roles as advocates. For this study an exploratory, descriptive design through use of a self-administered questionnaire was selected as the method of inquiry. This is an appropriate method for this research in order to identify the characteristics regarding nurse's beliefs and practices on politics and advocacy and to acquire knowledge regarding a little known phenomenon (Grove, Burns & Gray, 2013). Descriptive studies are a method of discovering new meaning, describing what exists, the frequency with which it occurs and categorizing information (Grove, Burns & Gray, 2013).

Data collection was through use of a cross-sectional survey at one point in time, providing quantitative or numeric descriptions of the beliefs and values of nurses in relation to politics and advocacy roles (Loiselle & Profetto-McGrath, 2011). The survey was selected for data collection to reach a wide sample of provincial nurses who are registered with the College of Nurses of Ontario (CNO). According to Loiselle & Profetto-McGrath, surveys are critiqued as being limited and at risk for bias through self-

reporting (2011). Mail surveys may present the risk of bias as response rates are typically low. On the other hand, mail surveys can reach a broader sample in order to make inferences about the characteristics and attitudes of the population being studied (Creswell, 2014). Mail surveys have the added benefit of offering participants complete anonymity (Grove, Burns & Gray, 2013; Loiselle & Profetto-McGrath, 2011).

Setting and Sample

There are currently 117, 322 registered nurses entitled to practice in Ontario (CNO, 2012). A random sample of 1000 registered nurses was obtained through the College of Nurses of Ontario (CNO). Random samples allow each member of a population an equal chance of being selected in the study which increases the likelihood that the sample shares the same characteristics of the population of interest (Leedy & Ormrod, 2005). The questionnaire was administered via home mailing addresses to the selected participants currently holding active registration with the College of Nurses of Ontario. A stratified random sampling method was utilized to obtain a sample that is representative of the nursing population in Ontario (Creswell, 2014). The sample was divided into two strata based on gender as females represent 90 % of the profession (CNO, 2012). Without stratification, male nurses would be under represented preventing generalizations to be made about this group of nursing professionals. Five hundred participants from each gender group were invited to participate in the survey. Inclusion criteria included all registered nurses currently holding active registration with the College of Nurses of Ontario, including all levels of experience, position and practice sectors. Exclusion criteria applied to those who are employed exclusively outside of Ontario. The response rate for the survey was 20.8% (*N*=201).

Characteristic of the participant's demographics (Table 1).

Table 1

Characteristics of Participant Demographics, (N=201)

Variable	Statistics
Gender	45.5 % Male, 54.5% Female
Age	24-79 years (*M*=48.98, *SD*=11.41)
Marital Status	63.9% Married, 5.9% Common Law, 4.5% Committed Relationship, 7.9% Divorced, 3.0% Separated,2.5% Widowed, 9.9% Single
Level of Education	0.5% Post-Doctorate, 0.5% Doctorate, 14.4% Graduate Masters, 38.8% Undergraduate Degree, 45.3% Diploma
Years of Nursing Work Experience	1-52 years (*M*=23.41, *SD*=12.17)
Primary Place of Employment	56.9% Hospital, 36.1% Other
Primary Position in Nursing	53.5% Staff RN, 46.5% Other
Practice Location	88.1% In Ontario, 3.5% Both In and Outside Ontario

Table 1

Characteristics of Participant Demographics, (N=201)

Variable	Statistics
Resident of which Local Health Integrated Region	6.9% Erie St. Clair 8.9% South West 6.9% Waterloo Wellington 12.9 % Hamilton Niagara\Haldimand Brant 3.0 % Central West 11.5% Mississauga Halton 14.9% Toronto Central 2.5% Central 10.9% Central East 3.0% South East 6.4% Champlain 2.5% North Simcoe/Muskoka 5.4% North East 4.0% North West 5.0% Not Sure
Political Party Affiliation	19.9% Conservative, 4.5% Green Party, 31.8% Liberal, 13.4% NDP, 26.5% “I do not closely identify with any political party”
Home Responsibilities	32.2% Young children living at home 27.7% Adult children living at home 30.2% Adult children living outside the home 5% Caregiver for elderly parent in the home 16.8% Caregiver for elderly parent outside the home 2.5% Caregiver for disabled child/parent in the home 4.0% Caregiver for disabled child/parent outside the home
Member of the Registered Nurses' Association of Ontario (RNAO)	45.3% No, 54.7% Yes

Measurement Instruments

The study investigated the characteristics of registered nurses through a self-administered three part survey (Appendix D). Part one of the survey included 55 questions with inquiry into the political and advocacy experiences of registered nurses regarding their beliefs, barriers and supports for political involvement and the political activities in which they may participate. These questions were designed by the author for the purpose of this research and are based on findings about these concepts from the literature (Antrobus, Masterson & Bailey, 2004; Beu, 2005; Borthwick & Galbally, 2001; Boswell, Cannon & Miller, 2005; Byrd, Costello, Shelton, Thomas & Petrarca, 2004; Bu & Jezewski, 2006; Carnegie & Kiger, 2009; Cohen & Milone-Nuzzo, 2001; Des Jardin, 2001; Drew, 1997; Fyffe, 2009; Gebbie, Wakefield & Kerfoot, 2000; Kubsch et al, 2004; O'Neill-Conger & Johnson, 2000; Primomo, 2007; Rains & Barton-Kriese, 2001; Rains & Carroll, 2000; Reutter & Duncan, 2002; Toofany, 2005; West & Scott, 2000). There are no standardized measures to study nursing attitudes, beliefs and practices on advocacy and politics. The question formats and response options were based on the guidelines from Dillman's (2007) work on mail surveys.

The survey was distributed to 12 registered nurses who pilot tested the instrument. The nurses were asked to critique and provide feedback on the clarity of the questions, grammar and spelling and ease of completion of the tool. Based on their feedback, adjustments were made to the tool and an estimated completion time between 20-30 minutes was established by an additional three registered nurses who trialled the final version of the survey.

Items appear to measure the construct they are intended to measure. The exercise of matching concepts to the research questions are outlined in the table of specifications (Appendix A). The questionnaire was neat in appearance, well organized and concise to increase the likelihood of higher response rates (Leedy & Ormrod, 2005; Polit & Hungler, 1999). Consistency in the style and format of the questions were maintained throughout the survey to improve validity (Grove, Burns & Gray, 2013, p. 394). An increase to the spacing of survey questions in the table format was changed to prevent formatting errors (Dillman, 2007).

The Social Justice Advocacy Scale

Part two of the survey consisted of a 43 item survey, *The Social Justice Advocacy Scale* (Dean, 2009). The scale uses a seven point Likert response to address four constructs of social justice advocacy including collaborative action, social/political advocacy, client-community advocacy and client empowerment. Permission was granted by the developer of the Social Justice Advocacy Scale (Dean, 2009) to utilize the instrument to measure the political advocacy experiences of RNs. A multidisciplinary review of the literature was conducted in 2002 by the American Counsellor's Association in which 73 competencies and skills related to advocacy were identified. The tool was developed to address the American Counsellor's Association advocacy competencies that were established in 2002 that to date the author recognized had not been measured through research. Attempts to ensure content validity through item content analysis such as correlating items, examining homogeneity of items, evaluating the utility of the instrument were conducted by five advocacy experts. The author assumed the recommendations and adopted the changes including a seven point Likert scale. A trial

survey of 100 participants was further completed to test the reliability of the new instrument (Grove, Burns & Gray, 2013). Construct validity was supported using convergent methods and addressed correlations between established tools including the Multicultural Knowledge and Awareness Scale (Ponterotto, J. G., Rieger, B. T., Barrett, A., Harris, G., Sparks, R., Sanchez, C. M., et al., 1996) and the Miville-Guzman Universality-Diverse Scale- Short Form (Fuertes, J. N., Miville, M. L., Mohr, J. J., Sedlacek, W. E., Gretchen, D., 2000). Factor analysis was utilized to identify clusters of related items on the survey in order to address the four concepts within the tool (Loiselle & Profetto-McGrath, 2011, p. 308).

The previous study was administered to a sample of 112 graduate counselling students in an effort to establish validity. Psychometric analyses in the previous study included examining empirical relationships between survey items and scores. The instrument was established as adequately reliable and valid to address social justice advocacy. The author reports there were no other quantitative instruments published at the time of the study.

According to Dean (2009) the Social Justice Advocacy Scale had good internal consistency with Cronbach alpha coefficients reported for the four subscales; collaboration, .92, social/political advocacy, .91, empowerment, .76 and client/community advocacy, .76. Reliability testing was performed using Cronbach's alpha coefficient to identify if items "hang well together" and measure the same underlying constructs in each of the scales (Pallant, 2010). The limitation of the previous study included a small sample size which may decrease the reliability of the instrument and runs the risk of the researcher erroneously rejecting their research hypotheses

(Loiselle & Profetto-McGrath, 2011, p. 215). Part three of the current survey included twelve general demographic questions to determine the characteristics of the sample.

Procedure

A cover letter accompanied the mail survey to introduce the study purpose and participant's rights (Appendix B). Terms of reference were provided to clarify the concepts within the survey (Appendix C). Questionnaires were addressed to 1000 registered nurses randomly selected from the CNO home mailing list. The questionnaire was delivered in a sealed letter sized envelope including a postage paid return envelope. To decrease additional mailing costs, return envelopes were numbered to avoid sending reminders unnecessarily to those participants who had completed the survey. Completed surveys were immediately separated from the return envelopes. As a result of this process anonymity during the data collection phase was not possible; however, confidentiality was protected. No links to participant information and identity appear in the completed research report. Respondents who completed the survey were invited to participate in a voluntary draw to win one of two $50.00 Visa gift cards. Those who wished to be included in the draw were asked to provide their name and contact information voluntarily. This information was immediately separated from the completed questionnaire and kept in a separate location from the survey. All participant contact information was maintained in a secure locked cabinet. To encourage a high response rate, a reminder notice was sent between three and four weeks following the initial mailing. The data collection period occurred over an eight week period. Of the initial sample, 36 participants were eliminated due to unknown addresses as identified by the postal service. Of the remaining 964 possible respondents, 201 completed

questionnaires were selected for the study after having met the inclusion criteria. This resulted in a 20.8% return rate.

Protection of Participants Rights

The study proposal received ethical clearance from the University of Windsor Ethics Research Review Board. A cover letter meeting the criteria of the research ethics board accompanied the survey explaining the purpose of the study, procedure, potential risks and benefits, compensation, confidentiality, participation/withdrawal and the participant' rights (Appendix B). There were no foreseen harms or risk to participating in the survey. The questionnaire was voluntary and completion of the survey served as the participant's consent to be included in the study. There were no costs to complete the survey. There were no further requirements of the participants following survey completion. Participants were provided the website address where results will be made available following completion of the study. Contact information of the faculty supervisor was provided in case a participant had questions or concerns regarding the study. A draw for one of two $50.00 Visa gift cards was offered to those who wished to participate voluntarily. Those who chose to participate were asked to provide their name and contact information which was separated immediately from the completed survey data.

