# Priority Setting and Policy Advocacy for Community Environmental Health: A Comparative Case Study of Three Canadian Nursing Associations

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## ABSTRACT

This thesis examined factors that influence three Canadian Nursing Associations' priority setting and policy advocacy for community environmental health (CEH). The research questions that guided the study were: (a) how do the nature and scope of nursing organizations' engagement for CEH policies differ according to provincial and federal contexts? and (b) how do nursing organizational factors and external system factors influence the priority-setting and policy advocacy choices for CEH policy? To answer these questions I undertook a qualitative comparative case study. The research was guided by epistemological and methodological principles of interpretative description and informed by whole-systems socio-ecological theory and institutional theory. Data were collected through participant interviews (n=41) and document review. Guided by framework analysis and the use of descriptive and conceptually-oriented matrices, cases were analyzed using an iterative and inductive approach to identify case patterns. These case patterns were then compared to identify cross-cutting factors that influence the Nursing Associations' priority setting and policy advocacy for CEH. Key findings are represented in an integrated conceptual framework. Nursing Associations' priority setting and policy advocacy are embedded in a dynamic policy field whereby structures and institutional pressure both create opportunities and narrow the Nursing Associations' options for engaged CEH advocacy. The findings lead to recommendations for practice, policy, and research that have relevance for the profession, nursing associations, and policy decision-makers.

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## LIST OF ABBREVIATIONS

| | |
|---|---|
| ARNNL | Association of Registered Nurses of Newfoundland and Labrador |
| CEH | Community environmental health |
| CEO | Chief Executive Officer |
| CIHI | Canadian Institute of Health Information |
| CNA | Canadian Nurses Association |
| CNFU | Canadian Federation of Nurses Unions |
| ED | Executive Director |
| ENS | Executive Network Structures |
| GTF | Governance Task Force |
| IJC | International Joint Commission |
| PESTM | Political, Economic, Social, Technological, and Management Model |
| HiAP | Health in All Policies |
| HPA | Health Professions Act |
| ICN | International Council of Nurses |
| RN | Registered Nurse |
| RNAO | Registered Nurses' Association of Ontario |
| WHO | World Health Organization |
| WPL | Workplace Liaison Structures |

## PREFACE AND ORGANIZATION OF THESIS

This doctoral thesis examined factors that influence nursing associations' priority setting and policy advocacy using community environmental health (CEH) as an exemplar. Employing a comparative qualitative case study (Yin, 2009), and guided by whole-systems socio-ecological theory (Edwards, Rowan, Marck & Grinspun, 2011; Gunderson & Holling, 2002; Gunderson. Holling, & Light, 1995) and institutional theory (Scott, 1994; Szyliowicz & Galvin, 2010), I questioned how organizational and systemic factors support or restrict the policy choices and actions taken by nursing associations.

The thesis is presented in a mixed manuscript-chapter format that conforms to the guidelines provided by the PhD in Nursing program and the Faculty of Graduate and Postdoctoral Studies at the University of Ottawa. To help transition the reader, a brief introduction is presented at the beginning of each manuscript and chapter.

Chapter 1, the Introduction, presents the study problem and provides a background of the study topic. The choice for CEH as the example issue is explained. A summary of the evidence exploring factors that influence nursing associations' priority setting and policy advocacy and policy work undertaken by nursing associations for CEH is provided. The research questions are stated. An overview of the philosophical underpinning, methodological principles, and theoretical perspectives guiding the study are presented. Details are provided for sections not appearing in the manuscripts due to space restriction. Chapter 1 concludes with a summary of the methods.

Chapter 2, "Priority Setting and Policy Advocacy by Nursing Associations: A Scoping Review and Implications Using a Socio-ecological Whole-Systems Lens", is presented in manuscript format. The paper was published April 2012 in the journal of *Health Policy*. The manuscript presents findings from an interpretative scoping review undertaken to examine organizational priority setting and policy advocacy and the factors that influence nursing associations' cross-sector public policy choices and actions. Findings from the review informed the development of a conceptual framework that guided the conduct of the study (Chapter 3).

Chapter 3, "A Conceptual Framework to Guide the Study of Nursing Associations' Priority Setting and Policy Advocacy for Community Environmental Health", is presented in manuscript format. This paper was published February 2012 in the journal Aporia. This

manuscript reports the development of a conceptual framework that guided the conduct of this study.

Chapter 4, "Methods", presents description of the methods. The study design and rationale are discussed. Information is provided about the study setting, case selection, and participant sampling. Details are provided for the data collection and analyses. The chapter concludes with a discussion of trustworthiness and ethical considerations. The methods chapter is followed by the findings from the independent analysis of each case in Chapter 5, "Within-Case Results".

Chapter 6, "Structural and Institutional Factors Influencing Nursing Associations' Engagement in Community Environmental Health: A Cross-Case Comparison of Three Canadian Nursing Associations", is presented in a draft manuscript format that will be submitted for review to *"Journal of Comparative Policy Analysis"*. The manuscript reports the integrated findings from the cross-case analysis.

Chapter 7, "Integrated Discussion and Conclusion", presents a discussion of the integrated cross-case results situated within the broader theoretical and empirical literature. A final conceptual framework is offered. The strengths, limitations, and contributions of this dissertation are also discussed. Recommendations for nursing and their associations and for policy makers are presented. Chapter 7 concludes with the implications for research.

