Poverty is Hazardous to Women's Health

by

Mary E. Smith, University of Victoria, 2009

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Project Committee:
Supervisor: Marjorie MacDonald
Committee Member: Laurene Sheilds
External Examiner: Bernie Pauly
ABSTRACT

There is significant evidence to support the claim that poverty has a negative impact on a person’s health status. There are many ways in which poverty can lead to ill health, including lack of access to affordable housing, transportation, food, and non-insured health benefits, such as medications. Poverty strikes women substantially more frequently and more severely than men, with forty per cent more women than men living in poverty. The distribution of income in a given society may be a more important determinant of health than the total amount of income a person earns. Unfortunately, health status worsens at every step down the socio-economic ladder, and this income inequality is growing in Canada. So with this evidence, why are we not attacking it like the epidemic it is? Although there is support and efforts to move forward, awareness of the devastating effects and impacts of poverty, not only on women, but for our society as a whole is limited. For example, many new health care providers enter the community practice setting with limited knowledge surrounding the determinants of health, particularly related to the impacts of socioeconomic status. Therefore, the purpose of this project was to: 1) develop an interactive presentation for community health providers by integrating the findings from academic and photovoice research, in order to facilitate increased awareness and understanding of why poverty is hazardous to women’s health, 2) increase provider’s knowledge, skills, and confidence related to client interactions with individuals and families impacted by poverty and, 3) increase quality and strength of the needed partnerships within and outside the organization to combat poverty.

I believe an awareness of the connection between the hard or empirical facts, and the heart or emotional facts is critical to addressing the impact of poverty in our communities. This paper describes how to: 1) raise awareness of, and promote discussion about the social determinants of health, specifically poverty, by identifying the facts related to the issue of
women and poverty in Regional Health Authority-Central MB (RHA-Central); 2) build empathy for women living in poverty by introducing photovoice research findings; 3) promote learning in a fun and supportive environment by facilitating an interactive game; and finally 4) start a dialogue for next steps.

Public health providers’ knowledge and skills have them well positioned to combat the complex issue of poverty. This project contributed to increasing participant’s cognitive and affective knowledge in order to motivate them to practice in a more responsive, effective, and appropriate manner.
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CHAPTER 1: INTRODUCTION

Issue statement

‘Poverty is hazardous to women’s health’. This statement on a poster that has hung on my office door for the last four years holds new meaning as a result of my graduate course work and practicum experiences. It is my hope that through this project implementation I will carry forward my knowledge, passion, and commitment to influence and impact other community providers to: 1) recognize the devastating effects of poverty on the women we provide services to in RHA-Central, and 2) stimulate collaborative action to address social justice issues. This project paper is a compilation of my learning throughout my Master’s course work and practicum experiences with a focus of interest being women living in poverty. My graduate experience provided me the opportunity to develop and facilitate a number of poverty consultations that helped inform my focus and approach to this project. Additional sources of information and feedback came from session participants and personal communication with experts in the field of women’s health at the Prairie Women’s Health Centre of Excellence (PWHCE), Women’s Health Clinic in Winnipeg, and the University of Manitoba.

Background

Results from focus groups held during my NURA 518 practicum with community health providers, along with consultative feedback from colleagues, particularly the Directors of Public Health, Healthy Living, and Staff Development, have supported and endorsed the need to focus energies in this area. The purpose of my project is to develop an interactive presentation for community health providers by integrating the findings from academic and photovoice research, in order to facilitate increased awareness and understanding of why poverty is hazardous to
women’s health. The ultimate goals of this project are to share, develop, and enhance practice knowledge and skills of the community providers for optimum client care of women living in poverty. It is my hope as well, that this professional development activity will reinforce the importance of intersectoral collaboration with, for example, the departments of Education, and Family Services and Housing, to combat the effects of poverty. One sector alone cannot eliminate poverty. The following discussion will describe: my motivation; the issue of poverty and the importance of addressing poverty as a health issue; the details of my project development, implementation, and evaluation; and how the project will contribute to nursing practice.

Motivation

There is widespread agreement of the need for collective action strategies to reduce the impact of the challenges associated with the social determinants of health and related issues such as poverty, violence, and access to health care (Kawachi & Kennedy, 1997; Raphael, 2002; World Health Organization, 2007). Of utmost importance is the role of healthcare providers. According to DeLashmutt and Rankin (2005), health care providers need to be well informed and sensitive to the unique conditions and diverse needs of this population group. They must understand and use a strength-based, client-centered approach. A result of these skills, health care providers can develop trusting client-provider relationships in safe and respectful environments. These key facilitators can positively influence the women’s experience and provide the necessary conditions under which effective counselling and care can take place (Coll-Black, Bhushan, & Fritsch, 2007; Stewart, 1995).
With over thirty years of nursing experience, I have witnessed many new providers enter the community practice setting with limited knowledge surrounding the determinants of health, particularly related to the impacts of socioeconomic status. “If only they would get their act together” or “if only they would stop having so many kids.” More than one person working in Public Health has uttered statements such as these. While facilitating poverty consultations during my final practicum, I was struck by how many community providers shared these thoughts and thus, were unable to truly empathize with this population. My belief that many providers have limited awareness and knowledge related to the issue of poverty was also validated during these consultations. It was evident that health care providers have limited experience and exposure to disadvantaged or marginalized groups that are different from themselves. When asked, “what does poverty mean to you?”, many in attendance voiced concern that they really didn’t know because they themselves are not poor. They did, however, attempt to imagine what it could be like and what the associated challenges would be. But as one experienced Public Health Nurse reported, “they don’t know what they don’t know” (Public Health Nurse, personal communication, September 19, 2008).

Many of the staff currently working in the community programs of RHA-Central have been employed for over twenty years in the same area. This is a common fact in our rural farming region where many staff were raised, schooled, and employed in the same area. Most likely, their basic education and employment training did not deal with social justice issues such as poverty and the ill effects on the population. A conversation with our Director of Regional Staff Development confirmed that, to her knowledge, there has not been any training related to the social determinants of health or poverty.
If we hope to work towards reducing poverty, we must recognize the knowledge gap of many new nursing graduates, as well as others who have not stayed current with the challenges facing the community health nurse of today (Winters, Gordon, Atherton, & Scott-Samuel, 2007). I do not want to over generalize or give the impression that all staff are unaware or unprepared in this area. I do know that some staff have an understanding of the relationship between a person’s health status and the social determinants of health, and recognize the need to work collaboratively with other sectors. Collins (1995) and Laverack (2004), who work in the areas of social services and health promotion, claim the problem lies in the fact that few providers have moved beyond awareness to action although, Cohen (2006) asserts that public health providers’ knowledge and skills have them well positioned to combat this complex issue.

I recognized that there was a need to get community health providers and leaders thinking about and acting on the social determinants of health, particularly socioeconomic status. This apparent need, along with the lack of action in the RHA-Central was the motivation for this project. Fortunately, I am in a position to do something about this in my current role as a senior manager responsible for the Regional Public Health and Healthy Living Programs and the northern area of our RHA where poverty is more prominent than in other parts of the region. I have been encouraged and supported in my desire to develop this project to facilitate individual provider and corporate awareness of the need to understand the devastating effects of poverty on the women within our communities of RHA-Central. The desired outcome will be a critical awareness of the need for developing collective action strategies at the provider level, along with corporate efforts to develop healthy public policy related to poverty. My colleagues have recognized that I will be able to bring my experience of using evidence-based, best practice research to the workplace. A secondary benefit has been the opportunity for coaching and
mentoring of other staff who are inspired to pursue advanced preparation for nursing leadership roles in our region.

However, before effective action can take place, the management, program planners, and front line providers need to have more than just the hard facts, they also need the heart facts. I believe that many possess the head knowledge but lack the heart knowledge about poverty. This heart knowledge, I believe is consistent with the provider’s emotional intelligence that will be discussed later in the paper. It is these heart facts that I believe will move them to action; to move beyond just the recognition and understanding of the impact of the social determinants of health. There is no clear evidence to support that this type of knowledge moves people to action although, the study by Garden (2008) in the area of empathy in health care implies a connection and the need for future research.
CHAPTER 2: LITERATURE REVIEW

The literature review for this project drew from research and theory related to the key concepts within this paper, such as the social determinants of health, poverty (causes, measurement, and income inequality), impacts of poverty on health in general, and then specifically on women.

Social Determinants of Health

A comprehensive list of social factors and conditions that promote individual and community health are commonly referred to as the determinants of health. They include: income and social status, gender, employment and working conditions, biology, education, healthy child development, health services, culture and ethnicity, personal health practices, social support, physical environments, and social environment (World Health Organization, 2007). Of these twelve determinants, the social determinants are identified as the social conditions in which people live and work and are grouped to include income, education, employment, housing, food, and inclusion (National Collaborating Centre for the Social Determinants of Health, 2006).

Many health activists stress how critical and influential the social determinants of health are on influencing the health of individuals, communities and society as a whole, along with their strong link to health inequities. Marmot and Wilkinson (1999) researched the social determinants of health in relation to health outcomes and the resources available to individuals and families. Their evidence revealed a link between the degree of poverty and health status of the community. Studies comparing four different countries conducted by Benzeval and Judge (2001) also revealed that income levels are related to health outcomes. Raphael (2002) noted that countries with positive health status indicators also had high rankings of social and economic determinants of health, such as high income levels, safe housing, and access to buy healthy food options.
Tarasuk (2004) analyzed household food expenditure data in relation to food security and found that low income is a barrier to accessing the recommended healthy food options in Canada’s Food Guide to Health Eating. Ronzio and Pamuk (2004) and Wilkinson (1996) revealed the impact of income disparity, in that countries with large differences between the income groups were unhealthier than countries with a more equitable distribution of wealth. Ungerlieder and Keating (2002) compared the educational attainment level of individuals showing that high school graduates were more likely to utilize preventative health care services and practice healthy lifestyle behaviours, compared to those who did not complete high school.