Data Analysis

Data analysis was performed using the Statistical Package for the Social Sciences (SPSS) current version (21). Data were described through frequencies, percentages and

means. Independent sample t-tests, correlations and regression analyses were the statistical tests used to compare and explore relationships between variables.

Descriptive statistics were used to address the research questions “How do RNs participate in political activities?”, “What are registered nurses’ beliefs regarding their role as a political advocate?” and “What do nurses identify as facilitators and barriers for involvement in political activism?’ Correlations were used to examine relationships between variables such as; “Do RNs beliefs influence their participation in political activities?” and regression analysis to answer “Are barriers and supports predictors of nurses’ advocacy activities in each of the four subscales of the Social Justice Advocacy Scale?” (collaboration, social/political advocacy, empowerment and client/community advocacy). Hierarchical multiple regression was used to assess the contribution of each of the independent variables on the outcome variables. This allowed the author to explore many variables at one time, predict outcomes from examining predictor variables and provide more meaningful data results (Pallant, 2010, p. 148). T-tests were used to compare mean differences between males and females, and staff RNs to other RNs for variables such as activity and empowerment. Demographics were described using frequencies, percentages and mean (Table 1).

Chapter IV

Results

This chapter summarizes the findings of the study. Results are reported using descriptive statistics and tabular presentations.

Data Screening and Analysis

Data screening and cleaning was performed to ensure an error-free data set through identifying and correcting errors. A log book was maintained to identify the treatment of data by date to ensure accurate records. The data set was first visually scanned for any obvious errors. A preliminary analysis was executed to explore missing data, normality and outliers. Data were examined for random or systemic patterns of missingness. The amount of random missing data was non influential at less than five percent. Normality was explored using the mean, median, standard deviation, minimum/maximum range and the 5% trimmed mean function which revealed little influence on the mean from the top and bottom five percent of cases. Histograms were assessed for skewness and kurtosis. Kolmogorov-Smirnov results (Sig. $p < .05$) indicated that some scales were non-normal (age, years of experience, barriers, social justice social/political advocacy and social justice empowerment). Age and years of experience theoretically would not be expected to assume a normal distribution. Multiple regression analysis is robust to violations of the assumptions of normality (Tabachnick & Fidell, 2001). Preliminary analyses were conducted to ensure no violation of the assumptions of normality, linearity, multicollinearity and homoscedasticity. The Durbin-Watson statistic suggested independence of errors for all analyses.

Two outliers were detected. All analyses were completed with and without the two outliers to explore the influence of these cases. Mahalanobis' distance and Cook's (cut off > 1) results were used to examine the presence of multivariate outliers or influential cases. The two outliers were found to be non-influential and as a result were retained in the data set. The assumptions of linearity and homoscedasticity have been met. Negatively worded items in the Social Justice Advocacy Scale were reversed and new variables were created and total scores for each subscale calculated. According to Dean (2009) the Social Justice Advocacy Scale had good internal consistency with Cronbach alpha coefficients reported for the four subscales; collaboration, .92, social/political advocacy, .91, empowerment, .76 and client/community advocacy, .76. Reliability testing was performed using Cronbach's alpha coefficient to identify if items "hang well together" and measure the same underlying constructs in each of the scales (Pallant, 2010). For the present study, the Social Justice Advocacy Scale revealed very good internal consistency for three of the four subscales (Table 2).

Measurement scales are summarized using the mean, standard deviation, reliability coefficients and range (Table 2).

Table 2

Scale means, standard deviations, reliability coefficients and range

Measure	*M*	*SD*	Cronbach's Alpha	Possible Range
SJ Collaboration	4.11	1.09	.91	1-7
SJ Social/Political Advocacy	3.43	1.23	.84	1-7
SJ Empowerment	4.91	1.04	.91	1-7
SJ Client/Community Advocacy	4.94	.84	.68	1-7
Beliefs	3.57	.59	.86	1-5
Barriers	*2.88*	.49	.73	1-5
Supports	3.03	.61	.74	1-5
Activities	6.35	2.21	.66	0-11

The Cronbach's alpha value for the author developed beliefs scale showed good internal consistency reliability at .86 and acceptable reliability for the barriers scale at .73 and the supports scale at .74. The activities scale Cronbach alpha was .66. These are satisfactory values for a new scale; however, values above .8 are preferable (Polit & Hungler, 1999, p. 413; Pallant, 2010, p. 100). Inter-item correlations and item-total statistics were explored for positive results implying that the items are measuring the same underlying characteristics (Pallant, 2010). Corrected item total correlations were examined to explore whether individual items correlated with the total score. All items were retained as deletion of any one item would not improve the overall Cronbach's alpha coefficient.

Scale correlations were conducted for the study variables; political beliefs, barriers and supports to political involvement, political activities, Social Justice Advocacy scale total and each of the four subscales; collaboration, social/political advocacy, empowerment and client/community advocacy (Table 3).

Table 3

Scale Correlations

Variables	2	3	4	5	6	7	8	9
1. Political Beliefs	-.59**	.63**	.43**	.52**	.51**	.46**	.41**	.56**
2. Barriers to Political Involvement	-	-.40**	-.31**	-.39**	-.39**	-.40**	-.48**	-.48**
3. Supports to Political Involvement		-	.39**	.63**	.56**	.50**	.44**	.63**
4. Political Activities			-	.42**	.48**	.24**	.27**	.42**
5. SJ Collaboration				-	.78**	.79**	.60**	.93**
6. SJ Social/Political Advocacy					-	.57**	.50**	.86**
7. SJ Empowerment						-	.63**	.87**
8. SJ Client/Community Advocacy							-	.76**
9. Social Justice Advocacy Scale Total								-

** $p < .001$ (2 tailed)

Independent samples t-test was conducted to compare the scores for; beliefs, barriers, supports, activities, social justice advocacy total, SJ collaboration, SJ social/political advocacy, SJ empowerment and SJ client/community advocacy for males and females. Of these variables, only the comparison between beliefs for males and females was found to have a significant mean difference, males (M = 3.72, SD = .57) and females (M = 3.46, SD = .59; t (198) = 3.11, two tailed). The magnitude of the differences in the means (mean difference = .26, 95% CI: [.09, .42]) was between a small and moderate effect (eta squared = .04). Results indicated that males and females differed in respect to their interests in politics, males scored higher in their desire to learn more about politics, level of confidence to address political issues, belief that their nursing education prepared them to act politically and reported greater understanding of the Ontario, federal and municipal government systems (Table 4).

Table 4

Independent Samples T-Test for Gender

Variable	*M*	*SD*	*t*	Mean difference	CI (95%)	eta squared
Beliefs 1			(194.5), 2.54*	.36	[.08 - .65]	0.03
Male	3.88	.97				
Female	3.51	1.05				
Beliefs 2			(196.7), 1.50	.21	[-.06 - .48]	
Male	3.66	.89				
Female	3.45	1.04				
Beliefs 3			(198), -.69	-.08	[.12 - .31]	
Male	3.96	.82				
Female	4.04	.83				
Beliefs 4			(198), 4.16**	.59	[.31 - .87]	0.08
Male	3.56	.99				
Female	2.97	.99				
Beliefs 5			(178.8), 2.37*	.35	[.06 - .64]	0.03
Male	2.69	1.10				
Female	2.34	.95				
Beliefs 6			(189), 1.14	.17	[-.12 - .46]	
Male	3.40	1.03				
Female	3.23	.99				

Sig * $p<.05$, ** $p<.001$ (2 Tailed)

Table 4

Independent Samples T-Test for Gender

Variable	*M*	*SD*	*t*	Mean difference	CI (95%)	eta squared
Beliefs 7			(197), 3.46**	.52	[.22 - .81]	0.06
Male	3.76	1.02				
Female	3.24	1.07				
Beliefs 8			(198), 3.83**	.55	[.27 - .83]	0.03
Male	3.76	.97				
Female	3.21	1.04				
Beliefs 9			(197), 2.77*	.40	[.16 - .69]	0.04
Male	3.67	.99				
Female	3.27	1.03				
Beliefs 10			(198), .13	.02	[-.24 - -.28]	
Male	3.77	.96				
Female	3.75	.90				
Beliefs 11			(197), -.04	-.003	[-.18 - .17]	
Male	4.33	.63				
Female	4.33	.60				
Beliefs 12			(198), -.11	-.01	[-.22 - .19]	
Male	4.15	.73				
Female	4.17	.73				

Sig * $p<.05$, ** $p<.001$ (2 Tailed)

Regression analyses were run with and without the variable home responsibilities (HomeRespCount); however, this variable did not have significant influence on the outcome variables (political activities and SJ advocacy activities) and was not further examined.

An independent samples t-test was conducted to compare the scores on beliefs, barriers, supports, activities, Social Justice Advocacy total, SJ collaboration, SJ social/political advocacy, SJ empowerment and SJ client/community advocacy based on nurse's primary position in nursing for staff RNs and "Other" nurses. Of these variables, all comparisons showed a significant mean difference except for beliefs (Table 5).

Table 5

Independent Samples T-test for Staff RNs and Other RNs

Variable	*M*	*SD*	*t*	Mean difference	CI (95%)	eta squared
Beliefs			(185), -1.48	-.13	[-.31, .04]	.01
Staff RN	3.52	.64				
Other RN	3.65	.55				
Barriers			(186), 2.40*	.17	[.03, .31]	.03
Staff RN	2.96	.51				
Other RN	2.78	.45				
Supports			(184), -3.99*	-.32	[-.49, -.14]	.06
Staff RN	2.88	.56				
Other RN	3.20	.65				
Activities			(186), -3.53*	-1.13	[-1.76, - .49]	.06
Staff RN	5.79	2.19				
Other RN	6.93	2.16				
SJ Total			(184), -3.55*	-.46	[-.72, -.20]	.06
Staff RN	4.13	.82				
Other RN	4.59	.95				
SJ Collaboration			(184), -3.99*	-.62	[-.92, -.31]	.12
Staff RN	3.82	.99				
Other RN	4.44	1.11				

*Sig * p <.05, **p<.001(2 Tailed)*

Table 5

Independent Samples T-test for Staff RNs and Other RNs

Variable	*M*	*SD*	*t*	Mean difference	CI (95%)	eta squared
SJ Social/Political Advocacy			(184), -3.46*	-.61	[-.97, -.25]	.06
Staff RN	3.15	1.03				
Other RN	3.76	1.38				
SJ Empower						
Staff RN	4.75	1.04	(180), -2.21*	-.34	[-.65, -.04]	.02
Other RN	5.09	1.05				
SJ Client/Community Advocacy			(184), -2.18*	-.27	[-.51 - .025]	.02
Staff RN	4.80	.79				
Other RN	5.07	.89				

Sig p <.05, ** p<.001(2 Tailed)*

To answer the first research question regarding nurses' beliefs about their role as a political advocate, 77.5 % (*n*=155, *M*=4.00, *SD*=.821) reported that they either agreed or strongly agreed that it is important for nurses to be politically active. Sixty six percent (*n*=132, *M*=3.76, *SD*=.925) of nurses agreed or strongly agreed that it is the role of the nurse to address health and nursing issues in their community. Additionally, 94.5% of nurses either agreed or strongly agreed (*n*=188, *M*=4.33, *SD*=.612) that it is a nurse's role to address professional issues in their places of employment. The total beliefs subscale is a 12 item construct measuring nurse's political beliefs, including interest, confidence, educational preparedness and an understanding of the provincial, federal and municipal government systems. Nurses overall agreed (*n*=200, *M*=3.58, *SD*=.592) that they had an interest, confidence and an understanding of their government systems.