# CHAPTER 1: INTRODUCTION

## Problem Statement: Nursing Associations' Priority Setting and Policy Advocacy

In order to support nurses in their practice and to meet the needs of the public served, leaders of nursing associations make choices among several worthy public policies to address (Canadian Nurses Association [CNA], 2011b). An examination of the nursing literature suggests policy issues of interest to nursing associations include nursing practice concerns (e.g., cultural competence and professional practice models) (CNA, 2010b; ICN, 2008a); nurses' socio-economic welfare (e.g., violence in the workplace and ethical nurse recruitment) (CNA & Canadian Federation of Nurses Unions [CFNU], 2008; ICN, 2010b); population issues (e.g., tobacco control and female genital mutilation) (ICN, 2006, 2010a); health care system concerns (e.g., patient safety and primary health care) (CNA 2009b; ICN, 2007b); and environmental and social issues (e.g., climate change and armed conflict) (CNA, 2008b, 2008c; ICN, 2007a). However, little attention has been paid to how nursing associations make choices about which issues they should address or how they can address them. Many of these policy issues require nursing associations to work with a range of stakeholders and to influence policies in diverse sectors (Cohen & Reutter, 2006; Sattler, 2005). Yet, scholars suggest that collaborating and advocating for policies that originate outside of the health sector is not well developed in nursing (Lemire-Rodger, 2006; Reutter & Duncan, 2002) and a nursing practice that addresses environmental and social determinants remains largely unfulfilled (Beck, 2010; Grinspun, 2010).

The main purpose of this study was to contribute insight about factors that shape nursing associations' priority setting and policy advocacy and to identify areas for action that could support associations' collaborative public policy work. Understanding priority setting, policy advocacy, and factors that shape choices can assist nursing associations to meet their vision and mission, to help them plan the most receptive time to address a policy issue, and to guide their decisions about appropriate stakeholders, strategies, and targets. Factors that undermine their attempts to meet objects or that prevent the implementation of their policy preferences can be addressed. The loss of opportunities to maximize organizational efforts can be avoided (Mitton, Patten, Donaldson, & Waldner, 2003; Peacock, Mitton, Bate, McCoy, & Donaldson, 2009). To understand nursing associations' priority setting and policy advocacy, CEH was selected as an example public policy issue.

## Background

### Canadian Nursing Associations

Canadian nursing organizations at the provincial/territorial and national level have responsibilities to protect and advocate for both the profession and the public health of Canadians through regulatory, professional, and collective bargaining roles. These organizations include regulatory bodies (sometimes called colleges), primarily responsible for enacting legislative regulatory authority for the profession; association bodies, primarily engaged in promoting the profession; industrial or union bodies, primarily associated with remuneration and working conditions; and specialty associations, primarily dedicated to specific health issues (e.g., environmental health) or domains of practice (e.g. community health nursing). Some of these organizations serve more than one of these functions and share common interests (Tyer-Viola et al., 2009; Williams et al., 2007).

This research focused on nursing organizations with a regulatory and/or association function. More specifically, nursing associations in this research referred to nonprofit corporate bodies that represent a large number of nurses at a provincial or territorial and national level with a primary role to protect the public through self-regulation (e.g., establish standards for practice and education, and determine and enforce competency and licensure) and/or the promotion of the profession and its roles (advancing professional interests, enhancing nursing knowledge and skills, building professional networks, protecting nursing values, and influencing government decisions about healthy public policy issues).

### Community Environmental Health

The domain of environment includes the settings in which nurses' work, as well as the surroundings in which people live. This research focused on the latter with a specific emphasis on CEH. For the purposes of this study and building on the work of Lausten (2006), Hansen-Ketchum, Marck, and Reutter (2009), and Gunderson and Holling (2002), CEH is defined as human-ecological health generated through human participation with natural, physical, chemical and biological systems and supported through ecologically sound practices and policies across system scales and levels.

### Rationale for the Selection of Community Environmental Health as an Exemplar

CEH was chosen as an exemplar for many reasons. First, the literature suggests nursing has a long-standing ethical commitment to protect the environment. A role for nursing to

intervene for healthier environments was formalized by Florence Nightingale over a century ago (Beck, 2010; CNA, 2005), and today the environment remains largely accepted by the profession as one of four metaparadigm concepts guiding nursing work (Fawcett, 2005). "Supporting environmental preservation and restoration and advocating for initiatives that reduce harmful practices" (CNA, 2008a, p. 20) is cited as one of Canadian nursing's ethical endeavours. In addition, this health policy issue has received extensive global attention as one of the most serious contemporary threats to public health and one that produces and exacerbates inequities (Boyd & Genuis, 2008; Pruss-Ustun & Corvalan, 2006; Stern, 2007).

Second, the health impacts arising from environmental conditions are projected to increase the demand for nurses' knowledge and skill in the treatment, prevention, and management of environmental health issues (CNA, 2005, 2008b). Some nurses will look to their associations for leadership and guidance to address the sources and the impacts arising from community environmental health conditions (CNA, 2007a).

Third, CEH was chosen as the exemplar because of considerable anecdotal variations in the degree to which nursing associations are engaged in CEH. An analysis of Canadian nursing association websites indicate that some nursing associations are actively engaged in policy efforts for pesticide legislation, environmental carcinogens, green energy and Kyoto Accord commitments, environmental exposures, and environmentally-responsible activity in the health sector (CNA, 2009a; RNAO, 2009b). Yet, many Canadian provincial and territorial nursing organizations appear silent about environmental health policy issues. Thus, it is important to compare associations that vary in their degree of engagement in order to identify factors that account for those variations.

## Summary of Evidence

The theoretical scaffolding for the conduct of the thesis was based on findings from a scoping review and a literature review. This section provides a summary of key findings from the review of this evidence.