A common theme throughout the readings in this area was the urging of the public health sector to move from an individually focused lifestyle approach, to a more collaborative approach that requires partnering with other sectors to combat the challenges associated with the social determinants of health (Brunner, 1997; Sutcliffe, Sarsfield & Gardner, 2007). We know that improving the water supply and living conditions has a significant positive effect in reducing the deaths attributed to once fatal diseases such as typhoid, diphtheria and influenza, more so than the related medical advances (McKinlay & McKinlay, 1987). Another example in the research shows that the contributions of medical science and lifestyle factor modification related to the incidence of chronic disease is less beneficial in comparison to reversing the negative socioeconomic conditions that produce negative health outcomes (Jetha et al., 2008). As early as 1978, Marmot et al. conducted a study that showed that mortality rates for coronary heart disease and stroke increased as the occupational level decreased. Contributing factors of unstable income owing to job instability, and lack of meaningful work were identified. This supports the importance of considering lifestyle behaviours along with the social and environmental factors that impact the health of an individual.
Poverty

Poverty has many complexities, and the term itself can spark an emotional reaction. I quickly realized how complex it was when I delved into the literature surrounding poverty. There was no simple, straightforward, or agreed upon definition as the researchers’ focus was dependent upon their adopted theoretical framework and approach for measurement.

Definition and measurement

The commonly accepted definition of poverty is the lack of basic necessities, such as food, shelter, medical care, and safety ("Poverty", 2009). Absolute poverty measures the number of people living below a certain income threshold, who are unable to afford basic necessities of life such as shelter, food, and clothing (Conference Board of Canada, 2009). However, a person’s needs are relative to, and dependant upon, their experiences within their environment. Relative poverty measures the extent to which an individual or family’s financial resources falls below an average income threshold for the economy (Payne, DeVol, & Smith, 2001). The definition by Deleeck and Van den Bosch (1992) considered poverty as a “relative, multidimensional and dynamic phenomenon” (p.2). A person is considered poor if they are not capable of meeting their basic needs. It considers the amount of money, but it is not only about the amount, it is also the environment and social context in which the person lives that greatly contributes to the extent of the person’s experience of poverty.

There are a variety of approaches for measuring poverty. The monetary approach is the most common and identifies poverty with the shortfall in income from a prescribed threshold. This amount then determines whether they are in poverty, and how far below the poverty line they are (Laderchi, Saith, & Stewart, 2003). O’Connor (2001) expressed concern that “the political influence is an exercise of power from the educated elite to categorize, stigmatize, but
above all to neutralize the poor and disadvantaged through analysis that obscures the political nature of social and economic inequality” (p. 12). An example of this monetary measurement is the Conference of Board of Canada’s (2009) claim, that “more than one in ten Canadians between the ages of 18 and 65 live in poverty”. This measure of poverty took into account the median income of that age group and then identified the group of people who were fifty per cent below that threshold. Canada has twice the poverty rate of Denmark and Sweden, who boast the lowest rates of about five per cent.

Another example of measurement is the ‘Low Income Cut Offs’ (LICO) which is the “proportion of persons in economic families and unattached individuals with incomes below the Statistics Canada LICO. The cut-offs represent levels of income where people spend disproportionate amounts of money for food, shelter, and clothing. LICOs are based on family size and degree of urbanization; cut-offs are updated to account for changes in the consumer price index” (Statistics Canada, 2008). There are thirty five different LICOs depending on family size and size of community. The poverty line for rural communities located in RHA-Central range from $16,275 for a family size of two, to $33,166 for a family size with over seven members. Figure 1 shows that twelve per cent of the families in our region are living below the LICO, and well below the provincial average (Regional Health Authority - Central MB, 2009). The challenge with this measurement is that income alone as a measure of poverty does not take into account additional in-kind resources, services and benefits. An example of this can be seen with the Hutterite communities in Manitoba. If we used an income measure alone, each individual and family would be considered to be living in poverty because it would not take into consideration the benefits gained through communal living.
There is value in using both measures, as the relative definition of poverty allows us to plan around the social and structural aspects of concern in a community, while the objective definition allows the tracking and comparison of data from one area to another, or across time (Canadian Council on Social Development, 2009; Laderchi, Saith, & Stewart, 2003).

Figure 1. Percentage of Families Living Below LICO by Region, 2005.

Source: Statistics Canada, 2006 Community Profiles.

NOTE: Churchill rates should be interpreted with caution due to small numbers.

**Income Inequality**

Another form of the poverty measurement relates to income inequality. The Gini coefficient is the measure used, and is generally defined by how much income deviation there is if the country had income distribution that was perfectly equal (Statistics Canada, 2008). Canada ranks tenth in comparison to seventeen other countries. According to the Conference Board of Canada (2009) indicators, Canada gets a dismal rating of a ‘C’ grade on this indicator.
As mentioned earlier, Denmark and Sweden with the lowest levels of poverty are the leaders on the income inequality indicator as well.

Unfortunately income inequality is growing in Canada, leaving a significantly wide gap between the very rich and the very poor. Over the last twenty five years, this gap has grown thirty seven per cent wider (Raphael, 2007; Statistics Canada, 2006). Recent Statistics Canada data from the 2006 Census showed the median earnings of individuals employed full-time between 1980 and 2005, increased by 16.4 per cent for the top income group, while for those in the bottom income group, their earnings fell by 20.6 per cent. Those in the middle income group saw no change (Statistics Canada, 2008). Researchers from many academic backgrounds agree that income inequality in Canada is a serious problem. If it is left unaddressed, income inequality will limit economic growth, undermine social cohesion, and lead to persistent poverty (Canadian Association of Social Workers, 2004; Hofrichter, 2003; OECD, 2005; Picot & Myles, 2005; Reid & Tom, 2006).

The capability approach focuses on indicators related to a person’s potential and quality of life. This focuses on the persons themselves, versus their income, but presents challenges because it is hard to determine how much is enough (Laderchi et al., 2003). Beyond income, an individual’s capabilities, levels of achievement, and ability to access resources, are considerations within this approach. Alkire (2002) identified key capabilities as health, nutrition, and education. Within this, is the social exclusion measurement that considers the degree to which individuals and groups are excluded from full participation in the society (Davison, Edwards, & Robinson, 2006). Brady (2003) argues that how much or how little an individual participates in the normal activities of their community, or their capabilities to function, can determine how marginalized or deprived they are. Ruspini (2001) suggested that income levels,
unemployment, access to housing, number and quality of social supports, and lack of citizenship are examples of indicators of social exclusion.

The participatory method involves the people impacted, in that they participate in decisions about determining the meaning and scope of being poor. Laderchi et al. (2003), in support of this method, criticized the monetary and capability approaches for being driven by business and government, and fails to see the perspectives of the poor people at the grass roots. They suggested that data collection methods should include asset mapping, along with perceived wealth and well-being rankings.

*Theories of causation*

Generally until 1980, theories of poverty focused on the individual’s role to explain the causes and impact of poverty. Since then, structural and societal factors were being considered, along with acknowledging the relationship and role of social, political, and economic factors in creating and maintaining poverty. Ross (2003) discussed the importance of understanding each of the competing theories, as each one helps to inform and guide our work in trying to address the complex and overlapping sources of poverty, particularly in the area of healthy public policy.

Bradshaw (2005) presented five theoretical perspectives that attempt to explain the causes of poverty. They range from 1) individual deficiencies, 2) cultural belief systems that support subcultures in poverty 3) economic, political, and social distortions, 4) geographical disparities, and 5) cumulative and cyclical interdependencies.

*Individual deficiencies*

The spotlight is on the individual with the poverty theory of individual deficiencies, as they are considered to be responsible for their poverty situation. In other words, an individual’s choices, behaviours, characteristics, and habits are considered as the prime causes of poverty.
In a sense, the individual is blamed for their situation, and if they weren’t so lazy or made such bad choices, they wouldn’t be poor. While most of us dismiss the individual deficiency theory, it is easy to see where some anti-poverty policies have originated in this theory in that they suggest penalties and incentives can change behaviour (O’Connor, 2001; Quigley, 2003). A classic example of this is entrenched in the Manitoba provincial income assistance program, with the practice of limiting income assistance to a lone female head of household if a male partner resides with her at any time. Unfortunately, many of the approaches arising from this theory are punitive in nature, such as handing out food vouchers instead of the cash to go out and buy the food themselves. Although school breakfast programs are an example of this approach, efforts such as these have a positive social safety-net component for those who cannot help themselves.

*Cultural belief systems*

The theory of cultural belief systems suggests that knowledge, skills, and values can be passed from one generation to another. This theory shares a similarity with the individual theory because of the connection between the individual and the community culture (Payne & DeVol, 2005). The major difference between this and the first theory is that the individuals are not blamed or considered responsible, because they are products of their dysfunctional culture. Quigley (2003) discussed how the culture of poverty theory explains the cycle of welfare dependency in which, for example, a young mother on welfare has come from a family where her mother and grandmother had both been welfare recipients. A Canadian income class mobility study by Corak (2006) explored the degree of change across the generations and concluded that twenty per cent of children born to low-income parents will become low-income adults.
Economic, political, and social distortions

This poverty theory is a stark contrast to the individual deficiency theory. Instead, the economic, political, and social systems are considered to be the cause of poverty. It is the system that limits people from achieving their potential. The example often cited for not being able to get ahead, is the challenges related to the low minimum wages, which limits opportunities and resources (Social Planning Council of Winnipeg, 2007; Yalnizyan, 2007). Education and training strategies that are based on this theory are geared to eliminate those barriers that may prevent the poor from moving into the better jobs (Payne, DeVol, & Smith, 2001).