The second research question explored which political activities nurses participate in. The five most common activities that nurses reported to be involved in were; voting at the federal and provincial levels, discussing health and nursing related issues with work colleagues, voting at the municipal level and agreeing with the statement "I always vote" (Table 6).

Table 6

Most Common Political Activities Nurses Participate In

Frequencies and Percentages

Activity	Frequency (*n*)	Percentage (%)
Voted Last Federal Election	179	88.6
Voted Last Provincial Election	176	87.1
"I discuss health/nursing issues about my community with my nursing colleagues"	175	87.1
Voted Last Municipal Election	164	81.2
"I always vote"	160	79.2

Nurses were less likely to have run for a political position as a candidate in an election 0.5% (*n*=1), to have attended nursing action activities such as demonstrations or Queen's Park Day 8.9% (*n*=18), or to have written a letter to their local newspaper to address a local health or nursing issue 11.4% (*n*=23). However 37.1% (*n*=75) of nurses surveyed reported having written to their MP or MPP to address feelings or concerns about a health or nursing issues. Of the 201 Ontario nurses surveyed *n*=91 (45%) stated that they are a member of the Registered Nurses' Association of Ontario (RNAO), the professional association that lobbies on behalf of RNs for health and nursing issues. Over 50% of those surveyed reported that they participate in volunteer work within their communities (*n*=102).

The third research question asked nurses to identify barriers and facilitators for involvement in political activism. The most frequent reported barriers of political involvement were identified as having little free time, a lack of educational preparation about politics, a lack of trust in politicians, not having the "right connections" and a dislike for conflict and/or confrontation (Table 7).

Table 7

Barriers for Involvement in Political Activity

Frequencies and Percentages

Barriers	Frequency (*n*)	Percentage (%)
"Little free time"	140	70
Lack of trust in politicians	114	57
"I don't like conflict/confrontation"	106	53.2
Lack of educational preparation about politics	103	52
"I do not have the right connections"	77	38.3

In the current study, 29.8% (*n*=60) agreed that public speaking was a barrier to their own involvement in political activities. Other questions in this construct included whether participants agreed with women's role in politics. Eighty nine percent (*n*=178) of respondents either agreed or strongly agreed with the statement "women belong in politics". Nurses were asked to rate their responses to the statement "politics is an issue of concern relevant to nurses", 76.1% (*n*=153) either agreed or strongly agreed that politics is an issue of concern relevant to nurses.

Nurses most frequently reported supports for involvement in political activity as; membership in their professional nursing organization, being a leader in the workplace, finding political involvement challenging in their career and having self- motivation and having an interest in political activities (Table 8).

Table 8

Facilitators of Involvement in Political Activity

Frequencies and Percentages

Facilitators	Frequency (*n*)	Percentage (%)
Membership in professional nursing organizations	126	62.7
Leadership in the workplace	102	51.0
“I feel it is my duty as a nurse to be politically active”	82	40.8
Self- motivated and interested in political activities	58	28.9
“I find involvement in political activities helps me feel challenged in my career”	44	21.9

Nurses reported that they lacked the support of political role models from the significant people in their lives such as family members or partners (*M*=2.37, *SD*=1.02, range 1-5). Further, nurses reported that their current work was not supportive of participation in political activities and did not require that they stay current on political issues (*M*=2.76, *SD*=1.09, range 1-5). Data from the Social Justice Advocacy Scale (SJAS) was explored to identify to what extent registered nurses participated in advocacy activities related to the four constructs; collaborative action, social/political advocacy, client empowerment and client/community advocacy. The data for the SJAS was collected using a seven point Likert scale. Averages are reported using a one to seven range (Table 9).

Table 9

Social Justice Advocacy Subscale

Scale means, standard deviations and range

Measure	*M*	*SD*	Possible Range
SJ Collaboration	4.11	1.09	1-7
SJ Social/Political Advocacy	3.43	1.23	1-7
SJ Empowerment	4.91	1.04	1-7
SJ Client/Community Advocacy	4.94	.84	1-7

As described earlier, 77.5% of participants surveyed reported that they either agreed or strongly agreed that it is important for nurses to be politically active. To further explore this concept and answer the question “Are nurse’s beliefs reflected in their political activities?” a comparison between nurse’s beliefs and their participation in political activities was explored. A total sum of nursing activities was calculated (M=6.36, SD=2.21, range 0-11) showing that the nurses sampled were moderately active. Correlation results indicate a significant positive relationship between political beliefs and activities (r =.432, $p < .001$). Investigation of nurse’s beliefs compared with their participation in social justice advocacy activities based on results of the Social Justice Advocacy Scale total revealed similar moderate activity levels (M=4.35, SD=.91, range 1-7). Correlation results between political beliefs and the total advocacy activities in the Social Justice Advocacy scale resulted in a significant positive correlation (r =.559, p <.001).

Correlations were used further to answer the research sub question “How do barriers and supports to political involvement relate to a nurse’s political activities?” Results indicate a significant negative correlation between barriers to political involvement and activities total (r = -.316, p < .001, n =200), whereas a significant positive correlation resulted between supports to political involvement and activities total (r =.348, p <.001, n=200). These results are logical in which participation in political activities would decrease as more barriers were identified and with greater support for political involvement, participation in activities would increase. Barriers and supports had a significant negative correlation (r = -.395, p <.001, n =200) as expected.

Barriers and supports to political involvement were explored to answer the research subquestion “How do barriers and supports to political involvement relate to political activities through assessing the Social Justice Advocacy Scale total (SJTotal)?” Barriers and SJTotal had a significant negative correlation (r = -.456, p < .001, n = 198). Supports and SJ Total have a significant positive correlation (r =.629, p <.001, n =198). To summarize, as barriers increase social justice advocacy activities decreased. Alternately, as supports for political involvement increased so did participation in social justice advocacy activities.

Barriers and supports to political involvement were explored for relationships to the four subscales of the Social Justice Advocacy Scale. A significant negative correlation (r =-.365, p <.001, n =198) was evident between barriers to political involvement and Social Justice Collaboration (SJColl). As barriers increased, social justice collaboration advocacy decreased. Whereas, a significant positive correlation was reported between supports for political involvement and social justice advocacy activities (r = 628. p <.001, n =198)

Similar to the previous analyses, a significant negative correlation was identified between barriers to political involvement and the Social Justice Social/Political Advocacy Scale (SJSocPol) (r = -.373, p <.001, n =198). Results show a significant positive correlation occurred between supports for political involvement and participation in SJ SocPol advocacy activities
(r =.557, p <.001, n =198).

For the third subscale of the Social Justice Advocacy Scale relationships between barriers and supports were explored along with empowerment (SJEmpower). A

significant negative correlation was identified between political involvement barriers and empowerment activities by the nurses surveyed (r = -.372, p <.001, n =198). Additionally, supports indicated a positive relationship with empowerment activites (r=.501, n=198) which was significant (p < .001). Results indicate that as barriers increased, empowerment activities decreased, whereas supports for political involvement positively related to participation in empowerment activities.

The fourth subscale client/community advocacy activities indicated like results as the previous subscales. Barriers to political involvement were negatively related to client/community advocacy participation (r = -.471, n=198) which was significant (p <.001). As supports increased for political involvement, participation in client/community advocacy activities were significant and positive (r =.442, p <.001, n=198). In summary, the current study findings for each of the four subscales of the Social Justice Advocacy Scale indicate that barriers had an inverse relationship on political advocacy activities. Whereas the variables supports for political involvement and advocacy activities responded similarly and appear to be positively related.

To answer the research sub question "How do barriers and supports relate to political activities?" a hierarchical multiple regression was used to assess the ability of the independent variables (beliefs, barriers and supports) to predict political activities on the social justice advocacy scale, after controlling for age and area of primary employment. Age and primary employment were entered in step one, and explained 12% of the variance in activities. After entry of beliefs at step two the total variance explained by the model as a whole was 29%, F (3, 180) = 23.95, p < .001. The independent variable beliefs explained an additional 16% percent of the variance in activities, after

controlling for age and primary employment, $\Delta R^2 = .16$, *F change* $(2, 178) = 41.41$, $p < .001$. In the final model, step three, barriers and supports were entered and explained 29% percent of the variance in activities, after controlling for age, primary employment and beliefs, $\Delta R^2 = .006$, *F change* $(2, 178) = .77$, $p < .001$. In the final model only two measures were statistically significant, beliefs ($\beta = .33$, $p < .001$) and age ($\beta = .28$, $p < .001$) (Table 10).

Table 10

Summary of hierarchical regression for effects of beliefs, barriers and supports on political

activity participation after controlling for age and primary employment.

Variable	B	SE B	β	R^2	Δ R^2
Step 1				.12**	
Age	.06	.01	.29**		
Primary Employment	.66	.32	.15*		
Step 2				.29	.16**
Age	.06	.01	.29**		
Primary Employment	.38	.30	.08		
Beliefs	1.54	.24	.41**		
Step 3				.29	.006 †
Age	.055	.013	.28**		
Primary Employment	.293	.31	.06 †		
Beliefs	1.23	.35	.33**		
Barriers	-.23	.35	-.05 †		
Supports	.31	.30	.09 †		

DV: Political activities
† *p* <.10, **p* <.05, ***p* <.001

A hierarchical multiple regression was used to assess the ability of the independent variables (beliefs, barriers and supports) to predict total social justice activities after controlling for age and area of primary employment to answer the question "How do barriers and supports relate to social justice advocacy activities?" Age and primary employment were entered in step one, and explained 8.4% of the variance in activities. After entry of beliefs at step two the total variance explained by the model as a whole was 36%, F (3,180) = 33.66, $p < .001$. The independent variable beliefs explained an additional 28% of the variance in activities, after controlling for age and primary employment, $\Delta R^2 = .28$, *F change* (1,180) = 77.42, $p < .001$. In the final model, step three, barriers and supports were entered and explained 49% of the variance in activities, after controlling for age, primary employment and beliefs, $\Delta R^2 = 13\%$, *F change* (2,178) = 22.43, $p < .001$. In the final model all three predictor variables were statistically significant: beliefs, barriers and supports. Supports resulted in the highest beta value ($\beta = .42$, $p < .001$) followed by beliefs ($\beta = .16$, $p < .05$) and barriers ($\beta = -.195$, $p < .05$) (Table 11).