A scoping review, conducted to examine organizational priority setting, policy advocacy, and factors that influence cross-sector public policy choices and actions, indicates that many internal and external factors are critical to how organizations succeed or fail to set achievable priorities and advance their advocacy goals (MacDonald, Edwards, Davies, Marck & Read Guernsey, 2012, Chapter 2). Internal organizational factors shown to

influence policy work include governance (Curtiss, 2004; De Vita, Montilla, Reid, & Fatiregun, 2004; Donaldson, 2007; Naegle, 2003), jurisdictional mandates (Andrews & Edwards, 2004; Nathan, Rotem, & Ritchie, 2002), professional mandates (Ballou, 2000; Rieger & Moore, 2002; St. Pierre Schneider et al., 2009), and membership (Andrews & Edwards; Ballou; Chomik, 2007; De Vita et al.). External factors shown to influence policy work include legislated authority (De Vita et al.; Georges, 2005; Jones, 2001), credibility (Afzal, 2007; Bryson, Crosby, & Stone, 2006; Sattler, 2005), and system disruptions (Hoffman, 1999; Jacobs & Boddy, 2008; Public Health Agency of Canada, 2007). Although narrative accounts (e.g., published discussion papers and non-research-based case reports) and grey literature suggest that similar internal and external factors influence nursing associations' policy work, a lack of empirical evidence "constrains the ability to describe how nursing associations manage conflicting priorities or how they conduct their policy work" (MacDonald, Edwards, et al., 2012, Chapter 2, Discussion section).

A literature review, conducted to identify research that explored or explained how nursing associations engaged in CEH policy setting and advocacy, indicates that nursing associations' involvement in CEH is an underdeveloped area of study (MacDonald, Davies, Edwards, Marck, & Read Guernsey, 2012, Chapter 3). Substantial public policy work undertaken by nursing associations for CEH is primarily charted in editorials or commentaries, discussion papers, reports, reflective reviews, and historical accounts. This anecdotal evidence indicates nursing associations' are involved in a broad array of community environmental issues (Afzal, 2007; CNA 2008b, 2008c; Sattler, 2005), employ a broad range of advocacy strategies (Afzal; CNA, 2008a, 2008b; Registered Nurses' Association of Ontario [RNAO], 2009b), and work in partnerships with others both in and outside of the health sector (CNA, 2008c; RNAO, 2009a). Yet, "the absence of empirical research to investigate this work leaves minimal opportunity to understand the factors that support or hinder their choices or actions" (MacDonald, Edwards, et al., 2012, Chapter 2, Findings from the literature review section).

The review of this evidence indicates that policy work transpires in complex contexts characterized by multiple demands and a need to employ multiple independent and collaborative efforts with diverse players across the system. There is ambiguity and changing efforts and targets in response to system disruptions. In order to understand the policy

choices, attention must be given to nursing associations' diverse structural and legal arrangements, to the systemic context in which policy work occurs, and to the dynamic of relationships (MacDonald, Davies, et al., 2012, Chapter 3, Discussion section).

## Study Questions

The research questions that guided this study were: (a) how do the nature and scope of nursing organizations' engagement for CEH policies differ according to provincial and federal contexts? and (b) how do nursing organizational factors and external system factors influence the priority-setting and policy advocacy choices for CEH policy? Exploring the variations among nursing associations' choices and actions for CEH can lead to insight about key factors that support or restrict their engagement in public policy issues.

## Philosophical Underpinnings, Methodological Principles, and Theoretical Perspectives

The study methodology and design were rooted in philosophical underpinnings and methodological principles of interpretative description (Thorne, Kirkham, & MacDonald-Emes, 1997; Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004; Thorne, 2008); informed by whole-systems socio-ecological theory as interpreted by Gunderson and Holling (2002) and as applied to health systems change (Edwards, Rowan, Marck, & Grinspun, 2011); and institutional theory (Hoffman, 1999; Scott, 1994; Stone & Sandford, 2009). The following section provides a more detailed description of how interpretive description, socio-ecological theory, and institutional theory guided this study.

### Interpretive Description

Interpretive description allowed me to answer research questions that were grounded in a disciplinary issue and for which findings would be transferable to action. Through this interpretive epistemological orientation, I was able to gain knowledge based on my belief that human experience is constructed, contextual, and expressed as multiple realities that are often shared (Thorne et al., 2004). Interpretive description permitted me to use flexible and pluralistic ways to gain knowledge (described in detail below) and to ensure there was a consistent overall logic within the study.

To attain this consistency, I applied interpretive descriptive methodological principles offered by Thorne (2008). The first principle included establishing the "theoretical scaffolding" (Thorne, p.54) for the study. I positioned the study by exploring the state of the

evidence through a scoping and literature review (Chapter 2 and Chapter 3), identifying the concepts of interest, and making explicit my assumptions and theories that informed the study. This exercise culminated in the development of a guiding conceptual framework (Chapter 3). This conceptual framework depicts nursing associations' priority setting and policy advocacy for CEH transpiring in a dynamic decision context in which factors internal and external to the association influence the choices and actions taken. The conceptual framework made explicit the theoretical assumptions, the biases and preconceptions that underpinned the design decisions, defined the boundaries of the inquiry, and oriented the inquiry (e.g., guided the line of questioning). Aligning with epistemological assumptions of interpretive description, the conceptual framework was not intended to serve as an analytic framework to guide analysis, but rather served to establish some parameters for the conduct of the study.

A second principle that guided the study was the selection of a qualitative comparative case study design. A qualitative approach supported a commitment to understanding the subjective and experiential knowledge of those involved in the priority setting and policy advocacy work of an association.

A third principle that guided the study was the explicit articulation of the design decisions (including choice of participants, data collection methods, and data analysis) and the supporting rationale upon which the credibility of the study could be judged. The rationale for all decisions is provided at appropriate discussion points throughout the thesis.