Geographical disparities

Terms such as rural poverty, urban poverty, or ghetto poverty derive from this theoretical framework. It is believed that groups in certain geographic areas are disadvantaged and lack the resources needed to support a sufficient income and degree of community well-being (Bradshaw, 2005). Explanations for why poverty can be more intense in certain geographic areas relate to lack of economic investment in the area and minimal natural resources. The economic agglomeration theory proposed by Bradshaw explains how concentrations of poverty in certain locations increase the conditions of poverty because of the lack of investment from the business sector. Areas that have a concentration of poverty have been found to attract more poverty. For example, it is believed that existence of low cost housing detracts from business investment in the area. That certainly reinforces the phrase ‘location, location, location’, when considering desirable places to live or work. Another consideration as to why geographic poverty can increase, relates to selective out-migration (Pendakur, Pendakur, & Woodcock, 2008). In this case, the most capable individuals leave for a ‘better’ area. These individuals, however, are usually the leaders or role models of the group which leaves a void that is often not easily filled.
An example of a current initiative that fits with this geographic theory, is located in the downtown core of Winnipeg. The City of Winnipeg, along with the Social Planning Council’s Poverty Reduction Group, has developed a downtown revitalization and improvement program with business reinvestment and increased amenities to make it more attractive to live and work in the area. Their community development approach involved community visioning and planning with the people most impacted being the poor themselves (Social Planning Council, 2006).

_Cumulative and cyclical interdependencies_

This theory of cumulative and cyclical interdependencies is complex and appears to be an amalgamation of the previous four theories. Bradshaw (2005) describes it as a spiral of problems that closely links together the individual and their community. Factors considered from this perspective are corporate influence on legislators, de-industrialization, globalization, economic disparity, job loss, social policy, and taxation patterns. A current example is the job loss from car factory closures, now being played out in the media with vivid depictions of personal and community problems. An example of a spiral of decline and lack of investment in my own rural community, shows how the closure of a major employer in the city resulted in closing of retail stores, declining local tax revenues, and a school closure owing to out-migration. Adding insult to injury, unemployment increased which led to decreased spending. Even if the individuals wanted to invest in training or start new businesses, they lacked the ability to do so. As a result, our community has seen a lack of expansion and investments in the community. Fortunately, due to recent immigration efforts by City Council and the Chamber of Commerce, we are seeing signs of renewal with new business investment and decreased unemployment rates (Mayor for City of Portage la Prairie, personal communication, February 12, 2009).
Poverty Impacts

The relationship of material advantage owing to educational levels, stable income and employment was explored in a British study conducted by Shaw et al. (2001). Their research clearly showed a strong link between income and health, whereby health status improved as you moved up the income and social ladder. Conversely, as you moved down the socioeconomic ladder, health status was adversely impacted. They also revealed that as income disparities increased, so too did the strain on the health care system. Their conclusion was that reducing inequalities in income require increasing the lower income bracket’s cash input and resources, in order to raise their standards of living. The individuals in the higher income brackets would bear the cost through increased taxing and would result in reducing inequalities overall.

Donner (2002) suggested that instead of focusing on the total income amount, we should consider the distribution of income as the more important determinant of health. Kawachi and Kennedy (1997) examined the association between income inequality and health, and argued that “it is this inequality of distribution of wealth in a society that affects the health of the whole population” (p.1040). So what is it about the unequal distribution of income that contributes to poor health status? Social cohesion research by Kawachi et al. (1994), determined that a large gap between the rich and poor in a society inhibits social integration that limits public policy development and investment in social programs. These limitations yield an inadequate support system for all members of society.

Wilkinson (1996) claims the negative health consequences arise because people living in poverty have less access to opportunities and healthy choices such as nutritious food and physical activity; more exposure to pollution and infections; more heart disease, diabetes, mental illness and cancer; more low birth weight babies; and shorter life expectancies.
These health impacts of poverty are also documented by Health Nexus and Ontario Chronic Disease Prevention Alliance (2008) and are true for many in Manitoba and the community members of RHA- Central. Appendix A, entitled “Poverty is hazardous to women’s health – the facts” and Appendix B, “Determinants of Health Quiz” provide data to support this claim.

The wealthiest Canadians have less experience with poor health (Phipps, 2003). According to Statistics Canada reports (2008), less than six per cent of wealthy individuals say they are in less than ideal health. Those on low-income are experiencing a heavier burden of illness and premature death. Over twenty seven per cent of the poorest Canadians claim to have poor to fair health, and over fifty per cent more low-income adult men have two or more chronic conditions than high-income.

Analysis by Lightman, Mitchell, and Wilson (2009) in “Sick and Tired: The Compromised Health of Social Assistance Recipients and the Working Poor in Ontario” revealed that social assistance recipients carry an overwhelmingly high burden of ill health. Compared to the non-poor, they had significantly higher rates of poor health and chronic conditions on 38 of 39 health measures – rates as much as 7.2 times higher than those of the non-poor group. Social assistance recipients, with a median household income of only $13,000 a year, had higher rates of diabetes, heart disease, chronic bronchitis, arthritis and rheumatism, mood disorders, anxiety disorders, and many other conditions. Perhaps most distressing, “one in ten social assistance recipients considered suicide in the twelve month period preceding the study and suicide attempts were ten times higher for social assistance recipients compared to the non-poor” (p.3).

Another interesting link relates to the relationship between hunger and obesity. Brown (2003) claims the apparent paradox of expanding waistlines and persistent hunger can co-exist in the same household and are attributable to food insecurity. For example, if a family is struggling
financially they will often buy cheaper, high calorie foods in order to get the most out of their money. What is cut back is the more expensive, nutrient-rich foods. In addition, the research showed that the mothers in low-income families sacrificed their own nutrition by not eating as much so there was more food available for the children. The resulting up and down in food intake contributes over time to obesity among low-income women.

A Toronto Public Health report entitled “The Unequal City: Income and Health Inequalities in Toronto” (2008), describes fifteen key indicators of health inequality, most of which show that as low-income is reduced, health improves. The specific findings of the report supports efforts to better understand the relationship between income and health, identify strategies that address inequalities and improve health, and provide a baseline for measuring progress.

Women and Poverty

“Poverty discriminates, striking women substantially more frequently and more severely than men” (Donner, 2002). To understand why, we must consider the following contextual influences on women and their health.

Contextual influences

Nursing theories such as Newman's theory of health as expanding consciousness, Rogers’ science of unitary human beings, and Roy’s adaptation model support the interconnectedness among the physical, mental, emotional, and spiritual aspects of every woman’s being, along with the economic, political, and cultural influences on their health (Alligood, 1997).

“The dominant ideologies of our society and healthcare systems are not structured in a way that supports the health, the lives of women, and in particular the lives of women living in poverty, or any woman located outside of the dominant group” (McDonald & McIntyre, 2002,
Global economic restructuring has negatively impacted minority groups considered to be outside the dominant groups of men and business. For example, many federal and provincial social programs that were geared to improve health outcomes of minority groups had their funding discontinued due to economic restructuring (Anderson, 2000). These discontinued social policies have contributed to the widening gap between rich and poor. The groups who suffered most from these decisions were disadvantaged groups such as women and people living in poverty (United Nations, 1995, Day & Brodsky, 1998).

By looking at the past, we can better understand the present. According to Ratcliffe (2002), the dominant positioning of men in society resulted in a power imbalance that has produced “male-centered assumptions about women; the gendered division of labor in society; the relative economic poverty of women; and the long standing patterns of sexism, racism, and other symptoms of oppression that affect women’s health and healthcare in ways different from their effects on men’s health and healthcare” (p. 1). The historical oppressive domination of men over women is documented in the literature with descriptions of oppression as vivid as denying ‘voice’ (Arslanian-Engoren, 2001, Reid & Tom, 2006).

Traditionally, women's health focused on issues surrounding reproduction and childbirth, As well, women were labeled ‘the other’ in medical care as Sigmund Freud and Erik Erikson considered women’s development to be deviant from the normal, with the norm being men (Clark, Feldberg, & Rochon, 2002). The social construction of health as described by Condon (2004) as a relationship between societal attitudes and practices, influenced the decisions in such areas as medical research, diagnostic, and treatment protocols. From a feminist perspective, the general devaluing of women compared to men contributed to the lack of research studies focused on women (Ratcliff, 2002, Kinser & Lewis, 2005). If and when women’s health issues and
concerns were considered, they were compared to men and written off as abnormal (Condon, 2004; Kinser & Lewis, 2005).

_Political_

A women’s perspective has been dwarfed by the men’s perspective until the rise of feminism. This movement, which began over thirty years ago, helped facilitate the needed recognition and spotlight on women’s health and medical care (Weisman, 1998). A feminist perspective considers the relationships among and between individuals, and their environments in relation to power and oppressive forces. The desired goal is to empower women and break the stereotypes of women as nurturing and emotional (Gary, Sigsby, & Campbell, 1998).

Wuest (2001) identified a limitation or challenge within this movement, related to the perception of women’s caring and care giving role, as to whether it is indeed a burden or rather a fulfillment. Feminists who were trying to erase the stereotypical image of women, considered the focus on caring in women’s lives a hindrance towards the cause of equality. At the individual level, the process of women’s caring may be considered both renewing and destructive (Kinser & Lewis, 2005). Pertinent to this discussion is the burden that accompanies the multiple demands on women who are primary care givers, particularly in single parent households. Thus, a concern is the prevailing trend for public policy to move away from social supports to emphasizing individual responsibility. This translates into increased demands on women to care (United Nations, 1995).

_Gender_

Gender refers to the all of the socially constructed roles and relationships, behaviours, characteristics, and relative power between the two sexes; while sex refers to the biological differences between females and males (Donner, 2003). Although over the past decade we have
seen heightened media attention and dedicated research in women’s health, Weisman (1998) maintained that this focus on women's health is not revolutionary or new. What is new, is the increasing focus on gender-based analysis attributed to the feminist movement and the current legislation that required all research to include women as subjects unless targeted directly for men.