Table 11

Summary of hierarchical regression for effects of beliefs, barriers and supports on participation

in SJ Advocacy Total Activities after controlling for age and primary employment.

Variable	B	SE B	β	R^2	Δ R^2
Step 1				.08	
Age	.009	.006	.11†		
Primary Employment	.45	.14	.24**		
Step 2				.36	.28**
Age	.009	.005	.11		
Primary Employment	.30	.12	.16*		
Beliefs	.81	.09	.53**		
Step 3				.49	.13**
Age	.008	.004	.11		
Primary Employment	.14	.11	.07†		
Beliefs	.25	.12	.16*		
Barriers	-.36	.12	-.20*		
Supports	.62	.10	.42**		

DV: Total Social Justice Advocacy Activities
† $p < .10$, * $p < .05$, ** $p < .001$

A hierarchical multiple regression was used to assess the ability of the independent variables (beliefs, barriers and supports) to predict collaborative activities on the social justice advocacy scale, after controlling for age and area of primary employment. Age and primary employment were entered in step one, and explained 7% percent of the variance in activities. After entry of beliefs at step two the total variance explained by the model as a whole was 31%, F (3, 180) = 27.05, $p < .001$. The independent variable beliefs explained an additional 24% of the variance in activities, after controlling for age and primary employment, $\Delta R^2 = .24$, *F change* (1, 180) = 62.51, $p < .001$. In the final model, step three, barriers and supports were entered and explained 45% of the variance in activities, after controlling for age, primary employment and beliefs, $\Delta R^2 = .13$, *F change* (2,178) = 21.45, $p < .001$. In the final model, only the predictor variable supports was statistically significant, ($\beta = .47$, $p < .001$) (Table 12).

Table 12

Summary of hierarchical regression for effects of beliefs, barriers and supports on SJ Collaboration Activities activity participation after controlling for age and primary employment.

Variable	B	SE B	β	R^2	R^2 Δ
Step 1				.07	
Age	.01	.007	.11 †		
Primary Employment	.49	.16	.22*		
Step 2				.31	.24**
Age	.01	.006	.11		
Primary Employment	.33	.14	.15*		
Beliefs	.92	.12	.50**		
Step 3				.45	.13**
Age	.01	.005	.11		
Primary Employment	.13	.13	.06 †		
Beliefs	.29	.15	.15		
Barriers	-.21	.15	-.09 †		
Supports	.83	.13	.47**		

DV: SJ Collaboration Activities
† $p < .10$, *$p < .05$, **$p < .001$

A hierarchical multiple regression was used to answer the research sub question "How do barriers and supports relate to social/political advocacy activities?" The study looked at the ability of the independent variables (beliefs, barriers and supports) to predict social/political advocacy activities, after controlling for age and area of primary employment. Age and primary employment were entered in step one, and explained 9% of the variance in activities. After entry of beliefs at step two the total variance explained by the model as a whole was 32%, F (3, 180) = 28.10, $p < .001$. The predictor variable beliefs explained an additional 23% of the variance in activities, after controlling for age and primary employment, $\Delta R^2 = .23$, *F change* (1, 180) = 61.11, $p < .001$. In the final model, step three, barriers and supports were entered and explained 40% of the variance in activities, after controlling for age, primary employment and beliefs, $\Delta R^2 = .08$, *F change* (2, 178) = 12.20, $p < .001$. In the final model, age, beliefs and supports were the three measures statistically significant, with supports recording the highest beta value (β =.36, p <.001) followed by beliefs (β =.21, p <.05) and (β =.18, p < .05) (Table 13).

Table 13

Summary of hierarchical regression for effects of beliefs, barriers and supports on SJ Social/Political Advocacy Activities activity participation after controlling for age and primary employment.

Variable	B	SE B	β	R^2	Δ R^2
Step 1				.09	
Age	.20	.008	.19*		
Primary Employment	.49	.18	.19*		
Step 2				.32	.23**
Age	.02	.007	.19*		
Primary Employment	.30	.16	.12		
Beliefs	1.016	.13	.49**		
Step 3				.40	.08**
Age	.02	.006	.18*		
Primary Employment	.13	.16	.05 †		
Beliefs	.44	.18	.21*		
Barriers	-.26	.18	-.10 †		
Supports	.72	.15	.36**		

DV: SJ Social/Political Advocacy Activities
† $p < .10$, *$p < .05$, **$p < .001$

"How do barriers and supports relate to social justice empowerment activities?" A hierarchical multiple regression was used to answer this research sub question to assess the ability of the independent variables (beliefs, barriers and supports) to predict empowerment activities on the social justice advocacy scale, after controlling for age and area of primary employment. Age and primary employment were entered in step one, and explained 5% of the variance in activities. After entry of beliefs at step two the total variance explained by the model as a whole was 24%, F (3, 180) = 18.74, $p < .001$. The independent variable beliefs explained an additional 19% of the variance in activities, after controlling for age and primary employment, $\Delta R^2 = .19$, *F change* (1, 180) = 44.10, $p < .001$. In the final model, step three, barriers and supports were entered and explained 32% of the variance in activities, after controlling for age, primary employment and beliefs, $\Delta R^2 = .08$, *F change* (2, 178) = 10.50, $p < .001$. In the final model, only the barriers and supports predictor variables were statistically significant, with supports recording a higher beta value ($\beta = .32$, $p < .05$) followed by barriers ($\beta = -.18$, $p < .05$) (Table 14).

Table 14

Summary of hierarchical regression for effects of beliefs, barriers and supports on SJ Empowerment Activities activity participation after controlling for age and primary employment.

Variable	B	SE B	β	R^2	Δ R^2
Step 1				.05	
Age	.003	.007	.29 †		
Primary Employment	.47	.16	.22*		
Step 2				.24	.19**
Age	.002	.006	.03 †		
Primary Employment	.33	.14	.15*		
Beliefs	.77	.12	.44**		
Step 3				.32	.08**
Age	.002	.006	.02 †		
Primary Employment	.18	.14	.08 †		
Beliefs	.25	.16	.14 †		
Barriers	-.38	.16	-.18*		
Supports	.54	.14	.32**		

DV: SJ Empowerment Activities
† p <.10, *p <.05, **p <.001

A hierarchical multiple regression was used to answer the research sub question "How do barriers and supports relate to social justice client/community advocacy activities?" The regression analysis was used to assess the ability of the independent variables (beliefs, barriers and supports) to predict client/community advocacy activities on the social justice advocacy scale, after controlling for age and area of primary employment. Age and primary employment were entered in step one, and explained 5% of the variance in activities. After entry of beliefs at step two the total variance explained by the model as a whole was 19%, F (3, 180) = 14.30, $p < .001$. The beliefs variable explained an additional 15% of the variance in activities, after controlling for age and primary employment, $\Delta R^2 = .15$, *F change* (1, 180) = 32.80, $p < .001$. In the final model, step three, barriers and supports were entered and explained 12% of the variance in activities, after controlling for age, primary employment and beliefs, $\Delta R^2 = .12$, *F change* (2, 178) = 15.50, $p < .001$. In the final model, only the predictor variables barriers and supports were statistically significant, with barriers recording a higher beta value ($\beta = -.34$, $p <.001$) followed by supports ($\beta = .27$, $p = .001$) (Table 15).

Table 15

Summary of hierarchical regression for effects of beliefs, barriers and supports on SJ Client

/Community Advocacy Activities activity participation after controlling for age and primary

employment.

Variable	B	SE B	β	R^2	ΔR^2
Step 1				.05	
Age	.003	.006	.04 †		
Primary Employment	.35	.13	.20*		
Step 2				.19	.15**
Age	.003	.005	.40 †		
Primary Employment	.25	.12	.14*		
Beliefs	.56	.10	.39**		
Step 3				.31	.12**
Age	.002	.005	.03 †		
Primary Employment	.11	.12	.06 †		
Beliefs	.04	.13	.03 †		
Barriers	-.59	.13	-.34**		
Supports	.37	.11	.27**		

DV: SJ Client/Community Advocacy Activities
† p <.10, *p <.05, **p <.001

Nurses were asked to identify the sources from which they obtained information about political issues and health related issues in their communities. For both concepts, nurses received their information from; the newspaper, television, radio, in discussion with colleagues and from the internet (Table 16).

Table 16

Frequencies chart of resources nurses use to obtain political and health-related information

Source of Information	Frequency *(n)*	Percentage (%)
Political Information		
Newspaper	175	87
Television	170	84
Radio	150	74
Internet	139	69
Discussion with colleagues	130	64.4
Health-related Information		
Newspaper	166	82
Discussion with colleagues	159	79
Television	154	76
Radio	134	66
Internet	132	65

Nurses were less likely to use sources such as the RNAO website (21%), interest groups (30%), conferences (30%) or social networking (31%) to obtain political information. Least commonly used resources for health-related information were data from community assessments (24%), participation in research (31%), Health Canada and other statistical sites (37%) and reading journals (51%). It would appear that there are opportunities to teach nurses about the resources available to them, how to access those resources and how to utilize the findings.

Chapter V

Discussion

This chapter summarizes the results from the previous chapter and discusses the key findings related to the problem statement and research questions. Significant findings, limitations, recommendations and implications for nursing will be reported about the study's findings.

The purpose of the study was to explore and describe the beliefs and practices of registered nurses in Ontario regarding the concepts of advocacy and politics. The current research study is a response to a request from nursing's professional regulatory bodies to fulfill an obligation to the profession's social mandate of political advocacy. Advocacy is a dominant concept throughout the College of Nurses Standards of Practice that provides guidelines for nurses in the province. However, it is a concept that is difficult to explain and define based on various meanings of the term. It is further complicated by the diverse roles that nurses fulfill and settings in which they work. Politics is a term associated with government affairs, power and strong opinions. Activism today is complicated by personal and professional barriers such as time restraints and a lack of

trust in the politicians. Today 3.9% of Ontario nurses currently fulfill formal roles related to politics and/or population health (CNO Membership Statistics, 2012). The problem lies in that, little is known about how nurses can combine these two concepts to fulfill their social mandate of political advocacy.

Significant Findings

It has been argued that in the past, women have lacked interest in public affairs and that this may still be the case today (West & Scott, 2000). Results of the current study reveal that there is a mean difference in the political interests between males and females. In the current study, gender was explored and revealed no mean difference in the variables; barriers, supports, activities, SJ Total, SJ collaboration, SJ social/political advocacy activities, SJ empowerment, SJ client/community advocacy activities for males and females. However, there was a significant mean difference in their beliefs. Males scored higher than females in relation to their interests in politics, desire to learn more, confidence levels to address political issues, reports of educational preparation and understanding of all levels of government. Nursing remains a predominately female profession with current representation of over 90% of the registrants in Ontario. New male presence in the profession is growing; however, current membership is 10 % (CNO, New Membership Trends, 2012).