**Whole-Systems Socio-Ecological Theory**

Whole-systems socio-ecological theory as interpreted by Gunderson and Holling (1995, 2002) guided my examination of the interplay of factors that influence nursing associations' decisions and the nature of their CEH policy work. While other socio-ecological approaches have been employed to understand strategic and organizational decision-making (Daft & Weick, 1984; National Defense University, 1997; Van de Ven & Poole, 1995), the use of this form of systems thinking drew attention to the nature of adaptive changes that occur across multiple scales, multiple levels, and at various rates of change. More specifically, systems change in this study refers to "uneven, nested cycles of adaptation that evolve within closely coupled, complex socio-ecological systems over time" (Edwards, Marck, Virani, Davies, & Rowan, 2007, p.2). In addition, this systems change lens

supported the examination of the professional, legal, social, economic, political, and ecological environments in which priority setting and policy advocacy transpire.

**Institutional theory**

While whole-systems socio-ecological theory draws attention to the broad context for change, the premises of institutional theory were used to direct more specific examination of institutional pressures and their mechanisms (Scott, 1994; Szyliowicz & Galvin, 2010) that may influence organizational priority setting and policy advocacy. According to Scott (1995), organizations can be explained by social institutions, which are symbolic and behavioural systems consisting of "cognitive, normative, and regulative structures and activities that provide stability and meaning to social behavior" (p. 34). These social institutions exist both inside and outside the organization, operate at multiple system levels, and are transported through structures, cultures, and routines (Scott 1994, 1995). An institutional focus allowed me to consider the less tangible and often less visible pressures that underpin the prioritization of policy issues and the actions taken (or not), which may be less well understood than the concrete components of a system such, as resources (Sheikh et al., 2011). This focus further supported consideration of the interplay between system structures and role of institutional influences.

## Summary of Methods

A qualitative comparative case study design (Yin, 2009) was chosen to answer the research questions. Yin's approach to case study supports the investigation of a "contemporary phenomena within its real life context, especially when the boundaries between the phenomena and context are not clearly evident" (p. 18). This study was undertaken in two provinces, where the participating Nursing Associations were located. The Nursing Associations were selected based on their provincial and federal location, their public policy or bifurcated mandate (regulatory and public policy), and involvement in CEH. All Association staff and members of the Boards were eligible to take part in the study if they also met the following criteria: a minimum of one-year experience with priority-setting and policy advocacy during the past 5 years with their Association and/or had experience working in the area of CEH policy, and spoke English. Data collection occurred from June 2010 to December 2010. Site visits lasting 7 to 9 days were made to each Association. Data were collected from participant interviews and document review.

The analysis was guided by framework analysis (Ritchie & Spencer, 1994; Ritchie, Spencer, & O'Conner, 2003) and matrix constructions (Miles & Huberman, 1994). The analytic process followed a series of interrelated stages: (a) Familiarization – to learn about the data and gain a sense of the whole, (b) Development and refinement of a descriptive coding framework, (c) Charting – to organize and visually display data in matrices so that substantive content could be viewed and compared across the data, (d) Mapping and interpretation of individual cases – to examine relationships among descriptive categories and identify case patterns, and (e) Mapping and interpretation across cases – to examine relationships among case patterns.

A final phase of the study included a small group discussion with the Executive Directors from the participating Associations in 2012. The purpose of this discussion was to provide an opportunity for the Executive Directors to reflect and respond to the integrated cross-case findings. These reflections informed refinements to the final integrated conceptual framework.

## INTRODUCTION TO CHAPTER 2

The following chapter is a manuscript that reports findings from an interpretative scoping review undertaken to examine organizational priority setting and policy advocacy and the factors that influence nursing associations' cross-sector public policy choices and actions. The manuscript was published in the journal of Health Policy[1]. Health Policy has an international audience of health policy researchers, legislators, decision-makers, and professions. Appendix A provides a list of articles included in the scoping review and was submitted as a supplementary document to Health Policy.

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[1] MacDonald, J., Edwards, N., Davies, B., Marck J. & Read Guernsey, J. (2012). Priority setting and policy advocacy by nursing associations: A scoping review and implications using a socio-ecological whole systems lens. *Health Policy*, *(107),* 31-42. Available online 19 April 2012. doi: 10.1016/j.healthpol.2012.03.017

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Review

# Priority setting and policy advocacy by nursing associations: A scoping review and implications using a socio-ecological whole systems lens

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Objective: We undertook an interpretative scoping review to examine organizational priority setting and policy advocacy and the factors that influence nursing associations' cross-sector public policy choices and actions.
Method: Evidence was drawn from research, narrative, and theoretical sources that described priority setting and policy advocacy undertaken by non-governmental, non-profit, and nursing associations. Text was extracted from selected papers, imported into NVivo 8, coded, and analyzed using a descriptive-analytical narrative method.
Results: Many internal and external factors are shown to shape organizations' policy choices and actions including governance and governance structures, membership arrangements, legislative, professional, and jurisdictional mandates, perceived credibility, and external system disruptions.
Conclusions: Internal and external factors are identified in the literature as critical to how organizations succeed or fail to set achievable priorities and advance their advocacy goals. Case comparisons and longitudinal research are needed to understand nursing associations' policy choices and actions for cross-sector public policy given their complex organizational structures and dynamic professional–legal–social–economic–political–ecological environments. A socio-ecological systems perspective can inform the development of theoretical frameworks and research to understand leverage points and blockages to guide nursing associations' public policy choices and actions at varying points in time.
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## 1. Introduction

Some of the world's most troubling health issues and inequities are amenable to government investments and measures that are often managed by sectors other than health [1,2]. Thus, solving problems and sustaining health gains are more likely to occur with whole-of-government approaches incorporating "Health in All Policies" (HiAP) that include champions within the health sector who bring a health perspective [2–4]. As the single largest health sector provider, and often the first to recognize health problems and the need for policy changes to address health