Gender-based analysis has been a positive influence, particularly in health planning where there is a deliberate attempt to determine the different issues and concerns between women and men (Donner, 2003; Spitzer, 2005). Although gender-based research revealed important distinctions between men and women in the physical domain, there is growing evidence of the need to focus on the social determinants and issues such as poverty (Day & Brodsky, 1998; Society for Women's Health Research, 1999). Organizations such as the Centres of Excellence for Women’s Health (2004) and the Canadian Women’s Health Network (2007) claim greater focus on gender-based health research and education is required to compensate for the differences, and in some instances, for the inequities in healthcare.

**Gender income gap**

The gender income indicator is defined as “the difference between male and female median full-time earnings as a percentage of male median full-time earnings” (Conference Board of Canada, 2009). Compared to fifteen other countries, Canada ranks a dismal fourteenth. Despite many years of equal rights legislation there is still a significant income gap between men and women (Donner, 2003). Canada has the second highest income gap of twenty five per cent, whereas Belgium has the lowest at nine per cent (Statistics Canada, 2008). The gender income gap is affected by a variety of factors such as age, occupation, and education (Rosenberg & Wilson, 2000).
Canadian women continue to be overrepresented in low-paying occupations in Canada. Many women have two jobs; one paid job outside the home, and one unpaid job at home doing the child care and housework (O’Donnell et al., 2005). Day and Brodsky (1998) identified the major factors in the wage gap, including the presence of children and limited choices, as these impact a woman's capacity for earning, career development, or advancement. The “Labour Force Indicators” table in Figure 2, shows that only fifty nine per cent of the women in RHA-Central are employed compared to seventy three per cent of men.

Figure 2. Labour Force Indictors by Gender, 2006.

<table>
<thead>
<tr>
<th>Labor Force Indicators</th>
<th>Central</th>
<th></th>
<th>Manitoba</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Male</td>
<td>Female</td>
<td>Total</td>
</tr>
<tr>
<td>Participation</td>
<td>68.7%</td>
<td>76.3%</td>
<td>61.3%</td>
<td>67.3%</td>
</tr>
<tr>
<td>Employment</td>
<td>66.2%</td>
<td>73.6%</td>
<td>59.0%</td>
<td>63.6%</td>
</tr>
<tr>
<td>Unemployment</td>
<td>3.7%</td>
<td>3.6%</td>
<td>3.8%</td>
<td>5.5%</td>
</tr>
</tbody>
</table>

Source: Statistics Canada, 2006 Community Profiles.

It is a sad reality that one in seven Canadian women are living in poverty (Gonsalves & Morris, 2005). Manitoba has the third highest provincial rate of poverty at 18.5 per cent compared to Canada’s 16.2 per cent. Thorndyke (2005) referred to a number of issues common among women with income levels below the poverty line, such as cross-cultural conflicts, illiteracy, and social and geographic isolation. Reid and Tom (2006) elaborated on the barriers specific to accessing healthcare services such as lack of personal resources, time constraints, transportation, childcare, language and literacy differences, lack of knowledge, and cultural differences.

The epidemiological profile for RHA-Central showed a significant number of women with incomes lower than the provincial average. The annual income for women in RHA-Central is $18,244 versus $21,480 for Manitoba. Forty per cent more women than men are living in
Poverty is Hazardous

poverty, while two-thirds of women living in poverty are working in low paying jobs and are not on income assistance. Marriage does not protect these women from poverty. Married couples with two children, who both work full-time at minimum wage, still live twenty five per cent below the poverty line. Worse yet, a single mother with one child, working full-time, and earning minimum wage lives 43.4 per cent below the poverty line (Regional Health Authority – Central MB, 2009). In keeping with the national trend, a greater discrepancy in income was found between women and men. For example, men who worked full time for a year earned an average of $34,200 while women earned almost $8,000 less, at $26,257.

*Overburdened women*

Many women who cope with multiple demands are primary care givers, particularly in single parent households living with incomes below the poverty line (Canadian Women’s Health Network, 2007). This is the case for over seventy five per cent of the families in RHA-Central, as identified in the “Family Structure and Income” graph in Figure 3.

Figure 3. Family Structure and Income, 2006.

<table>
<thead>
<tr>
<th>Family Structure</th>
<th>Central</th>
<th>Manitoba</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of census families</td>
<td>25,625</td>
<td>312,805</td>
</tr>
<tr>
<td>Married couple families</td>
<td>20,930</td>
<td>225,875</td>
</tr>
<tr>
<td>Common-law couple families</td>
<td>1,915</td>
<td>33,720</td>
</tr>
<tr>
<td>Single parent families</td>
<td>2,785</td>
<td>53,210</td>
</tr>
<tr>
<td>Female single parent</td>
<td>2,085</td>
<td>42,930</td>
</tr>
<tr>
<td>Male single parent</td>
<td>700</td>
<td>10,280</td>
</tr>
<tr>
<td>Median family income – all</td>
<td>$53,211</td>
<td>$58,816</td>
</tr>
<tr>
<td>Couple families</td>
<td>$57,853</td>
<td>$67,013</td>
</tr>
<tr>
<td>Single parent families</td>
<td>$28,599</td>
<td>$31,518</td>
</tr>
</tbody>
</table>

Source: Statistics Canada, 2006 Community Profiles.
Many investigators, along with validation from my own experiences, revealed commonalities among women living with incomes below the poverty line (Reid & Tom; Williams & Lawler, 2001). Our community health providers have adopted the term “overburdened” to describe women in poverty and their reality of multiple demands (situations, stressors, or behaviours) that are known to be associated with family difficulties (Landy & Tam, 1996). Also, women as a population group are unique and diverse with respect to many factors such as race/ethnicity, age, ability/disability, socioeconomic class, education, and sexual orientation. I believe the term ‘overburdened’ provides a more realistic and less stigmatizing label than others, such as high risk or problematic, which are commonly used in the practice setting.

Client feedback from a poverty consultation held during my NURA 518 practicum illustrates being overburdened as well, “I have to choose between paying the bills, putting food on the table, or buying my kids the clothes they need” (Healthy Baby program client, personal communication, October 27, 2007).

Risk factors

A parent survey tool from The Families First Home Visiting Program in RHA-Central identifies the factors relevant to determining the overburdened families living in our communities. The ten key risk factors explored during a conversation with a family are: the parent’s or caregivers experiences during childhood; lifestyle behaviours including drug and alcohol use; involvement with the justice system; history of mental illness; how they manage anger within their relationship and with others; coping skills and support; knowledge and understanding of infants and children’s developmental milestones; parents’ views about discipline and parenthood; current stresses with respect to the parental relationship, housing,
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finances; and other challenges that may affect the parent’s ability to care for their children (Healthy Child Manitoba, 2005). According to Willms (2002), families experiencing risk factors related to mental health, partner abuse, child abuse, and neglect are considered at increased risk for poor outcomes. Although each individual, family, and community has assets and strengths, there are at times imbalance and strain that many struggle with as they attempt to survive and support themselves and their families. Figure 4 shows an increasing trend in RHA-Central for the number of families living with greater than three risk factor areas identified on the screening tool. This number has increased from nineteen to twenty two percent over three years.

Figure 4. Prevalence rates of three or more risk factors for Central and Manitoba, 2003-2006.

Source: Healthy Child Manitoba, Families First Screening Form 2007.
Challenges of poverty

Women living in poverty are more likely to have: poor scholastic achievement; work in dangerous, stressful or unstable jobs; live in poor housing conditions and unsafe neighbourhoods; spend most of their income on housing that is most often only temporary; have fewer social supports and networks which makes them vulnerable to abuse; and engage in health risk behaviours such as smoking, drugs, and alcohol. They are also more likely to have challenges accessing health care services due to lack of transportation, childcare issues, and financial constraints (Donner, Isfeld, Haworth-Brockman, & Forsey, 2008).

Living conditions present hazards to women’s health such as poor housing with mould, poor heating, and undependable water supply, along with insufficient clothing to dress properly for cold weather (Sudbury & District Health Unit, 2006). Other contributing factors are lack of access to an adequate supply of healthy food options, communication tools such as phone or internet, and educational opportunities that limit employment opportunities and socialization (Wilkinson & Pickett, 2006).

Income and power often goes hand in hand, especially in relationships between men and women. The less money a woman has, the more vulnerable she is to violence by her partner (Reid & Tom, 2006). Morris (2003) claimed there was a long term impact in women’s abilities to leave unstable relationships which, in turn, increased women’s vulnerability to abuse. This is not to say that only poor women are vulnerable, as violence against women crosses all income brackets. The sad truth is that women living in poverty have limited resources, resulting in limited choices (Blackburn, 1993). It is difficult for women to leave abusive relationships if they don't have sufficient financial resources to take charge of their own lives. Feelings of being
trapped, helpless, and worthless are commonly expressed by women in these situations (Williams & Lawler, 2001).

In relation to handling crises, women living below the poverty line often lacked some key resources such as time to deal with a crisis, knowledge of how to solve the crisis, and access to professionals who could assist in solutions. They also experienced increased levels of stress due to less leisure time and greater financial pressures (Williams & Lawler, 2001). Although it is common to see poverty associated with mental illness, it is difficult to determine which comes first (Marmot et al., 1998).

Other challenges for people living in poverty were identified by an Ontario Public Health Association report from Health Nexus and Ontario Chronic Disease Prevention Alliance (2008). The following ten basics were listed in the report as things that people living in poverty often do without, yet things most of us take for granted.

1. Regular savings of at least $20 per month
2. Fresh fruit and vegetables every day
3. Meat, fish, or vegetarian alternative every day
4. A small amount of money to spend each week on oneself
5. Replacing worn out furniture
6. Appropriate clothes for a job interview
7. Being able to get around in the community either with a public transit pass or a car
8. Having at least two pairs of shoes
9. Able to buy modest presents for family members at least once a year
10. At least two good meals a day for adults.
Aboriginal women

Poverty is found more frequently in some groups than others. The PWCE (2006) study entitled “Women, Income and Health in Manitoba” found that nearly forty three per cent of Aboriginal women living off reserve were poor, compared to twenty per cent of non-Aboriginal women in Manitoba. That statistic is more staggering within our region with fifty one per cent of all senior women on their own, and seventy per cent of Aboriginal women all trying to survive while living below the poverty line (RHA - Central MB, 2009).