Nursing Beliefs

In the current study, registered nurses' beliefs were explored regarding their role as political advocates. Nurses were asked to rank their response to statements such as; "I would like to learn more about politics" and "I am confident in my ability to address

political issues". Seventy eight percent of nurses surveyed either agreed or strongly agreed that it is important for nurses to be politically active; 68% (n=136) reported an interest in politics. Gebbie (2000) asked "Does the scope of professional nursing practice include an obligation to be involved in public policy and political activities?" Although nurses thought it important to be politically active and were interested, only 30% of respondents reported that they were motivated to become involved. Of the current study findings, 76% of respondents agreed or strongly agreed that politics is the concern of nurses, 89% stated agreement with the statement "women belong in politics" and 67% of nurses responded that it was "the duty of a nurse to be politically active". Nurses responded strongly (94%), that "it is their role to address nursing issues in their places of employment". These numbers are encouraging and can be related to the four stages of nurse's political development (Cohen et al., 1996). In the first stage of political activism or "buy in" there is an increased awareness of nursing issues, a desire to learn political language and occasional participation in political activities. The second stage is focused on self-interest when the nurse moves from awareness to activism. More complex political action such as campaigning, legislation and public relations are experienced in stage three, while leadership and initiation of policy development is integrated in stage four.

Nurses reported that they lacked the support of political role models from the significant people in their lives such as parents or partners. This finding is inconsistent with the literature that reports family influence and political role models as a common support for political involvement (Des Jardin, 2001; Gebbie, Wakefield & Kerfoot, 2000; Primomo, 2007).

Barriers to Political Involvement

In the present study, nurses were asked to identify barriers to their political involvement. The results of this study are consistent with the literature having identified as the most significant barriers to political involvement; time restraints (Des Jardin, 2001; Boswell, Cannon & Miller, 2005), a lack of trust in politicians (Ennen, 2001), dislike for conflict and confrontation (Antrobus, Masterson & Bailey, 2004), a lack of educational preparation (Antrobus, Masterson & Bailey, 2004; Boswell et al., 2005; Des Jardin, 2001; Primomo, 2007) and "not having the right connections" (Rains-Warner, 2003).

Time restraints were identified as the leading barrier to nurse's political involvement. Nurses experience many demands of home, family and career (Boswell, Cannon & Miller, 2005). The work of nurses presents physical, mental and emotional challenges along with long work hours. It is logical that the busier one is, the less time one has for involvement in political activities. However the current study indicated that a greater number of home responsibilities did not significantly contribute to the outcome variable of participation in political activities and total social justice advocacy activities (SJTotal). Traditional female roles associated with gender such as homemaker and mother may move one to assume that women would have more barriers than men due to home responsibilities and therefore would be less politically involved. The current study explored gender and revealed no mean difference between males and females in regards to their political barriers or supports, SJ Total and the four scale constructs; collaboration, social/political advocacy, empowerment and client/community advocacy.

Fifty seven percent of nurses reported a lack of trust in politicians as a barrier for involvement in political activity, which is consistent with the literature (Ennen, 2001).

The lack of trust may be a result of negative images of politics that are prevalent in the media. Nurses are held in high esteem in the public and this is a direct contradiction with the image of politicians. Frequent policy changes based on the current values or ideals of the government of the day make it difficult for nurses to hold constant a connection with any particular party or candidate. Des Jardin (2001) believes perceived moral-ethical conflicts and negative images of politics are causes for nurse's political apathy.

Nurses (*n*=106) reported a dislike for conflict and confrontation as a barrier to their political involvement. Great effort and risk taking is necessary when trying to accomplish a goal with people in power and positions of authority. These measures are needed to create a credible argument in order to influence politician's decisions. Nurses are criticized as being dutiful, subordinate and obedient servants (Sumner & Danielson, 2007). These negative images do not serve nurses well in political environments. Nurses need to be both seen and heard at debates about health. Experienced nurse activists encounter disagreement and resistance in every effort when competing for resources, policy change and in addressing social inequities. Cathy Crowe, a street health nurse and advocate for the homeless in Toronto recalls her experiences with the political system and describes "countless struggles for resources that are limited and that do not come without a fight" (2009, p. 6).

In addition to the fear of conflict, 30% of nurses in the current study reported having anxiety related to public speaking. The literature describes the fear of public speaking as a common insecurity for nurses and creates difficulty when strong arguments are needed for political debates (Antrobus, Masterson & Bailey, 2004; Byrd et al., 2004; Des Jardin, 2001). Experienced nurse activists recommend a need for nurses to be more

visible to the public and the media as a strategy for political success (Rains-Warner, 2003); however, this would be especially difficult for an individual with the fear of public speaking. One solution to address issues of fear of conflict and public speaking is to register as a member with a professional nursing organization who speak and lobby on behalf of its members (Boswell, Cannon & Miller, 2005).

Lack of educational preparation is among the most prevalent barriers identified in the literature (Harrington et al., 2005; Primomo, 2007; West & Scott, 2000; Fyffe, 2009; Gebbie, Wakefield & Kerfoot, 2000; O'Neill-Conger & Johnson, 2000). In the present study 52% of nurses stated that they lacked educational preparation about politics. Further, 60% of respondents reported an interest in learning more about the subject. Nurses have called for educational preparation in policy advocacy and beginning research suggests that political education enhances competencies in political advocacy (Reutter & Duncan, 2002). An internet search of six Ontario universities offering undergraduate nursing programs revealed that courses in political science are not required. Cohen et al., (1996, p. 260) describes a "political awakening" that is needed in nursing education. Reinstatement of mandatory courses in political science, democracy, and civic engagement are crucial (Gehrke, 2008).

Little debate is found in the literature about the need for educational preparation. O'Neill and Conger, (2000) asked, "How will the education be accomplished and at what level of nursing education will it be introduced?" In the current study when participants were asked to identify when political education should be introduced in curriculum, 89% of them stated that politics should be introduced at the undergraduate level; some respondents added comments that political education should begin earlier at the

secondary school level. Byrd et al., (2004) agrees that engaging students early in their education is a first step in preparing them to be politically active professionals. In one recent study of new graduates, nursing students' attitudes towards poverty were quite negative, proving that curriculum and course work alone cannot move one to act politically (Falk-Rafael, 2005).

Networking is an effective strategy in making connections and these links are an important means of influencing policy (Ennen, 2001). In this study, although nurses reported having a lack of the "right" connections, 87.1% reported as a support of political involvement that they do collaborate with colleagues in discussing health and nursing issues about the community and overall nurses were somewhat likely to participate in collaborative social justice activities (*M*=4.11, *SD*=1.10, range 1-7). Collaboration with government, citizen councils and local people are needed to build relationships for political advocacy (Carnegie & Kiger, 2009). In a study of six nurse activists, networking and collective action were among the major concepts that were identified as facilitators for political success (Rains-Warner, 2003).

Supports to Political Involvement

Respondents were asked to identify facilitators that they considered to be supportive in their political involvement. Sixty three percent of respondents reported membership in professional nursing organizations to be the most important factor. This finding is congruent with the literature, which claims that membership in professional organizations encourage political behaviours such as voting, getting to know policy makers, mobilizing resources, writing letters to MP/MPPs and analyzing policy (Boswell, Cannon & Miller, 2005; Cohen & Milone-Nuzzo, 2001; Rains & Barton-Kriese, 2001;

Reutter & Duncan, 2002). Although the majority of nurses reported membership as the most important facilitator to political involvement, their beliefs are not reflected in actual RNAO membership which was reported to be 45% in this study. The provincial membership is currently 35% of the RNs eligible to work in Ontario (CNO, Membership Statistics, 2012). This raises the question if RNAO members were more likely to complete the survey than non RNAO members.

Additional supports for political involvement were identified as fulfilling a leadership role in the workplace (51%) and finding political involvement challenging to their work (22%). Contrary to this result, nurses reported that their current employers were non-supportive of participation in political activities and 30% reported a fear of retaliation from their employers and people in authority. Forty six percent of participants reported that it was not a requirement of their jobs to stay current on political issues. Nurses should be free of fear from retaliation from employers and persons of authority. Workplace health and safety policies are in place to protect employees from incidents of harassment, threat and harm. Nurses at all levels and positions of nursing should have awareness of health and nursing issues that impact their communities. Nursing's social mandate is political competence in addressing continuous health-related needs of society (Rains & Barton-Kriese, 2001). Professional nurses have a responsibility to act and have been called upon to take action from governing bodies of nursing. The Canadian Nurses' Association (CNA) has asked nurses to pursue roles of advocacy and social responsiveness in order to pursue change and human rights (2010). The International Council of Nurses (ICN) and the World Health Organization (WHO) remind nurses of "social and political responsibilities to focus on community, national and global social

policies through external political action" (Des Jardin, 2001). Nurses have been criticized as being "invisible" in contributions towards health, political action and power (Falk-Rafael, 2005; Rains & Barton-Kriese, 2001). All nurses need to be supported in their roles as advocates.

Political Activities

Voting was identified as the most frequent political activities that nurses participated in. Nurses reported strong voting habits; 79.2% stated "I always vote" 87.1% voted in the last Ontario election 89% voted in the last federal election, and municipal election participation was reported at 81.2%. These findings from the sample are much higher than the voter turnout in the general population. In the 2006 Canadian election voter turnout was 58.8% while similar numbers were seen in the previous provincial election at 58.6% (http://www40.statcan.gc.ca/101/cst01/govt09c-eng.htm, retrieved June 16, 2012). Boswell, Cannon & Miller (2005) have described nurses' apathy towards politics as pandemic. The current study findings do not suggest that the sample participants are apathetic towards politics. Results raise the question, "Are these participants different from the population in their interests about politics and voting habits?" If this is true, it seems logical to think that they would have been more likely to have completed a survey about politics.

Nurses appear to receive information about political and health-related issues through traditional means of the newspaper, television, radio, and in discussion with colleagues, and less often through the internet. Nurses were less likely to use professional sources such as the RNAO website, interest groups, conferences or social networking to obtain political information. Least commonly used resources for health-

related information were community assessment information, participation in research, Health Canada, other statistical websites and reading nursing journals.

Staying current on all political and health-related news is important; however, the sources that nurses have reported using are not always reputable or favourable to nursing. The media has been criticized for largely ignoring nurses (Rains-Warner, 2003) and as a result, many professional nursing organizations have made it a priority to strengthen their relationship with the media. It would appear that there are opportunities to teach nurses about the dependable resources available to them, how to access those resources and how to utilize the findings. The literature suggests that nurses need to use the media as a strategy for political success and by recognizing the power of media they can become more visible by addressing healthcare issues in the public eye (Rains-Warner, 2003; Fyffe, 2009).