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**Table 1**
Search terms and approach.

| Key concept | Keywords and MeSH headings | Search approach |
|---|---|---|
| Nursing associations, NGOs, and NPOs | Keywords:<br>(professional or nursing) associations or (professional or nursing) societies or (professional or nursing) organizations or (non-governmental organization or NGO) or (non-profit organization or NPO)<br>MeSH:<br>(MH "Organizations, Nonprofit+") or (organization or college or association) or (health planning organizations/or health care coalitions) or (MH "Professional organization+") or (MH "Nursing Organizations+") or (MH "Student Nurses Organizations+") or (MH "State Nursing Organizations+") or (MH "Nursing Organizations, International+") or (MH "National Federation for Specialty Nursing Organizations") or (MH "New Zealand Nurses Organization") or (MH "Nursing Organizations Alliance") or (MH "State, Provincial and Territorial Nursing Organizations+") or (MH "American Organization of Nurse Executives")<br>AND | |
| Priority setting | Keywords:<br>(priority setting or setting priorities) or (resource allocation) or (policy or organizational or collective) decision making<br>MeSH:<br>(MH "Decision Making, Organizational") or (MH "Goal-Setting") or (MH "Strategic Planning") or (Strategic planning or Leadership or Priorities) or (decision making, organizational/or organizational culture/or organizational innovation/or organizational objectives/or planning techniques/or resource allocation)<br>AND | OR |
| Policy advocacy | Keywords:<br>(advocacy) or (resource allocation) or (policy engagement)<br>MeSH:<br>(MH "Consumer Advocacy") or (MH "Public Policy") or (MH "Health Policy") or (MH "Organizational Policies") or (Policy Making")<br>MeSH = mapped subject heading; +denotes explosion | |

related issues, nursing has the ability to improve health by providing critical health information that policy makers require to make decisions [5,6]. Nursing associations in particular have a long history of mobilizing nurses to address policy issues and directly influencing policy choices by government for improved societal health and well-being [7,8]. However, leaders of nursing associations identify that there is a wide range of policies and programs worthy of attention [9], thus they are left with difficult choices about which issues their associations will address and to what ends.

Priority setting and policy advocacy taken by individual nurses is reported in the literature. Priority setting processes are described related to what patients will get attention first or the order of nursing interventions [6,10]. Nurses' knowledge and experience, patient conditions, ward organization, and resources are among factors that influence how nurses establish preferential orders [10]. Similarly, the literature is replete with policy advocacy taken by individual nurses and the factors that influence their advocacy efforts including lack of preparation and knowledge, limited opportunities, and fear that careers may be jeopardized if political action is taken [11–14]. However, this literature does not address priority setting by nursing associations or the factors that influence actions taken by associations.

Understanding organizational priority setting and policy advocacy processes and the factors that can or restrict these choices and actions can be used by leaders of nursing associations to plan the most receptive time to address a policy issue, the stakeholders who need to be involved, and the targets and strategies for action [15,16]. Successful priority setting and policy advocacy can help nursing associations advance their vision, mission and goals.

We undertook a scoping review to understand how leaders of nursing associations set priorities and take action for healthy public policies. We report on the approach and findings of this review, which required bridging evidence from multiple fields that was both diverse in its scope and its contribution. The processes and outcomes of organizational priority setting and policy advocacy, as well as the factors that influence the decisions taken at the organization level, are described. Findings are discussed using a socio-ecological perspective on whole systems change. Future research priorities are considered.

## 2. Methods

### 2.1. Overview

Our approach followed established methods for an interpretative scoping review as described by Arskey and O'Malley [17]. A scoping review is an approach to identify, examine, and summarize literature based on relevancy and contribution of evidence rather than rigidly determined methodological considerations [17,18]. It is emerging as a viable review method to bridge diverse literature and inform new directions for nursing and policy research [18,19].

### 2.2. Identification of relevant literature

Choosing the type of evidence that would best inform our understanding about nursing associations' priority setting and policy advocacy required an iterative search strategy that progressively culminated with the inclusion of four types of papers spanning the nursing and

**Table 2**
Screening and selection criteria.

| Inclusion criteria |
|---|
| 1. Organization involvement: The authors describe priority setting or policy advocacy taken by organizations opposed to independent efforts by individuals |
| 2. Topic relevance: The authors describe: |
| (a) Priority setting or advocacy undertaken by a nursing association (includes professional and practice issues) |
| (b) Priority setting or policy advocacy for public policy issues undertaken by NGO or NPO |
| 3. Source: The manuscript is one of the following: |
| (a) Primary or secondary research |
| (b) Synthesis documents or technical reports (e.g., commissioned research) |
| (c) Theoretical paper that describes the development of conceptual frameworks or propositions about priority setting or policy advocacy |
| (d) Narrative papers that describe nursing associations' priority setting or advocacy work (includes discussion or position papers and non-research based case reports) |

non-nursing literature. These papers included research and narrative accounts about nursing associations' public policy work, research about non-governmental organizations (NGOs) and non-profit organizations' (NPOs) public policy work, and theoretical papers about priority setting and policy advocacy.

Professional librarians assisted with the final search strategy design. The first author conducted searches using three primary sources. First, a search was executed for empirical and theoretical literature published in English from four electronic databases (CINAHL, PubMed, HealthStar, and ABI Inform/Global) using a combination of key word and MeSH headings searches for nursing associations, NGOs, NPOs, priority setting, and policy advocacy. Table 1 provides a list of specific search terms and the search approach. Manual searches of the reference lists from retrieved publications served as a second source. Grey literature from nursing association, academic, health organization, and government websites referenced in papers were also retrieved. Publications were retrieved for the period from January 1999 to October 2010. Papers reporting the development of priority setting or policy advocacy frameworks published earlier were also included. RefWorks was used to store and organize data. The database search yielded 5705 papers after duplicates were removed (original total $N=7946$). An additional 110 papers were found through the reference list and grey literature searches, resulting in a combined total of 5815 papers that were screened for relevancy.