Pendakur and Pendakur (2008) studied the income gap between Aboriginal and non-Aboriginal people and found alarming evidence to show that even when controlling factors such as age and education level, Aboriginal people are significantly poorer. For example, the income of Aboriginal males living on reserve is fifty percent lower than for non-Aboriginals, and for women the comparison was twenty one per cent lower. Closer to home, the study revealed that Winnipeg, who has the highest concentration of Aboriginals in Canada (ten percent of the city population), has Aboriginal men earning forty seven per cent less than non Aboriginals, while women earned thirty eight per cent less. The researchers also confirmed my earlier claims regarding income disparity, and noted that many more Aboriginals find themselves in the lowest income brackets and experience the impacts of poverty more than others.

Women and children

Women living in poverty share this struggle with their children. Child poverty is defined as the proportion of children seventeen years and under living in households where disposable income is less than half of the median in a given country (Conference Board of Canada, 2008). Manitoba has the second highest child poverty rate of 23.7 per cent, compared to 13.7 per cent overall in Canada. Children of single parent mothers comprise a third of all the people who
Poverty is Hazardous

depend on the social welfare system for financial support. The health impacts are doubly
significant with twice the infant mortality rate compared to the highest income group. This group
is also more than twice as likely to have growth and development problems, attain lower levels
of education, and grow up to live in poverty as adults (Fleury, 2008; Social Planning Council of
Winnipeg, 2007).

The recently published study by Smylie (2009) entitled “Indigenous Children’s Health
Report” conducted a comparative study of children under twelve years old in Canada, Australia,
New Zealand, and the United States, and found that Aboriginal children’s mortality rate was four
times higher than the rate among non–Aboriginal youth in Canada. She reinforced the
significant role of the social determinants of health compared to the biological factors, since
hunger and housing were identified as significant variables. To illustrate, thirty three per cent of
Aboriginal families experienced moderate and severe hunger situations and poor housing
conditions compared to nine per cent of non-Aboriginal families.

Health impacts

There is much support for the link between income and women’s health, therefore an
understanding of the impact of poverty on women and their health is important for any provider
working in the community (Kettel, 1996; Marmot, Fuhrer, & Ettner, 1998). A report by the
Canadian Association of Social Workers (2004) showed that there are considerable and
increasing health differences for low income women, in the areas of life expectancy, incidence
and acuity of illness, and the experiences of violence in their lives. According to the Canadian
Research Institute for the advancement of Women (CRIAW), there are a number of health
problems that can be associated with women’s poverty, such as acute and chronic ill health,
susceptibility to infectious and other diseases, increased risk of heart disease, arthritis, stomach
Poverty is Hazardous

ulcers, migraines, stress, vulnerability to mental illness, clinical depression, and self destructive coping behaviours which can contribute to disability and early death. Further to this, the cardiovascular health research study conducted by Young and Cunningham (2006) revealed the negative influence of poverty and social exclusion on low-income single mother’s ability to alter risk behaviours, owing to an imbalance of power and resources.

RHA-Central’s 2009 Community Health Assessment (CHA) revealed that women living in poverty had a higher prevalence of many health conditions. Health services utilization data revealed an increased reliance on health services (not necessarily preventative ones) which drives up health care costs. As well, focus groups completed during the region’s CHA process revealed that many women considered themselves to be living in poverty. When asked how income affected their health, the participants articulated that lack of money and stress wore them down emotionally and physically. Many of the single mothers in the focus groups spoke of the difficulties for them to support a family on low salaries, usually less than $10/hour due to a lack of education or previous work experience, along with a lack of child supports. They stated that their self esteem and confidence was reduced, making it difficult to feel healthy and provide a positive environment for their children. Many spoke to feeling trapped in a cycle with no way out. The key challenges they identified were finding stable work above minimum wage, adequate housing, and subsidized child care. From this discussion, it is understandable why researchers such as Donner (2002) believed that “economic security, social support and a more equitable distribution of income are more important to women’s health status than lifestyle factors such as smoking, alcohol consumption, and physical activity” (p. 81).
Poverty reduction strategies

The ways to eliminate poverty are as complex as the theories and will reflect the chosen theoretical framework, whether deliberate or not (Mullaly, 1997). There is a strong correlation between social spending and poverty rates. Countries with lower poverty rates have invested more in national healthy public policy strategies geared to increase self-sufficiency, and less in hand-out type programs (Payne et al., 2001). For example, Denmark and Sweden with the lowest poverty rates, have attributed their success to a universal welfare policy that includes three major components: 1) social cohesion, including gender equality, 2) strategies for economic growth, such as introducing tax incentives for lower-paid workers, providing job creation and training, and providing universal child care, and 3) accountability and transparency within all levels of the system (Conference Board of Canada, 2008).

Bradshaw (2005) recommends that if we ever hope to eliminate poverty, anti-poverty campaign strategies must be comprehensive and facilitate the process by which individuals and families can achieve self-sufficiency. He identified six mutually dependant elements that are key to self-sufficiency: 1) income, 2) education and training, 3) safe and affordable housing, 4) access to health and social services, 5) social support network, and 6) personal resourcefulness.

Manitoba, like many other provinces have developed their own anti-poverty campaign in partnership with the Social Planning Council that has membership from across the sectors. The previous budget announcement of an increase to employment and income assistance benefits was a move in this direction. To balance the strategy, however, efforts are required in the area of job creation and training.
CHAPTER 3: THEORETICAL PERSPECTIVES GUIDING THE PROJECT

Critical social and feminist perspectives

The literature has clearly documented the need for nursing’s knowledge base to be built on nursing theories and conceptual models. Aggleton and Chalmers (1986) as cited in Kenney (2002) claimed that “providing nursing care without a theory base is like practicing in the dark” (p. 276). I believe that one of the real challenges facing Central’s RHA public health leadership is the fact that we do not have an identified theoretical nursing framework to guide our programs. This was evident to me as I was researching and preparing for this project. To be effective, I first had to understand and appreciate the conceptualizations and then move forward to integrate theory into practice. Potvin et al., (2005) challenge us in the field of public health practice to “formulate program theory that embraces social determinants of health and local actors mobilization for social change” (p. 591).

The two primary theories chosen to guide this project’s development and implementation are critical social and feminist theory. Both are characterized by idealism where society would be a better place if there was equality and freedom from oppression so that all could enjoy a productive and happy life (Campbell & Bunting, 1991). In utilizing this theoretical perspective I was able to question the traditional sources of knowledge, that being biomedical causes of disease, and women’s oppressed position in society. Thereby, I was also able to focus on the social determinants of health that related to the concepts of poverty and income inequality. Exploring the context of poverty related to the social physical environment, race, class, and gender influences helped facilitate a recognition and appreciation of women's subjective experience beyond low socioeconomic status (Anderson, 2000, Arslanian-Engore, 2001). I then analyzed the what, why, and how of the individual and societal power relations while
recognizing women’s rights and issues. The fact that this project highlights the issues of poverty from a women’s perspective and identifies gender specific data wherever possible demonstrates a feminist lens. The project’s title “Poverty is Hazardous to Women’s Health” promotes the need to reframe the traditional social problem of poverty, into a health issue. Potvin et al. (2005), supports this need to influence and incorporate critical social theory into public health practice theory, so as to “inform and potentially transform contemporary public health practice” (p. 592).

My desire to organize the presentation into the various subjective components of the lived experience of poverty is supported by Bourdieu (2004). Bourdieu proposed a reflexive knowledge approach to understand and appreciate the relationship between objective, subjective, and structural information for developing social change programs. It is my hope that the presentation will assist community providers to look beyond traditional medical health services, to the social, economic, and political conditions that undermine or can improve women’s well-being (Doane & Varcoe, 2005; Payne, DeVol & Smith, 2001).

This project involves educating providers, therefore it was necessary to review and incorporate educational theory to guide the development and implementation. There were two assumptions I made that played a key role in determining the most appropriate and effective theoretical approach to take for this project. First, my belief that community providers have some awareness of the statistics and facts related to poverty, but lack exposure to subjective personal stories that I consider the ‘heart facts’ from those experiencing poverty. Secondly, that there has been no opportunity for critical dialogue to challenge the inaction of our system related to poverty. With these assumptions, I chose to utilize a constructivist, popular education approach.
Educational theory: Pedagogy of popular education

From my initial literature review related to educational theories, I came to appreciate that there is a diversity of models and perspectives in the realm of adult learning. A collage of sources influences and inspires how we learn and what we choose to learn. Participation in acquiring, processing, and utilizing new knowledge is complex and multidimensional, with no one single explanation capturing the nature and uniqueness involved in the process of learning (Merriam, 1993). Upon review of the education literature, I looked for educational theory that would be consistent with the feminist and critical social theoretical perspective. As well, it was important that it was appropriate for the workplace, incorporating a learning process that would facilitate a variety of interactive methods to keep the learners engaged and having fun while learning. Arnold et al. (1991), in “Education for a change” described the popular education approach that immediately appealed to me as a perfect fit for my project. “Popular education is a form of adult education that encourages learners to examine their lives critically and take action to change social conditions” (Kerka, 1997, p. 1).

The goal of popular education, as the fit with my project, is to develop capacity for social change by critically analyzing the community’s social issues through reflection and participation (Bates, 1996; Heaney, 1992; Kerka, 1997). The term popular refers to the focus on, and of the people. This approach takes into consideration that each and every person sees the world through their own eyes (Carr, 2008). This compliments the nursing literature that acknowledges the paradigms that provide a particular set of lenses for each person to see and make sense of the world around them (Storch, Rodney, & Starzomski, 2004). Key characteristics of popular education that I incorporated into the presentation development were: 1) everyone participates so everyone teaches and learns, and 2) critical reflection and empathy are necessary for collective
action for change (Arnold et al., 1991). For effective learning, Mackenzie (1993) suggested an assortment of techniques to insure that the needs of the participants are met based on their need to have fun, be active, engaged through their most appropriate learning styles, and for their learning to be relevant to their lives. My choice therefore, of focusing on a topic that impacts their work and utilizing a visual presentation, an interactive game, discussions and handouts for the presentation will meet these requirements.