When exploring how barriers and supports relate to political activities, after controlling for age and primary employment, beliefs and age were the most important predictors of political activity. For total social justice advocacy activities (SJTotal) the most significant predictors were supports, beliefs and barriers. Social/political advocacy activities were predicted by supports, belief and age. Support was the single most important predictor of collaborative activities while empowerment and client/community advocacy activities were predicted by both supports and barriers. It is difficult to find trends among these results; however, it would appear that supports for political involvement is a consistently identified predictor for all areas of social justice activities. Age was a significant predictor for both political activities and social justice social/political activities which measure similar concepts. The current study findings

identify that the older participants were more likely to participate in political activities compared to the younger respondents. Further comparisons of age groups and differences in supports and barriers for political involvement would be of interest. Beliefs were a predictor shared by both SJ total activities and the social/political advocacy activities, while SJTotal and client/community both experienced barriers as a mutual predictor.

Limitations

The response rate for the present study was 20.8 % (n=201) of a possible 964 participants, after 36 surveys were undeliverable based on unfound addresses by the postal service. Low response rates are a limitation of mail surveys (Leedy & Ormrod, 2005, p. 193). The data collection phase extended beyond the anticipated plan to an eight week period. Further limitations of mail surveys included high costs and a lengthy data collection period (Polit & Hungler, 1999, p. 349). Mail surveys are criticized for potential problems related to validity and accuracy of self-reported information (Polit & Hungler, 1999, p. 312). Participants may have a tendency to want to present themselves in a positive light and may not be truthful. The author has no choice but to trust that the respondents have been accurate and honest in their reporting. Polit & Hungler, (1999, p. 313) warn that the researcher must be aware of the limitations and shortcomings of self-reported surveys and use.

According to Dean (2009), the Social Justice Client/Community Advocacy Scale (SJCliCom) has good internal consistency, with a Cronbach alpha coeffieicent reported of .76. In the current study, the Cronbach alpha coefficient = .68. Values above .7 are considered acceptable however, values above .8 are preferred. When using an

established and validated scale, removing items would prevent making comparison of the current research findings to other studies using the scale (Pallant, 2010, p. 100).

The political activities scale which was developed by the author reached a Cronbach's alpha = .66. Removal of an item was considered however with almost no variance this would present little if any contribution to the findings. As a result, the item was maintained. Future researchers using the scale should be aware of the limitations when interpreting results. The barriers scale had a Cronbach's alpha of .73, there were some negatively correlated items found in the corrected item-total correlations statistics. This may indicate that items did not "hang well together" as a whole. The barriers scale is written in negative terms such as; "I do not trust politicians" and "I do not have the right connections". Removal of any of the items if deleted would not improve the overall Cronbach's alpha and therefore was not altered.

One item in the supports scale did not appear to have good correlation with the other scale items as a whole. Removal of the item would improve the overall Cronbach's alpha by .03, however the item was maintained as it addressed one of the most frequent facilitators identified in the literature, although it did not result in significant findings here.

There are some similarities in phrasing of questions between the barriers and supports scales. This is noted as a limitation for future use of the tool as there may be an overlap in the measures of these two variables.

Recommendations for Future Research

The present study reported nurses feeling strongly that it was their role to address nursing issues in their places of employment (94%) and in their communities (66%).

Future research is recommended to perform a critical appraisal of the nursing role to determine whether public policy reform is a legitimate role of the practice of nursing (Ballou, 2000; Reutter & Duncan, 2002, p. 303). Professional nursing bodies are prompting nurses to fulfill their social mandate of becoming more involved in socio-political matters at the community, national and global levels however, no directives or formats as to how to achieve this goal have been set forth.

In the current study, nurses agreed that political activism is important, a concern to the nursing profession and that nurses have a "duty" to be involved. Although they reported that politics was overall important, nurses reported a lack of motivation to become involved (30%). Only 43.7% of nurses reported feeling confident in their ability to address political issues. Additionally, 41% of nurses surveyed believed their vote in the last Ontario provincial election to be influential. Future studies could include the role of self-efficacy and motivational theories in relation to political activism and nursing.

Further exploration is needed to examine the fear of retaliation and lack of support from employers and persons in authority as reported by 30 % of nurse respondents in the current study. Future research is needed to examine nurse's experiences of harassment, threats and/or harm, workplace policies and management/administration responses to nurses' political involvement.

According to West & Scott (2000), historically women have been assumed to have less concern with public interests and it has been argued that this identity may still be relevant today. The current study results supported this statement as findings revealed a mean difference in relation to political interests for males and females. Future research

studies could provide a more detailed exploration of the differences in political beliefs between genders.

Additional research using the critical social theory is needed to explore how nurses can facilitate self- advocacy in their patients through use of enlightenment or raising awareness of the inequalities in their lives. Nurses are encouraged to evaluate socio-political causes of illness.

Implications for Nursing

The current study will add to the body of knowledge through describing the political activities, experiences and beliefs of Ontario registered nurses. This population had not previously been studied in regards to the concept of political advocacy. Findings may provide information on how best to understand the concept of political activism as a form of advocacy. The implications of this study are two-fold for the nurse as a person and a professional. Nurses are both recipients and providers of healthcare and experience the challenges of the healthcare system from both roles. It is well documented that nurses are busy individuals with personal and professional responsibilities. It is difficult to fulfill family obligations and strive to be an active professional nurse. Nurses need to reflect on their values and beliefs, consider the inequities that they witness daily in their work lives and find the motivation within to address these issues. Nurses are reported as having a professional, social and moral-ethical obligation to fulfill nurses' social mandate of political competence. Competency does not occur without education, practice and experience. Nurses must make an effort to engage in learning opportunities to effectively and confidently address the root causes of the social determinants of health. Only then will nurses fulfill their social mandate as

directed by their governing bodies of nursing. Demonstration of accountability to the public includes political advocacy that supports the health of individuals, communities, nations and globally. There are opportunities at all levels of nursing to address social/political issues of health.

Canadian universities and colleges need to examine current curriculum and ensure that course work includes learning activities in democracy, politics, advocacy, civic engagement and activism (Gehrke, 2008). Students need to be engaged early in their undergraduate education in preparation to become politically active professionals (Byrd et al., 2004). Students fail to see the connection between their personal, professional and political self and lack the skills to progress towards political competence. There is a need for active learning courses such as; mentorship programs in which students can learn alongside nurse leaders in quality learning environments (Cohen et al., 1996). Experienced nurses in leadership positions would benefit from health policy education which currently is learned informally while on the job (Harrington et al., 2005). Students and experienced nurses require education, scholarship and research activities to support their efforts (O'Mahony Paquin, 2011). A lack of nursing research development in this area is a hinderance to nurse's political activism (Bu & Jezewski, 2006).

Professional nursing organizations such as the RNAO are in an ideal position to formulate guidelines on how to prepare nurses to fulfill their social mandate as political advocates. RNAO is recognized as a support to nurse's political involvement and efforts must be made to strengthen membership (Boswell, Cannon & Miller, 2005). Collectively nurses can make a difference, including a significant delegation of voters and lobbying for healthcare and nursing related issues. Networking with other nursing professionals

has been identified as a facilitator to political involvement, a trait of successful nurse leaders and an activity that the majority of nurses surveyed participated in.

Places of employment of nurses should offer continuing education and mandatory annual competency testing. Employers should focus continuing education time on the political domain including issues such as health care reform, analysis of current policy issues related to health and/or nursing, host candidate panels and/or policy debates. On site political science, democracy and healthcare policy courses in collaboration with local schools of nursing could be offered to provide convenient continuing education while saving nurses time driving or parking for example. Work places must ensure that nurses who are politically involved are supported and do not experience retaliation or harassment from coworkers or persons of authority.

Conclusion

The present study revealed that Ontario registered nurses believe political involvement to be important, have an interest in politics and that the majority of nurses would like to learn more. This study suggests that nurses lack the motivation necessary to become more politically involved. This may be due to their lack of free time and educational preparation. Despite these barriers, nurses need to explore their own values and beliefs, identify inequities that they observe in their work and communities and act upon opportunities that arise to improve the health of their clients. Use of critical social theory serves as a framework for civic engagement, social justice and empowerment of patients to recognize alternatives to their social circumstances.

Nurses believe that there is value in membership in professional nursing organizations such as the Registered Nurses' Association of Ontario; however, there is room for improvement in actual membership numbers. Nurses stated that leadership roles and politics make their work more challenging and served as facilitators to being politically active. Among these findings, a fear of retaliation from employers and persons of authority were discovered. Employers need to ensure that nurses remain safe and free of threats or harm in their workplaces. Nurses' reported having a fear of conflict and public speaking which may prevent them from becoming politically active.

The current study identified that nurses have strong voting habits, and are likely to discuss health-related and nursing issues with their colleagues. Nurses were less likely to participate in activities such as demonstrations or writing a letter to their local newspaper to address a nursing or health issue. Nurses need to be visible in discussions about health, policy and the profession, particularly in the media. This study found that a nurse's beliefs are related to one's participation in political activities; however, nurses were only moderately active in both political and social justice advocacy activities. Support systems from significant others, employers and nursing networks are needed to promote political activism.

Critical social theory emphasizes that all persons have a responsibility to create social change. Nurses are additionally challenged by being a member of a profession, one of which holds the value of caring (Browne, 2000; Wilson-Thomas, 1995). Nursing professional bodies are urging nurses to meet their social mandate of political advocacy and competence . It remains unclear as to how nurses are to achieve this goal.

Nursing's professional bodies need a strategy with clear guiding principles to provide nurses with direction and purpose. Nursing educational institutions need to reconsider mandatory courses in political science, introduction of political content at the undergraduate level and to ensure that students have active learning courses in politics and advocacy. Students need opportunities to learn and practice skills related to political advocacy such as how to contact your MP/MPP, writing letters to a local newspapers to address a health related issues, identifying the socio-political causes of illness and being responsive to government decisions that have negative impact on the health of citizens and the healthcare system. Experienced and future nurses need to be empowered to advocate beyond the individual client: real change is attainable with upstream thinking from cooperative efforts of the 117 322 registered nurses in Ontario (CNO, Membership Statistics, 2012).