### 2.3. Screening and selection

Inclusion was based on the assessment of organization involvement (i.e., nursing associations, NGO, or NPO), topic relevance (i.e., priority setting or policy advocacy), and the source of evidence (i.e., research, synthesis reports, narrative accounts, or theoretical papers) (refer to Table 2). Nursing associations were defined as non-profit corporate bodies that represent a large number of nurses at a local, provincial/territorial/state, national, or international level with a primary role to protect the public through self-regulation (e.g., establish standards; enforce competency and licensure) and/or to promote the profession and its roles (advance professional interests; influence healthy policy issues) [20]. NGO's and NPO's in this review included corporate bodies that existed to further the interests of a community or population and that addressed public policy issues.[5] Priority setting was defined as a process by which organizations determine what policy issue should be given precedence or special attention and included decisions about the allocation or rationing of human, financial, or material resources in order to meet organizational goals [21,22] Policy advocacy was defined as action taken to influence structural and system-level decisions that further the interests of the public [23–25].

The first author and a trained assistant independently conducted a three-staged screening process starting with titles, followed by abstracts, and then full text review of papers. Papers that did not meet inclusion criteria were eliminated. When uncertainty existed about the eligibility of papers based on either the title or abstract assessment, full articles were retrieved. Discrepancies that occurred at the final stage of screening were resolved through discussion until consensus was reached. In total 5816 titles, 1062 abstracts, and 287 full text papers were assessed. The screening process resulted in the inclusion of 86 papers ($n=56$ nursing and $n=30$ non-nursing).

### 2.4. Charting the data and collating results

A descriptive-analytical narrative method was used to chart data [5]. This included extracting common descriptive demographic information including author(s) and publication date; source of evidence; purpose of the paper or study; study design and methods for research papers; and type(s) of organizations, their countries of origin, and their jurisdictional authority. In addition, text about priority setting and policy advocacy processes, outcomes, and factors that influenced those choices and actions were extracted and imported into NVivo 8 – a computer assisted qualitative analysis program that supports the management of text data.

A common coding framework and themes were identified inductively from the imported text. To accomplish this, manuscripts were read and a list compiled of key ideas,

[5] The term NGO was first used by the United Nations to distinguish government from non-government established organizations. While there is an absence of consensus, NGO status generally refers to organizations that are non-profit or not-for-profit, not considered a political party, not involved in criminal activity, and remain free from government control. However, freedom or independence from government control remains an elusive criterion for NGO status as many work closely with government and may receive funding. NGO status may be maintained by excluding government representatives from membership. NGOs are generally committed to addressing social needs and improving the human condition, and include charitable organizations, voluntary health agencies, foundations or grant-making institutions, social welfare organizations, and professional and trade organizations [for additional information refer to the Gale Encyclopedia of Public Health: United States Nongovernmental organizations available at http://www.answers.com/topic/non-governmental-organization].

concepts, events, and relationships. A coding framework comprised of ten broad descriptive codes was developed from a review and search for recurrent patterns within the list of key ideas. For example, a descriptive code was developed for "membership" based on repeated references to membership arrangements, needs, and relationships. The descriptive coding scheme was then applied to all relevant text. Coded text was then reviewed and key dimensions for a concept identified and organized thematically. For example, a key dimension for the concept of membership included the composition, with heterogeneity of members identified as a theme. Coding and the development of themes was an iterative process that required rereading original papers, importing and coding additional pieces of text, and identifying and refining themes with the full research team.

## 3. Results

The findings from the analysis of included papers are organized into four broad areas. These include: (1) organizations and their policy work; (2) organizational priority setting frameworks; (3) organizational policy advocacy frameworks; and (4) factors that influence organizational priority setting and policy advocacy.

### 3.1. Organizations and their policy work

#### 3.1.1. Sources

Research papers comprised 46.5% ($n=40$) of the included papers. Of these, thirty-one were primary research papers (36.0%) including case studies, multiple case studies, qualitative and quantitative studies, and mixed methods research. Three extensive literature reviews comprised a much smaller percentage of papers (3.5%). Five of the research papers (5.8%) were commissioned reports. Sources also included six theoretical papers (7.0%) that described the development of conceptual frameworks, propositions, or tools about priority setting and/or policy advocacy. Narrative accounts comprised nearly half of the sources (46.5%, $n=40$).

The majority of papers 64.0% ($n=55$) described priority setting and advocacy by nursing associations. Most of these were narrative accounts including non-research descriptive case studies and discussion papers (72.7%, $n=40$). The remaining nursing documents were research papers (25.6%, $n=14$). Thirteen papers were primary research studies (23.6%) and one nursing paper was a literature review (1.8%).

Of the 26 papers (31.4%) that described NGOs' and NPOs' policy work, 19 (73.0%) were primary research and two (7.7%) were reviews. Another five papers (19.2.0%) were commissioned reports by the World Health Organization, which included a synthesis of primary research, literature reviews, and findings from previous case study research.

#### 3.1.2. Types of organizations and geographic locations

Priority setting and policy efforts were described for nursing organizations with regulatory, and/or professional, and labor relation mandates, as well as for specialty associations such as midwifery, oncology, and executive nursing bodies. These nursing organizations operated across provincial/state, national, and international jurisdictional authorities.