Consistent with the feminist and critical social theoretical perspective, Arnold et al. (1991) emphasized that within popular education, the issues of empowerment and emancipation are considered to uncover the current power and social conditions. With this perspective, I was aware that oppression can take different forms in different settings. An example of this oppression would be if I chose only to present the facts of poverty, and did not share the perspectives from the women themselves through photovoice. This also relates to the importance of considering a gender-based analysis, whereby gender differences are highlighted and differentiated throughout (Donner, 2003). Popular education has advantages beyond just teaching about marginalized groups; the methodology supports critical pedagogy, requiring critical thinking and analysis of issues (Bates 1996; Meredith, 1994). From the critical social theory lens, a key consideration throughout my planning was to promote and motivate participants to be active and engaged in the process of learning, to work collectively, and to build cooperation and consciousness. This process allows learners to better understand the social consequences of the social problems rather than individualizing them.

Within popular education, is an approach described as good teaching by Haberman (2004). The good teaching approach is a process of drawing out ideas and thinking differently, rather than information dumping. I appreciated this approach because it aligned so well with my
goals to have an interactive, enjoyable and fun learning experience. There is also an important focus in popular education on three essential characteristics of the educator, those being knowledge, commitment, and passion. These are needed to impact the learner effectively (Beder, 1996). This suited me because I believe I have the practice experience, knowledge base, and passion to produce a successful project, as well as a strong connection with, and understanding of the topic area and participants, since I had supervised many of the community providers who would be attending the presentation.

The following table outlines twelve conditions identified by Haberman (2004) as necessary for good teaching and how I took these into consideration when developing and delivering my presentation.

<table>
<thead>
<tr>
<th>Good teaching happens when students are:</th>
<th>Project Considerations:</th>
</tr>
</thead>
</table>
| Involved with issues they regard as vital concerns | - women’s health is a core program within Public Health Services  
- through informal conversations I recognized that women’s health issues and poverty were of interest to many providers  
- sign up sheet for attendance was filled up quickly, many days before the event, indicating that there was ample interest in the topic |
| Involved with explanations of human differences | - opportunities for dialogue and reflective sharing after the photovoice presentation and during the interactive game |
| Helped to see major concepts, big ideas, and general principles | - the session was organized to build on their existing knowledge, and provided more than one way to be exposed to the concepts of poverty and the associated impacts on women |
| Not merely engaged in the pursuit of isolated facts | - session featured more than just the evidence and encouraged reflection and questioning through the scenarios provided  
- lunch was provided to facilitate |
| Involved in planning what they will be doing | - informal discussions with focus group members from poverty consultations from my previous course practicum  
- developed project presentation with input from Regional Directors and then provided an opportunity for their preview for feedback prior to delivering session  
- at the beginning of the session, the plan and objectives were shared  
- stressed non-threatening, interactive, informal nature of the session, inviting dialogue |
| Involved with applying ideals such as fairness, equity, or justice to their world | - the issues related to the topic area of poverty highlighted these ideals  
- each person was a key member who participated in both the large and small group activities |
| Directly involved in a real-life experience | - photovoice photos were from rural Prairie women  
- played out scenarios within the game with brainstorming opportunities |
| Actively involved in heterogeneous groups | - before the interactive game, I numbered each participant to move them into five groups |
| Asked to question common sense or widely accepted assumptions that relate new ideas to previous ideas | - opportunity to reflect and question issues that were presented or stimulated by the information sharing, photos, and game |
| Involved in redoing, polishing, or perfecting their work | - encouraged to reflect on their own practice, and identify what they would do differently |
| Involved with the technology of information access | - provided hard copy of handouts and related publications, as well as resource listings of electronic access to all the information provided |
| Involved in reflecting on their own lives and how they have come to believe and feel as they do | - provided safe, welcoming environment to facilitate opportunity to reflect and share |
**Constructivist approach and emotional intelligence**

Within popular education is the premise that learning occurs in a social context. The constructivist approach supports open discussion, self examination and questioning for the learner in order to “deconstruct their own prior knowledge and attitudes, comprehend how these understandings evolved, explore the effects they have on actions and behaviour, and then consider alternate actions” (Abdal-Haqq, 1998, p. 2). Fosnot (1996) acknowledged the important connection between the cognitive and subjective heart facts learning that I propose, in that both measures are needed to approach issues of social justice.

“In our culture, we have tended to value purely cognitive intelligence, almost to the exclusion of any other type of intelligence” (Salovey and Mayer, 1990, p. 189). Emotional intelligence is the ability to understand how our feelings and the feelings of others influence and guide a person’s thinking and action (McQueen, 2004). Salovey et al. (2002) outlined four requirements for emotional intelligence. They are the ability to: “1) perceive one’s own and others’ emotions and accurately express one’s own emotions; 2) facilitate thought and problem solving through use of emotion; 3) understand the causes of emotion and relationships between emotional experiences; 4) manage one’s own and others’ emotions” (p.3). It is more than empathy because of the additional focus on the provider’s own emotions, however I will utilize the term empathy in the presentation since it is more commonly understood.

I believe that emotional intelligence is relevant when considering the best way to convey the heart facts of this project. This is supported by several authors that have suggested that emotional intelligence of providers is extremely important in establishing the emotional work of nursing that is required to effectively interact with clients, and also considered a key predictor of client satisfaction (Cadman & Brewer, 2001; Freshwater & Stickley, 2004; McQueen, 2004;
Vitello-Cicciu, 2002). The community providers need to understand and interpret how the clients feel. However, the providers must also have self awareness of their own emotions to provide for optimum care (Reynolds & Scott, 1999).

**Effective relationships**

In reviewing the literature in this area, I have come to realize the connection between effective relationships and emotional intelligence. Vitello-Cicciu (2002), suggested that nurses with higher emotional intelligence are aware of how their attitude and behaviour impacts others, are non-judgmental, and demonstrate excellent interpersonal skills and empathy. This capacity helps them have a better understanding of the clients’ perspectives and needs. When nurses are self-aware, they are more likely to manage their own feelings and have less potential for disrespectful and damaging interactions (McQueen, 2004). The decision to incorporate the photographs and statements of the photovoice research participants was a deliberate attempt to make that emotional connection that could then be translated to engagement with their clients.

**Photovoice research**

Because photovoice research is a relative newcomer in the nursing literature, it is important to review this methodology and its value to this presentation. Photovoice is a methodology developed by Caroline C. Wang and Mary Ann Burris in 1992, as a way to help rural Chinese women influence government and community policies that traditionally oppressed or excluded them (Wang & Burris, 1994; Wang & Burris 1997). This research approach combines the principles of community development with photography and journalism (Wang, Yi, & Tao, 1998). Photovoice projects, such as the one led by Carlson and Engebretson (2006) with a low-income African American community in Texas, focused on specific issues in their community that they wanted changed. The aim was to empower participants, to inform others,
and to be actively involved in decisions that affected their own lives and their community’s development. Simply, photovoice projects enable participants to provide a glimpse of their own lives from the inside, and to reveal themselves to the outside world (Wang, 1999).

I was impacted significantly when I first saw the powerful images captured by the women who participated in the PWCE (2006) photovoice research projects as described in Appendix C. Although I have thirty years of nursing experience, with many of those years working in the Northwest Territories where poverty was unmistakable, I was still taken aback by the reflections of their lived experience related to poverty. It struck me that this experience of gaining a glimpse into the lives of women in poverty is necessary for all providers, if there is any hope of working effectively with this population. Just reading about it cannot result in the awareness that comes from the visual impact. I believe reading without seeing contributes to keeping the issue of poverty invisible. I do recognize however, the merit of and need for, the background knowledge related to the contextual influences on poverty and its impacts. Thus, the motivation to develop this project focused on both elements, the facts and the pictures depicting the lived experience of poverty relating to the realities of living in poverty. The incorporation of the PWCE photovoice project photographs will make poverty visible, providing a visually captivating accompaniment to the written words of the handouts. I recognize that no picture can depict truth. The images will be presented as a representation of the reality of poverty, in an attempt to get closer to truly understanding the women’s lives, needs and challenges. As with my personal experience, I hope that it will motivate the providers to enhance and bring about change in policy and practice to benefit these women, their families, and the community at large.
CHAPTER 4: THE PRESENTATION

Setting the stage

As I prepared the project presentation I pondered the following: what information do I believe is critical to share with the providers related to poverty?, what do I want them to feel about this issue?, and what do I hope they will do after participating in the session? I then considered, what help and resources I would need, and also what could block my progress. This reflective thought process was very helpful and necessary as it provided the direction for my research and development of the project.

Public Health has an “explicit role in righting social injustices” (Kass, 2001). “Too often, public health agencies use the language of social determinants of health and the need to reduce health disparities but do not internally transform in ways that would allow for the non-traditional actions required to address social injustice as a risk to the public’s health” (Plough, p. 423; In Levy & Sidel, 2006).

I believe this project is in keeping with the vision identified in the Public Health Agency of Canada (PHAC) document “Building the public health workforce for the 21st century: A Pan-Canadian framework for public health human resources planning”. The goal is to have a “flexible and knowledgeable public health workforce working in safe supportive environments to meet the population's public health needs, and reduce health and social disparities” (PHAC, 2008). I believe it is fitting to utilize the Public Health core competencies to guide professional development sessions such as this. These core competencies are a “set of essential skills, knowledge and abilities necessary for professionals to practice public health”, considered to be the foundation needed to practice effectively in public health. The current sixty two competencies fit within seven domains: 1) core public health sciences, 2) assessment and
analysis, 3) policy development and program planning, 4) partnership, collaboration and advocacy, 5) communication, 6) socio-cultural, and 7) leadership.