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Appendix A: Table of Specifications

Research Subproblems	Variable(s)	Item Number(s)	Method of Inquiry
PART I: What are registered nurses beliefs regarding their role as a political advocate?	Interest, motivation, attitudes, importance	1-12	Descriptive statistics-frequencies, percentages Chi sq-associations between variables and demographical variables Linear Regression-correlations between variables
	Party affiliation		
	Self-efficacy, confidence		
	Knowledge		
	Educational Preparedness		
	Political action-responsibility of nursing practice		
	Nursing beliefs regarding role as an advocate		
How do RNs participate in political activities?	Activism	34-46	Descriptive-frequencies, percentages, Chi sq-associations between variables
What do nurses identify as facilitators and barriers for involvement in political activism?	Barriers	13-26	Linear regression-correlations between variables
	Supports/Facilitators	27-33	
PART II: Social Justice Advocacy Scale	Collaborative Action (20 items)	1,4,5,8-10,13,15, 19-22,25,27-29,34,37, 40,42	Linear Regression-examine correlations between variables and within constructs (can explore many variables at one time)
	Social/Political Advocacy (7 items)	3,6,7,11,14,24,36	
	Client Empowerment (8 items)	2,18,23,26,30,32,33,35	
	Client/Community Advocacy (8 items)	12,16,17,31,38,39,41,43	
PART III: Characteristics of the sample.	General demographics	1-14	Descriptive statistics-frequencies, percentages Chi sq-associations between demographical variables

Appendix B

Letter of Information for Consent to Participate in Research

LETTER OF INFORMATION FOR CONSENT TO PARTICIPATE IN RESEARCH

Title of Study: **Political Advocacy: Beliefs and Practices of Registered Nurses**

You are asked to participate in a research study conducted by Mrs. Crystal Avolio a graduate student from the Faculty of Nursing at the University of Windsor. The results will contribute to a Masters' of Science thesis. I have received your contact information from the College of Nurses of Ontario mailing list.

If you have any questions or concerns about the research, please feel free to contact Dr. Debbie Kane, Faculty Supervisor at dkane@uwindsor.ca or (519)253-3000, ext. 2268.

PURPOSE OF THE STUDY

The purpose of this research is to first explore and describe the beliefs and practices of registered nurses regarding the concepts of advocacy and politics and second, to explore if nurses believe political activism is a function of their advocacy role.

Nurses' regulatory bodies (Registered Nurses Association of Ontario, Canadian Nurses' Association, International Council of Nurses and the World Health Organization) are urging nurses to accept political advocacy as their social mandate. Despite governing bodies having claimed that nurses as professionals have a responsibility to act, there remains the question as to how nurses will fulfill this obligation.

PROCEDURES

If you volunteer to participate in this study, you will be asked to complete a survey and answer questions regarding your political and advocacy beliefs and practices. The survey is expected to take no longer than 25 minutes to complete. The survey consists of three parts, including a brief demographic section. Once you have completed the survey, you are asked to return the questionnaire in the return postage paid envelope provided. There may be up to two mail reminder postcards following the initial receipt of the survey. Data will be collected at one point in time, you will not be asked to provide any further information.

POTENTIAL RISKS AND DISCOMFORTS

There are no foreseeable risks associated with this study.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

Participation may raise interest or awareness in issues of political advocacy and social justice.

The study may add to nursing's body of knowledge through describing the political activities, experiences and beliefs of registered nurses in Ontario. This group has not previously been studied in regards to these concepts. Findings may provide information on how best to understand the concept of political activism as a form of advocacy. Study findings may assist in identifying the learning needs of the profession which may guide the development of curriculum and nursing education. This knowledge may assist in providing recommendations for professional organizations to formulate guidelines to better prepare nurses to fulfill their social mandate.

COMPENSATION FOR PARTICIPATION

Participants may volunteer to complete a ballot in order to have your name entered into a draw for a chance to win one of two $50.00 gift certificates.

CONFIDENTIALITY

Consent will be achieved through voluntary completion and submission of the mail survey. Anonymity is not ensured during the data collection phase as participants return mail envelopes will include a reference number of their address in order to prevent reminder notices being sent to those who have already completed the survey. Once the data is received the reference number will be checked to the address list and "checked off" as having been completed. The envelope will then be destroyed.
Confidentiality will be ensured, as data will be secured in a locked file cabinet and only accessible by the primary researcher. Once survey data has been transferred to a secure electronic data file all surveys will be shredded. Disclosure of the findings of the data will be presented in grouped format. No identifying information will be included in any presentations or publications that result from the research.

PARTICIPATION AND WITHDRAWAL

Your participation in this study is voluntary. You may withdraw at any time without consequences of any kind. If you decide you do not want to participate in the study do not return the survey. Since the survey will be anonymized by deleting the address, you

cannot withdraw your answers once the survey has been submitted. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

FEEDBACK OF THE RESULTS OF THIS STUDY TO THE PARTICIPANTS

Results will be made available on the University of Windsor's Research Ethics Board website at www.uwindsor.ca/reb/study-results. Click on participants and visitors and look for the title: Political Advocacy: Beliefs and Practices of Registered Nurses.

SUBSEQUENT USE OF DATA

This data may be used in subsequent studies.

RIGHTS OF RESEARCH PARTICIPANTS

If you have questions regarding your rights as a research participant, contact: Research Ethics Coordinator, University of Windsor, Windsor, Ontario N9B 3P4; Telephone: 519-253-3000, ext. 3948; e-mail: ethics@uwindsor.ca

SIGNATURE OF INVESTIGATOR

These are the terms under which I will conduct research.

Crystal D. Avolio, RN, B ScN., M Sc. (c) *May 14, 2013*

Appendix C

Terms of Reference

PLEASE UTILIZE THE FOLLOWING TERMS OF REFERENCE TO ASSIST YOU IF YOU SHOULD NEED CLARIFICATION OF THE CONCEPTS IN THE SURVEY.

Advocacy

Efforts intended to support and empower clients and/or to act on behalf of others who cannot act for themselves. “Downstream” refers to advocacy efforts on behalf of individuals, while “upstream” activities are social actions aimed at changing legislation, policies, practices, opportunities or attitudes. These advocacy efforts impact large groups of people such as a community or population.

Activism

The activities that nurses participate in to address areas of inequity and unfairness for clients, the profession or health care system (i.e. voting, writing a letter to a MPP, campaigning, attending demonstrations, etc).

Politics

Politics refer to how decisions about the organization of society are made and how resources are distributed. Politics is about power and influence, attitudes and values, and the means of shaping society. Politics is an ongoing exercise in influencing policymakers to act in a certain way.

Social Justice

Social justice examines the fair distribution of society’s benefits by focusing on changing practices and social structures that benefit some and disadvantage others. Social justice is a responsibility to social action through partnership with others to address failures in

health and social systems that challenge the health of populations (Bekemeier & Butterfield, 2005).

Appendix D: Survey Questions

PART I: POLITICAL BELIEFS AND PRACTICES: The following questions address your political BELIEFS. Check the most appropriate response which is true of you.

	QUESTIONS	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	NA
1.	I am interested in politics.	○	○	○	○	○	○
2.	I would like to learn more about politics.	○	○	○	○	○	○
3.	It is important for nurses to be politically active.	○	○	○	○	○	○
4.	I am confident in my ability to address political issues.	○	○	○	○	○	○
5.	My nursing education prepared me to act politically.	○	○	○	○	○	○
6.	My vote in the last Ontario Provincial election was influential.	○	○	○	○	○	○
7.	I have a good understanding of the **Ontario Provincial** government system.	○	○	○	○	○	○
8.	I have a good understanding of the **Canadian Federal** government system.	○	○	○	○	○	○
9.	I have a good understanding of my **municipal** government system.	○	○	○	○	○	○
10.	It is my role as a nurse to address nursing issues in my **community**.	○	○	○	○	○	○
11.	As a nurse, it is my role to address nursing issues in **my place of employment.**	○	○	○	○	○	○
12.	I am aware of the health issues of the population in my community.	○	○	○	○	○	○

The literature identifies BARRIERS that prevent nurses from being politically active in questions 13-26. Which of the following can you relate to as a barrier to being politically active? Check the response that is most true for you.

	BARRIERS TO POLITICAL INVOLVEMENT	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	NA
13.	I have little free time.	○	○	○	○	○	○
14.	I have not had educational preparation about politics.	○	○	○	○	○	○
15.	I do not understand the political system.	○	○	○	○	○	○
16.	I don’t feel that I can make a difference.	○	○	○	○	○	○
17.	I do not care about politics.	○	○	○	○	○	○
18.	I am anxious to speak publically.	○	○	○	○	○	○

	BARRIERS TO POLITICAL INVOLVEMENT	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	NA
19.	I don't like conflict and/or confrontation.	○	○	○	○	○	○
20.	I don't believe that women belong in politics.	○	○	○	○	○	○
21.	I find political language confusing.	○	○	○	○	○	○
22.	I do not trust politicians.	○	○	○	○	○	○
23.	Politics is not the concern of nurses.	○	○	○	○	○	○
24.	I do not have the "right" connections.	○	○	○	○	○	○
25.	I lack the energy.	○	○	○	○	○	○
26.	I may experience retaliation at my workplace.	○	○	○	○	○	○

The next questions 27-33 explore things that may help or support you in being politically active. Indicate which of the following you consider SUPPORTS for your participation in political activities. Check the most appropriate response that is true of you.

	SUPPORTS TO POLITICAL INVOLVEMENT	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	NA
27.	Being a member of a professional nursing organization (i.e. RNAO) is supportive of being politically active.	○	○	○	○	○	○
28.	My work requires that I am up to date and current on political issues.	○	○	○	○	○	○
29.	I am a nurse leader in my workplace and/or community.	○	○	○	○	○	○
30.	I find involvement in political activities helps me feel challenged in my career.	○	○	○	○	○	○
31.	I feel it is my duty as a nurse to be politically active.	○	○	○	○	○	○
32.	Significant people in my life (i.e. parent/spouse) were/are involved in politics.	○	○	○	○	○	○
33.	I am motivated and interested to be involved in political activities.	○	○	○	○	○	○

Questions 34-46 address which ACTIVITIES you may participate in. Check "yes" if you have participated in the activity or "no" if you have not participated in the activity.

	Question	Yes	No
34.	I voted in the last Ontario provincial election.	○ Yes	○ No
35.	I voted in the last Canadian federal election.	○ Yes	○ No
36.	I voted in the last municipal election.	○ Yes	○ No
37.	I always vote.	○ Yes	○ No
38.	I have run for a political position as a candidate in an election.	○ Yes	○ No
39.	I have volunteered in a political campaign for a candidate.	○ Yes	○ No
40.	I have written a letter to express my feelings or concerns about a health or nursing issue to my government representative (i.e. MP or MPP).	○ Yes	○ No
41.	I have written to my local newspaper to address a local health or nursing issue.	○ Yes	○ No
42.	I discuss health and/or nursing issues about my community with nursing colleagues.	○ Yes	○ No
43.	I am a member of my professional provincial nursing organization (RNAO).	○ Yes	○ No
44.	I attend nursing action activities (i.e. Queen's Park Day, demonstrations, etc.).	○ Yes	○ No
45.	I volunteer in my community.	○ Yes	○ No
46.	I am a member of a committee(s) to improve nursing work issues in my workplace	○ Yes	○ No

For questions 47-55 check the most appropriate response.

47. At which educational level do you think politics should be introduced?

- o Post-doctoral
- o Doctorate
- o Graduate-Masters
- o Undergraduate (College or University)

48. Which of the following methods do you use to obtain information about **political** issues, electoral candidates, etc.? **Check all that apply**.