The non-nursing research papers described a variety of NGOs and NPOs such as advocacy organizations, health services, academic and funding institutions, voluntary organizations and community groups (e.g., women's groups, senior citizen groups, churches). Although included, trade unions and professional associations (categorized as one form of organization in these papers) were less frequently represented than other types of NGOs and NPOs (for example refer to De Vita et al.) [26].

The majority of documents described organizations located in the United States 51.2% ($n=44$; $n=16$ research and $n=28$ narrative accounts). Seventeen (19.8%) papers included organizations from multiple countries ($n=10$ research and $n=7$ narrative accounts). These papers included commissioned research that reported evidence for organizations that were based in as many as 15 countries. Policy work specifically undertaken by Canadian organizations was reported in 10.5% of the papers ($n=7$ research and $n=2$ narrative accounts). Eight (9.3%) theoretical and review papers did not specify the geographic origins of organizations.

#### 3.1.3. Types of policy issues addressed

The types of policy issues addressed[6] included professional or practice issues (31.4%, $n=27$); targeted health issues or populations (38.4%, $n=33$); and social determinants of health (SDOH), equity, or public policy in general (24.4%, $n=21$). Close to half (49.1%, $n=27$; $n=11$ research and $n=16$ narrative accounts) of the advocacy efforts undertaken by nursing associations were for professional issues such as scope of practice, prescribing rights, education requirements, and workplace issues such as nursing shortages. Three (5.4%) nursing research papers reported advocacy efforts undertaken by nursing associations for policy issues outside professional practice issues. These included policies related to domestic violence [27], HIV/AIDs [28], and environmental health [29]. However, narrative papers described a broader scope of policy advocacy undertaken by nursing association targeting an array of health issues and population concerns (30.9%, $n=17$) [30–46]. Seven (12.7%) narrative papers further described action taken by nursing associations for the SDOH, equity, or public policy in general [47–53].

Half (50.0%, $n=13$) of the non-nursing research described advocacy by NGOs and NPOs for targeted health issues or targeted populations [26,54–63]. The other half (50.0%, $n=13$) of the non-nursing research papers described action on SDOH, equity or public policy in general [22,23,63–73]. Table 3 provides additional details for research papers by type of research, geographic location, and types of policy issues. Table 4 provides additional details for narrative account papers by geographic location and types of policy issues.

[6] Six theoretical papers could not be categorized by type of policy issue addressed.

**Table 3**
Research papers by type of research, geographic location, and types of policy issues.

| | Included research papers ($n=40$) | | |
|---|---|---|---|
| | Nursing research articles ($n=14$) | Non-nursing research articles ($n=26$) | Total ($n=40$) |
| Type of research | *n* (%) | *n* (%) | *n* (%) |
| Primary research | 13 (32.5) | 19 (47.5) | 32 (80.0) |
| Extensive literature review | 1 (2.5) | 2 (5.0) | 3 (7.5) |
| Synthesis reports | 0 | 5 (12.5) | 5 (12.5) |
| Geographic location[a] | | | |
| Canada | 2 (5.0) | 5 (12.5) | 7 (17.5) |
| United States | 6 (15.0) | 10 (25.0) | 16 (40.0) |
| Other country | 3 (7.5) | 2 (5.0) | 5 (12.5) |
| More than one country | 3 (7.5) | 7 (17.5) | 10 (25.0) |
| Types of advocacy issues | | | |
| Professional or practices issues | 10 (25.0) | [b] | 10 (25.0) |
| Targeted health issues or targeted populations | 4 (10.0) | 13 (32.5) | 17 (42.5) |
| SDOH[c]/equity/generic public policy issues | 0 | 13 (32.5) | 13 (32.5) |

[a] The geographic location were not codable for two papers.
[b] Only research reporting non-governmental organizations and non-profit organizations advocacy for public policy related to SDOH included.
[c] Social determinants of health.

### 3.2. Organizational priority setting

Seven frameworks for priority setting by organizations were identified from the non-nursing literature [15,16,22,68,70,74,75] and one tool was identified from the nursing literature [76]. The frameworks were developed from theoretical, empirical, and practice evidence and depicted macro-level decisions. Although variably defined [16,22,70], priority setting at the macro-level referred to the future allocation of resources across diverse program areas or sectors and included decisions about investments in population issues, health conditions, interventions, and/or services. The frameworks incorporated principle-based approaches, which used economic [15,70,75] and ethical [76] criteria to guide decisions. A process-focused approach was also proposed, which depicted conditions for fair and legitimate choice-making [74]. Others described comprehensive and collaborative approaches to priority setting incorporating both principles and processes [16,68]. Sibbald et al. [22] drew attention to the key elements for evaluating the success of priority setting.

Key processes for transparent, deliberate and legitimate priority setting were depicted among the frameworks. These included the identification and selection of relevant stakeholders [16,22] the selection of criteria and values upon which to adjudicate decisions (e.g., effectiveness, cost-effectiveness, equity, capacity) [15,16,70,74,76,77]; a means to apply weighting to decision criteria [15,16,70,77]; ways to identify, gather, manage, and synthesize evidence on alternatives [16,22]; and mechanisms for reviewing and evaluating decision options and their consequences [22,74].

However, very little theoretical or empirical evidence was found specifically related to nursing organizations priority-setting. The one tool designed to guide decisions by a nursing association, the Social Justice Gauge, helped to screen whether a program or policy was a social justice issue and thus whether appropriate for organization involvement. However, the tool was not designed to determine what social justice issues should be given preferential treatment. Moreover, no empirical evidence was found documenting whether the framework changed decision-making.