Learning Plan

My overall goal as the facilitator was to enhance and develop the skills of the community health providers by providing appropriate evidence-based information to impress upon the providers both on an intellectual and emotion level, the importance and significance of poverty as a health hazard, and the need for collaborative action to effect systemic change. Levy and Sidel (2006) stressed that this action must focus on inequities, to advocate for the reduction of sources of oppression. Individual providers and the organization must understand and be able to describe inequities that exist, reasons for their presence and how they affect population sub-groups in order for responsible action to take place (Payne, DeVol, & Smith, 2001).

With this project, I was motivated to explore and demonstrate the integration of advanced nursing theory and practice related to the issue of women and poverty. In developing the presentation, I drew upon educational theory and practice as well as my advanced practice competencies and experiences to bring: community health and leadership expertise, a review of literature and relevant information on the issues impacting women living in poverty, an understanding of the interrelatedness of the various sectors and levels, and a holistic perspective to the process. In determining how much to present and the detail of the content, I considered the previously mentioned focus group results that recognized the providers’ variable knowledge and understanding of the many factors that impact the women living in poverty. Having participants understand the lived experience of the women living in poverty was my original goal for the session. In trying to explain and work with that, I soon learned that I required a great deal of reflective thinking to help me focus on what I truly wanted to do and share with the participants.
I knew I wanted to promote the need for providers to recognize the factors, such as the strengths, stressors, and support systems of the women living in poverty, and to help facilitate effective relationships for strength-based, solution-focused strategies. These strategies arise from the assumption that people have strengths and resources for their own empowerment so that they can control the process of determining what actions are needed for the change. In other words, clients, and not providers define the goals and identify and mobilize their strengths and resources. This means the providers need to be ever mindful of the danger we can be to people by inadvertently using power over others and approaching them as if we are the experts rather than considering them as the experts (Beitz, 2007; Norwood, 1998). From that, it was clear I needed to develop a learning plan for this session that was grounded in the theoretical approaches described earlier, as well as consistent with the current process of supporting professional development in their community health roles (Mellon & Nelson, 1998). Therefore, while developing the draft plan, I consulted with the Directors of Public Health, Healthy Living, and Staff Development, as well as a cross section of staff for their feedback. It was important for me to know that the session consisted of learning activities that were pertinent to their learning needs. Designing a comprehensive, yet practical learning plan would provide the opportunity for effective learning (Drevdahl, Dorcy, & Grevstad, 2001).

With a clearer focus, the ultimate goal was to share, develop, and enhance practice knowledge of this complex issue with approximately eighty Public Health Program community providers so as to improve and support their interpersonal and resource support and referral skills in working with this target population. The presentation will facilitate an opportunity to influence attitudes and practices at the individual level, and will be repeated and delivered by myself or staff educators until all the staff have participated.
The purpose of the presentation is to:

- develop an interactive presentation by integrating the findings from academic and photovoice research, in order to facilitate increased awareness and understanding of why poverty is hazardous to women’s health.
- increase provider’s knowledge, skills, and confidence related to client interactions with individuals and families impacted by poverty.
- increase quality and strength of the needed partnerships within and outside the organization to combat poverty.

The desired outcome is that the participant’s increased cognitive and affective knowledge will motivate them to practice in a more responsive, effective and appropriate manner. The objectives of the presentation are to: identify the facts related to the issue of women and poverty in RHA-Central; introduce photovoice research findings; and facilitate an interactive game. The goals presented were to: raise awareness of and promote discussion about the social determinants of health, specifically poverty; build empathy for women living in poverty; promote learning in a fun and supportive environment; and start a dialogue for next steps. The learning goals correspond with the values and beliefs based on the Canadian Nurses Association Code of Ethics and the PHAC core competencies. The detailed learning plan can be found in Appendix D.

Initially I had planned to develop a self-learning module, but after consultation with a sample draft, I realized the time commitment of the learning module for the learner was unrealistic. Therefore, the revised format of the session included three components, 1) viewing a PowerPoint presentation entitled “Poverty is Hazardous to Women’s Health”, with information and photos from a photovoice research project (Appendix E), 2) playing an interactive board
game, and 3) group discussion. I believe that continued efforts in providing interactive workshops such as this will make a difference to increase the competency and facilitate collaborative efforts of the providers. Focused efforts towards building multisectoral partnerships are needed to facilitate systemic change to community conditions (Davison et al., 2006).

Implementation

Having completed the development of the presentation, it was now time to set the date and initiate the advertisement. I was fortunate to have the support of the Public Health Director and her administrative support to develop an email bulletin that was distributed to staff throughout the community programs. A benefit of having the Director involved in the review and feedback group was her strong endorsement of the importance for staff attending this education session. Advertising the session as a “Lunch and Learn” from 11:00 a.m. to 1:00 p.m. with a free lunch proved successful. Other sessions offered by Staff Development where participants brought their own lunch were not as well attended, averaging only five to eight people. My initial sign up list had twenty-eight people registered and of those, twenty-five attended. Participants included Public Health Nurses (10), Families First Home Visitors (5), Community Mental Health Worker (1), Income and Security Workers (3) Health Promotion Facilitators (3), and Directors of Public Health and Health Living Programs (3). I was fortunate to have secured funding through the RHA education budget line to cover lunch, which turned out to be a key incentive. I strongly believe in the importance of providing food and a comfortable relaxed setting to facilitate open discussions. My plan to arrive two hours before the start time proved helpful. I was able to setup and test the computer and projection equipment, ensure I had all the necessary handouts, setup the resource display of relevant publications for further reading, and rearrange the physical layout of the room. It was challenging to transform a provincial building board room into a
relaxed setting, although I believe the desired look and feel of a safe, comfortable learning environment was achieved.

I valued the participants’ time so I made sure that we started and ended on time. Having speaker notes embedded in the PowerPoint was helpful to keep me on track and insured that I captured the important points. The initial slides reviewed the purpose and goals, and then moved on to identify the key messages related to poverty and why poverty is hazardous to women’s health, including specifics to Manitoba and RHA-Central. Most of the slides were of the photovoice pictures. This compelling visual format provided the venue to deliver the heart facts. I slowly and purposefully read aloud the women’s quotes accompanying each of their photos. I did not promote discussion until all the photos were viewed. This had a dramatic effect and allowed the pictures to speak for themselves. The second part introduced the game, which fostered productive dialogue regarding the social determinants of health while providing an interactive and fun educational experience. The third component was the opportunity for group discussion. A two page fact sheet entitled “Poverty is Hazardous to Women’s Health” (Appendix A) and a handout “Determinants of Health Quiz” (Appendix B) was distributed with the encouragement to post on their bulletin boards within their area, and at their desks as a reminder of the need for action.

The active participation component of the session featured a board game, called “The Last Straw”, in which participants were challenged to consider the social determinants of health and the varied issues that impact the individual as a client, member of a family, and the community at large, both at the macro and micro level (Rossiter & Reeve, 2008). Initially I had planned to develop my own game, but was fortunate to find that our Director of Healthy Living Program had just purchased this resource because she had played it during a health promotion
summer course. The developers of the game, Reeve and Rossiter came up with the idea as part of a course assignment during their graduate work in health promotion. I was thankful to incorporate this game into my project for the obvious reason of not having to create one myself, but also as a way to demonstrate it’s usefulness as a resource. Too often valuable resources sit on the shelf because the staff are unaware, or don’t have the time to test out the applicability to their practice.

I had set up the room ahead to accommodate five teams, each with five players. In keeping with the game rules, I provided the character profile for each team, identifying their particular biological and social circumstances that included gender, socioeconomic status and race. I asked each team to choose a name for their character to help build ownership and an empathetic connection. The teams were then awarded vitality chips (coloured poker chips) based on their profile. The various life stages (childhood, adolescence, adulthood and old age) are experienced by each character as they proceed through the game. A variety of cards for each life stage featured events and scenarios with positive or negative effects on a character. To illustrate the impact of these events, vitality chips were gained or lost. Only one character had vitality chips left at the end of the game, and was considered the winner. For the other four characters, the real-life challenges of staying healthy were brought to light as they ran out of chips, and eventually ran out of life.

My primary focus as facilitator was to make sure that the game flowed while providing key discussion points for group brainstorming related to the scenarios chosen as they moved along the board. For example, I initiated discussion related to gender when I asked the group to consider why men get more vitality chips than women, despite the fact that women have a longer life expectancy. I was able to provide information drawn from my literature review, explaining
that although women may live longer, they often live with more disability. And despite efforts towards equality, women continue to face a variety of challenges such as gender-based violence, primary responsibility for child rearing, and caring for elderly parents. It was also obvious who was more affluent, as the group recognized the disparity between the number of vitality chips each team had piled up. To further illustrate the inequitable gap between rich and poor, I asked the team with the most vitality chips to go first. The less advantaged characters all acknowledged discontent with loud booing.

The following questions were distributed to each team for discussion with the plan to have them report back to the larger group.

1. What factors influenced your character’s health?
2. When did your character gain and lose vitality chips?
3. What was your character’s cause of death?
4. What other factors influenced health?
5. Did you learn something new about the social determinants of health?
6. Do you feel more empathetic than you did before playing the game?

Unfortunately, we ran out of time before each group could report back, however, there was lively discussion of the large group throughout. At the end of the session, I thanked everyone for their enthusiastic participation and distributed the evaluation.