- o Newspaper
- o Television
- o Radio
- o Talk to colleagues
- o Discuss with family and friends
- o Internet
- o Social networking
- o Conferences
- o Interest groups
- o RNAO website
- o Other: describe____
- o None, I do not obtain information about political issues

49. Which of the following methods do you use to obtain information about **health related** issues in your community? **Check all that apply**.

- o Newspaper
- o Television
- o Radio
- o Talk to colleagues
- o Discussions with family and friends
- o Health related internet sites
- o Journals
- o Participate in research
- o Health Canada and use of other statistics
- o Community Assessments
- o Network with other healthcare professionals
- o Through direct patient care
- o Other: describe____
- o None, I do not obtain information about health issues in my local community

50. With which political party do you most closely identify yourself?

- o Conservative party
- o Green party
- o Liberal party
- o New democratic party (NDP)
- o Other: ___________________________
- o I do not closely identify with any political party

51. I know the name of my federal Member of Parliament (MP)

- o Yes
- o No

52. I know the name of my provincial Member of Parliament (MPP)

- o Yes
- o No

53. Who would you describe as the primary recipients of your advocacy efforts? (Choose the most applicable answer).

- o Individual patients and families
- o Community
- o Fellow nursing colleagues
- o None, I do not practice advocacy

54. I am familiar with the social determinants of health.

- o Yes
- o No

55. Describe the ways or activities you perform to advocate for your patient(s) or community. (May use the back if more space is required).

PLEASE PROCEED TO PART II ON THE NEXT PAGE

PART II: SOCIAL JUSTICE ADVOCACY SCALE

The following questions explore the concept of advocacy. Indicate the degree to which the following are true of you. Please check the most appropriate response for questions 1– 43.

	SOCIAL JUSTICE ADVOCACY SCALE	Strongly Disagree	Disagree	Some-what Disagree	Neither Agree or Disagree	Some-what Agree	Agree	Strongly Agree
1.	I network with community groups with common concerns related to social justice issues.	○	○	○	○	○	○	○
2.	I work with clients to develop action plans for confronting barriers to their well-being.	○	○	○	○	○	○	○
3.	I contact legislators on behalf of clients' needs.	○	○	○	○	○	○	○
4.	I have little knowledge of provincial laws and relevant policies pertaining to populations I am likely to see.	○	○	○	○	○	○	○
5.	I stay abreast of current laws and policies affecting populations with which I work.	○	○	○	○	○	○	○
6.	I have never communicated with my legislators regarding social issues that impact my clients.	○	○	○	○	○	○	○
7.	I contact my legislators to express my views on proposed bills that will impact client problems.	○	○	○	○	○	○	○
8.	I create written materials to raise awareness about issues that affect my clients.	○	○	○	○	○	○	○
9.	I encourage clients to research the laws and policies that apply to them.	○	○	○	○	○	○	○
10.	I collaborate with potential allies for social change.	○	○	○	○	○	○	○
11.	I do not know of any nurses who lobby legislators and/or other policy makers.	○	○	○	○	○	○	○
12.	I do not assist my clients in developing the communication skills needed to serve as self-advocates.	○	○	○	○	○	○	○
13.	I work to bring awareness to the public regarding issues that affect my clients.	○	○	○	○	○	○	○
14.	I engage in legislative and policy actions that affect marginalized groups.	○	○	○	○	○	○	○
15.	I teach my colleagues to recognize sources of bias within the institutions and agencies in which I am involved.	○	○	○	○	○	○	○
16.	Serving as a mediator between clients and institutions is not an appropriate role for a nurse.	○	○	○	○	○	○	○
17.	Assisting clients in calling provincial and federal agents and navigating other bureaucracies is inappropriate for nurses.	○	○	○	○	○	○	○
18.	I strive to examine problems by looking at the "bigger picture" using a problem solving approach in an effort to understand their influences on client problems.	○	○	○	○	○	○	○
19.	I typically seek feedback regarding the effects of my interactions with the communities with which I work.	○	○	○	○	○	○	○

	SOCIAL JUSTICE ADVOCACY SCALE	**Strongly Disagree**	**Disagree**	**Some-what Disagree**	**Neither Agree or Disagree**	**Some-what Agree**	**Agree**	**Strongly Agree**
20.	I carry out my plans of action for confronting barriers to my clients' well-being.	○	○	○	○	○	○	○
21.	I build relationships with trusted community members and establishments within the communities in which I work.	○	○	○	○	○	○	○
22.	I work with professional organizations to influence public policy pertaining to social justice.	○	○	○	○	○	○	○
23.	I use interventions that utilize client resources to buffer against the effects of oppression (i.e. poverty).	○	○	○	○	○	○	○
24.	I am not actively involved with organizations working toward social justice.	○	○	○	○	○	○	○
25.	I use creative means to bring attention to client issues and perceived injustices.	○	○	○	○	○	○	○
26.	My research interest focuses on giving voice to underserved populations.	○	○	○	○	○	○	○
27.	When working with community groups, I conduct assessments that are inclusive of community members' perspectives.	○	○	○	○	○	○	○
28.	I seek feedback from my clients regarding the impact of my advocacy efforts on their behalf.	○	○	○	○	○	○	○
29.	I assess the influence of my public information/ awareness efforts.	○	○	○	○	○	○	○
30.	I support my clients' self-advocacy efforts.	○	○	○	○	○	○	○
31.	I use effective listening skills to gain understanding of community groups' goals.	○	○	○	○	○	○	○
32.	I understand the effects of multiple oppressions (i.e. poverty, homelessness, etc.) on clients.	○	○	○	○	○	○	○
33.	I work to understand clients as they are impacted by social problems.	○	○	○	○	○	○	○
34.	When working with community/organizational groups, I routinely seek information regarding the history of the problem from community members.	○	○	○	○	○	○	○
35.	I assess whether client concerns reflect responses to oppression (i.e. poverty)	○	○	○	○	○	○	○
36.	I work to change existing laws and regulations that negatively affect clients.	○	○	○	○	○	○	○
37.	I collect data to show the need for social change to the institutions with which I work.	○	○	○	○	○	○	○
38.	I believe I am unable to distinguish those problems that can best be resolved through social/ political advocacy.	○	○	○	○	○	○	○
39.	My skills as a nurse do not transfer to work with community groups.	○	○	○	○	○	○	○

	SOCIAL JUSTICE ADVOCACY SCALE	**Strongly Disagree**	**Disagree**	**Somewhat Disagree**	**Neither Agree or Disagree**	**Somewhat Agree**	**Agree**	**Strongly Agree**
40.	I assess the effects of my interaction with the community.	○	○	○	○	○	○	○
41.	I feel ill prepared to seek feedback regarding others' perceptions of my advocacy efforts.	○	○	○	○	○	○	○
42.	I identify potential allies for confronting barriers to my client's well-being.	○	○	○	○	○	○	○
43.	My interventions with clients of different cultural groups do not include strengthening their racial and ethnic identities.	○	○	○	○	○	○	○

Questions 1-43 with permission adapted from: *"Quantifying Social Justice Advocacy Competency: Development of the Social Justice Advocacy Scale"* (Dean, 2009).

PLEASE PROCEED TO THE NEXT PAGE

PART III: DEMOGRAPHICS

Please tell me a little about yourself. You will not be asked to disclose your personal identity for the survey and all information you provide will remain anonymous and secure. You may wish to submit your name voluntarily for the draw at the end of the survey which will be separated immediately from your responses upon receipt.

1. What is your current age? _______ Years old

2. Gender

- o Male
- o Female

3. Which Ontario LHIN (Local Health Integration Network) do you live in?

- o Erie St. Clair
- o South West
- o Waterloo Wellington
- o Hamilton Niagara Haldimand Brant
- o Central West
- o Mississauga Halton
- o Toronto Central
- o Central
- o Central East
- o South East
- o Champlain
- o North Simcoe/Muskoka
- o North East
- o North West
- o Not sure

4. What is your current marital status?

- o Married
- o Common Law
- o In a committed relationship
- o Divorced
- o Separated
- o Widowed
- o Single

5. Check **all of the following** that apply to you, I have:

- o Young children living in my home
- o Adult children living in my home
- o Adult children living outside my home
- o Elderly parent caregiver responsibilities in my home
- o Elderly parent caregiver responsibilities outside my home
- o Disabled child/parent caregiver responsibilities in my home
- o Disabled child/parent caregiver responsibilities outside my home
- o Other (please specify): ____

6. What is your highest completed level of education in nursing?

- o Post-Doctorate
- o Doctorate
- o Graduate-Masters
- o Undergraduate Degree
- o Diploma

7. How many years of experience do you have as a nurse? ________ Years

8. Are you currently employed as a nurse?

- o Yes → **Proceed to question 10 (skip question 9)**
- o No → **Proceed to question 9 (skip questions 10-12)**

9. **If you answered NO in Question 8** your current status is:

- o Retired
- o Sick leave
- o Disability
- o Student
- o Other (specify): ______________________________

10. I practice nursing:

- o In Ontario
- o Outside Ontario
- o Both in Ontario and outside Ontario

11. Of which of the following is your **primary** place of employment?

- o Hospital
- o Community Care Access Centre (CCAC)
- o Community Health Centre
- o Community Mental Health Program
- o Hospice
- o Nursing/Staffing Agency
- o Physician's Office/Family Practice Unit
- o Public Health Unit/Department
- o Long-Term Care Facility
- o Retirement Home
- o College/University
- o Government/Association/Regulator Body/Union
- o Industry
- o Schools
- o Self-Employed
- o Insurance
- o Other (describe): ____

12. What is your **primary** position in nursing?

- o Advanced Practice Nurse
- o Case Manager
- o Clinical Educator
- o Consultant
- o Educator/Faculty
- o Infection Control Nurse
- o Informatics Analyst
- o Middle Manager
- o Occupational Health Nurse
- o Office Nurse
- o Outpost Nurse
- o Policy Analyst
- o Primary Health Care Nurse Practitioner RN (EC)
- o Public Health Nurse
- o Researcher
- o Senior Manager
- o Staff Nurse
- o Visiting Nurse
- o Volunteer
- o Other (describe): ____

13. Is there any other information that you would like to share about your experiences, practices and/or beliefs regarding politics and/or advocacy? (May use the back if more space is required).

THANK YOU FOR YOUR PARTICIPATION, YOUR TIME IS MOST APPRECIATED.

PLEASE ENCLOSE YOUR COMPLETED SURVEY IN THE POSTAGE-PAID ENVELOPE PROVIDED.

In appreciation for your participation you may enter your name and contact information below into a draw for a chance to win one of two $50.00 VISA gift certificates. Please note that this ballot will be separated immediately from the data you have completed above, therefore your identity will not be connected in any way to your responses. The winners will be notified by phone and/or email. Winners of the draw will be reported with the study results at www.uwindsor.ca/reb/study-results

NAME: ____

HOME PHONE: ____

EMAIL ADDRESS: _____________________________________

VITA AUCTORIS

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