Evaluation

Upon reflection, I felt very satisfied with the outcome, and relieved that the presentation was completed. I do admit to feeling nervous about presenting, but those nerves were balanced with an excitement to share what I have learned, along with my passion that has been fuelled throughout my studies.
Having worked with, and supervised many of the participants, I had an understanding of their work environment and experiences. What I needed to determine, was the individual participant’s current knowledge and understanding of the social determinants of health and the impacts of socioeconomic status on a person’s health. Therefore, at the beginning of the session while participants were entering the room, I distributed a pre-test as outlined in Appendix F, with statements geared to tell me quickly their current understanding in those areas. The Likert Scale was used with one indicating strongly agree through to five indicating strongly disagree. I was able to review quickly the pre-test while they were helping themselves to refreshments and healthy food options. The results, found in Appendix G, showed that although sixty per cent of the participants could identify the social determinants of health, only fifty per cent understood the impacts on a person’s health, and only sixty four per cent applied this knowledge in their interactions with clients experiencing the impacts if poverty. Over seventy per cent of the group validated my assumption that most providers do not acquire knowledge about the social determinants of health through their schooling. The providers attributed this knowledge to work experience (fifty six per cent) or interaction with clients (sixty four per cent). This information was helpful and supported my purpose and goals in developing this project. Another key advantage was learning that eleven participants, close to half the group, could not identify the social determinants of health, or the impacts of socioeconomic status on a person’s health. Knowing this at the onset helped me to adjust my approach whereby I spent more time on the basic overview. Had I not made this adjustment, I would have lost half the group right from the start, along with their ability to participate.

The post-test evaluation form and results in Appendix H and I included rated questions, asking them if they learned something new about the social determinants of health, or whether
they felt more empathetic towards people living in poverty. In addition, I asked questions related to the delivery format and participant satisfaction with the session. An option to provide narrative feedback was provided and I was pleased to receive the following comments:

- Great job – I loved the heart facts part that made us really think about things from their perspective.
- Thanks for a great thought provoking presentation.
- In a fun way, we experienced real life poverty and gained an understanding of what influences health and illness at both the individual and community levels.
- Really enjoyed the lunch & learn – Thanks for reminding us how important this issue is in our work.
- This presentation needs to be part of our community health orientation so that this important message is shared with everyone.
- You need to give this presentation to the Board and senior management as well and any other group that will listen.
- It was good to see that some Income Security staff attended and you should talk with their Director so that all their staff can get this presentation as some of them really need it so that they have some empathy to this group.
- We should have this as a refresher every year so that we don’t get complacent.
- I really enjoyed the format. It was fun, informative and well prepared.
- Thanks for sharing your passion - would have liked more time for discussion.
- I was really touched by the photovoice photos – they were so powerful. They helped bring the message to life and I have a better understanding of what they are experiencing.
I definitely feel motivated to work on this issue with our community partners so that we can decrease the effects of poverty in our community.

Upon review of the narrative comments on the evaluation survey, I was pleased to see evidence of participant satisfaction, increased knowledge about the key messages related to the heart facts, and expressions of feeling motivated to act. As well, I believe the photovoice component and the interactive game contributed to the participant’s emotional intelligence. It was strikingly obvious to me how the energy in the room changed from upbeat and casual to intense and focused, as we progressed through the slides. Some participant’s body language showed they were emotionally affected, ranging from shaking their heads as in disbelief, crouching down in their chairs, and seeking tissues to wipe tears from their eyes.

The feedback received after the session, both verbally and from the evaluations, revealed that the providers gained a better understanding of the social determinants of health and the interplay between forces at the individual and community levels. An example to illustrate this was when a participant spoke out during the board game about her challenges while living in a small rural community. Choosing healthy food options for her family was difficult when the only small grocery store in the village did not carry fresh produce every day. When fresh produce was available, it was more expensive than the city stores. An additional challenge was that she did not have regular transportation to the city for buying these healthy items at the cheaper price. The evaluation survey showed all participants acknowledged that I encouraged learning in a fun and supportive environment, while the game promoted discussion. I was pleased to see that eighty four per cent of the group revealed that they learned something new about the social determinants of health and felt more empathetic towards people living in poverty. All but one person indicated that they strongly agreed to be motivated to apply this increased awareness and
knowledge, and identify at least one thing that they would do differently in their practice. I believe that the kinds of conversations that occurred during the session allowed for a deepening awareness of the determinants of health. At times during the discussion, some individuals responded by making jokes. While this suggested to me that they were engaged and having fun, I was also conscious of what they were laughing at and who was not laughing. I know that it was possible, and in a few cases likely, that some participants may have experienced events or conditions that were featured during the session.

The last question on the evaluation form related to an audit I wish to perform to see if the desired learning outcomes were achieved; that is the providers will be able to 1) identify at least three impacts of how poverty is hazardous to women’s health, such as the threats, barriers, and environmental influences, and 2) identify three ways that they as providers positively impacted and influenced the women’s lives. The yes or no statement was: “I am willing to be contacted in three months to see how I have applied the learning from this session”. All twenty-five participants agreed to be contacted and my hope is to audit fifty per cent and achieve positive reports that they have experienced empowering interactions with this population group.

I am pleased to report that the PowerPoint presentation and accompanying handouts will be integrated into the orientation curriculum for all community providers in RHA-Central. The “Determinants of Health Quiz” and the “Poverty is Hazardous to Women’s Health” handouts will be incorporated into the Regional General Orientation for all new staff members. There are plans to have this session presented as an educational agenda item for the RHA-Central Board members and Portage Community Stakeholder group.
CHAPTER 5: DISCUSSION AND CONCLUSION

Importance to nursing practice

There is no denying the relationship between socioeconomic status and health. Assisting individuals and groups to reflect on the socioeconomic and environmental factors that influence health, sharing expertise, and providing support are required in order to bring about change. MacLeod and Nelson (2000) and Landy and Tam (1996) stressed important learning goals for community nurses are to understand and address the multiple risk factors (situations, stressors, or behaviours) and barriers to accessing health services for women living in poverty. Although every individual and family, regardless of their economic status, has assets and needs, those living in poverty have additional struggles and strain as they attempt to cope and seek help for their complex needs. I believe an increased understanding of poverty and its impacts will help heighten the profile and stimulate action from the providers.

Hamric (2005) identified advanced practice nurses as leaders with the knowledge and skills to create innovative approaches to system and client care improvements. Utilizing my advanced practice core competencies, this project focused in the area of community health to help facilitate the process to look beyond health services, to the conditions that undermine or improve women’s well-being.

Health programs cannot do this alone, particularly when most of the determinants of health lie outside the exclusive jurisdiction of the health system (Ratcliffe, 2002). Collaboration with other disciplines, agencies, and sectors is necessary and was strongly promoted throughout the session, because no one agency or professional can provide the multiple interventions needed to meet the complex needs of these women living in poverty. The best support for women and
their families living in poverty happens when there are collaborative, multi-level, and multisectoral efforts (Healthy Child Manitoba, 2006).

Community health nursing is a rewarding yet challenging and stressful environment in which to work. Many providers I have supervised have spoken of feeling sad, frustrated, and helpless when working with clients living in poverty. McCann and Pearlman (1990) predicted that vicarious trauma, which arises with repeated exposure to sad and frustrating experiences, will only increase in community health settings. This is because workloads and pressures for services with overburdened families living in poverty have increased. In addition, the providers’ coping mechanisms are being depleted and opportunities for adequate training, support and supervision have decreased. Education and support provided in a project such as this may help reduce the impacts of vicarious trauma due to an increased understanding of the issues. Research could be carried out to test this proposition.

Conclusion

Poverty is not simply about the level of income, nor is it only about a lack of access to social services. What is considered to be poverty may vary from place to place, across time periods and families. It is more correctly understood as the inability to participate in society, economically, socially, culturally, and politically.

Poverty is a complex issue that requires a thorough understanding of all the contributing conditions and issues. The five poverty theories presented have differing perspectives, as do the strategies aimed at eliminating this challenging issue. A combination of the theories and approaches presented has the potential to yield a more complete picture in understanding the depth of poverty.
Socioeconomic status is a key indicator for a woman’s health. The adequacy of a woman’s income plays a role in determining how healthy she is as an individual, which then impacts the health of her family, which then leads to the health of the community. Inadequate income denies opportunities and can be the pathway to disease, dysfunction and disruption in our communities (Raphael, 2007). It is a social injustice that women living in poverty are sicker and don’t live as long as those who are living in the upper income brackets.

My project was designed to provide an engaging educational session to facilitate an empathetic and broader understanding of the lived experience of poverty, and explain why that experience is hazardous to women’s health. As well, I wanted this form of participatory education to be perceived as innovative and entertaining by the participants. The community providers who participated in the interactive session first viewed a PowerPoint presentation that contained compelling photovoice pictures taken by women who were living in poverty, then played a board game to vicariously experience poverty, and finally engaged in a structured discussion that challenged them to think and practice differently in regards to their interactions with clients experiencing the impacts of poverty. The participants’ comments reinforced my intent that this presentation can be a foundation for a social determinant clinical guideline that will be part of the community health providers’ orientation package. Increasing the awareness and visibility of poverty will have benefits for not only the front line community health providers who interact directly with this population, but also for the Program Directors and Management responsible for the planning and implementation of programs and services.

It was a successful, rewarding, and fun experience for both myself as the facilitator, and the participants. The challenge ahead is to build on the learning plan goals and focus on the action steps required. Strategies must be developed collaboratively for all causes and factors of
Poverty is Hazardous

Poverty. It may require that organizations examine, and if necessary, change their program designs, policies, procedures, and front-line staff skills.

I am fortunate to have organizational support to move forward, continuing with the plans to facilitate sessions with the RHA Board and other partner groups, presenting the compelling research related to socioeconomic well-being and poverty. This project was intended to provide a foundation for understanding the depth and nature of poverty, encourage empathy, and inspire action.

Talking about the social determinants of health in our meeting rooms is no longer enough. We now need to translate those words into action that is prioritized at all levels. Therefore, creating healthy public policy to reduce the negative impacts of the social determinants of health is our challenge ahead. Without strategies such as this, I fear we will continue to ignore and be blind to the causes and impacts of poverty that further increase the poor health outcomes of women and our society. I am motivated to take up that challenge and continue working in this area with the hope of having a positive, sustainable, and far-reaching impact on my community, because poverty is indeed hazardous to women’s health.
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