**Table 4**
Nursing narrative account papers by geographic location and types of policy issues.[a]

| | Nursing non-research papers ($n=40$) *n* (%) |
|---|---|
| Geographic location | |
| Canada | 2 (5.0) |
| United States | 28 (70.0) |
| Other country (e.g., Brazil, UK, Zambia) | 3 (7.5) |
| More than one country | 7 (17.5) |
| Types of advocacy issues | |
| Professional or practices issues | 16 (40.0) |
| Targeted health issues or targeted populations | 17 (42.5) |
| SDOH/equity/generic public policy issues | 7 (17.5) |

[a] Six theoretical papers could not be categorized by geographic location for organizations.

### 3.3. Organizational policy advocacy

Six frameworks [23,55,61,63,76,78] and one tool [24] developed from theoretical, empirical, and practice evidence depicted public policy advocacy work by non-nursing NGOs and NPOs. Policy advocacy was conceptualized as strategies taken to initiate, enact, and enforce structural and policy change(s) to benefit populations [24,61,63,71]. Policy advocacy approaches comprised a combination of independent and 'collective', 'intersectoral', or 'cross-sector' approaches to solving complex and multicasual public policy issues [23,24,55,78].

The frameworks depicted policy advocacy as having several core elements. These included extensive stakeholder analysis and inclusion processes [24,55,71,78]; the use of multiple types of knowledge or evidence (e.g., scientific, lay, and critical) [23,55]; navigation through various stages of the policy change cycle [23,26,55,78]; deployment of efforts in various settings (e.g., forums, courts, arenas)

[23,55,71]; and use of direct (e.g., providing testimony for bills or meeting with politicians) and indirect tactics (e.g., newspaper editorial submissions or public awareness campaigns) [23,24,26,55,63,71,78]. Common among the frameworks was the need for multiple approaches and multiple targets. Also emphasized was the relational nature of policy advocacy that entailed working in both collaboration and in conflict with other stakeholders. Outcomes for policy advocacy ranged from enhanced organizational visibility, leadership, and capacity [26,63], to more overt outcomes that included shifts in human, financial, and/or material resources and policy reform [23,26,63,78]. Ultimately, advocacy efforts aimed to improve social and health outcomes [26,63].

### 3.4. Factors influencing priority setting and policy advocacy

Several internal and external factors were shown to shape organizations' priority setting advocacy efforts. Supporting evidence for each factor is described in the following section organized as follows: internal factors, which includes governance and governance structures, membership, professional mandates, and jurisdictional mandates; and external factors, which includes legislative authority, credibility, and system disruptions.

#### 3.4.1. Internal factors

*3.4.1.1. Governance and governance structures.* Governance, defined as a set of organizing and monitoring activities [66], was identified in the non-nursing literature as central to the policy choices and actions taken by organizations. Governing bodies reported strategic planning and priority setting as their most important role [26]. In some cases, governing bodies led the choice of issues to be addressed; while in other cases, policy advisory committees and executive directors assisted with that function [26,56,79]. Assigning responsibility for advocacy efforts to executive directors and policy staff provided flexibility to address issues. However, the leveraging of contacts and resources by board members was diminished [56,79]. Governing bodies were less often used to gain visibility or political access [26,56]. At a minimum, support and buy-in from governing bodies was essential for the development of an advocacy program by an organization [46,56,79,80].

The non-nursing literature also identified governance structures that were necessary to support organizations' planning and policy work. Structures included organizations' designated authority and division of tasks, operating procedures, rules, and by-laws, as well as strategic plans or goals[7] [26,61,63,64]. Organizations were more likely to be active and succeed if advocacy functions were written into organizational policies, strategic plans, and goals [26,56,61]. While few references were made, the nursing literature confirmed that organization policy might serve to support and enhance policy advocacy initiatives [81]. The non-nursing literature further reported that formal processes for decision-making were key building blocks for policy work [56,61,63,82,83]. However, highly bureaucratic organizations were sometimes shown to potentially undermine mobilization for a policy issue by organizations [61,64].

*3.4.1.2. Membership and inter-professional nursing relationships.* The non-nursing and nursing literature extensively described how members shaped policy work. Membership in organizations included combinations of individual and organizational members. Some operated as federated systems with various jurisdictional affiliates [26,39,64]. Within these membership configurations, motives for joining organizations, and the backgrounds, perspectives, interests, skills, and expertise of members were diverse. Organizations with more homogeneous membership facilitated an organization's ability to speak with one voice [26,64,81]. However, diversity enhanced access to high-level policy-makers and added legitimacy to their voice [26]. On the other hand, heterogeneity among members contributed to tensions, exacerbated internal conflicts, lowered levels of participation, and created delays in the fruition of policies. Divisiveness that accompanied diversity was particularly noted in the nursing literature [67,80–82,84–89].

Both bodies of literature reported that the inclusion of members in policy decisions and actions ensured selected policy issues had meaning for the public served [26,48,76,90–92] and for members [16,36,37,85,86,90,92,93]. Members were also viewed as critical to the work accomplished by organizations, as they served as champions for their organizations' cause(s) [48,82,94]. Low levels of member participation partly explained limited involvement of organizations in policy issues [26,50,51,84,95]. Clearly communicating an evidence-based policy position that could be easily understood [48], providing education and tools [24,91], and strategically selecting members for key decision-making positions and responsibilities [27] built capacity for enhanced policy efforts by members.

Authors reported that organizations often had affiliates with shared identities at different jurisdictional levels (i.e., local, national, and international specialty groups), shared membership (i.e., provincial/state organizations comprise a national organization), or shared interests (i.e., nursing professional, regulatory, labor union bodies). Cooperation and collaboration among these different organizational bodies were shown to advance organizations' initiatives [26,40,42,44–47,49,51,63–65,90,93,96,97]. Collaborations provided access to policies outside organizations' jurisdiction authority and enhanced advocacy capacity [26,48,56,59,62]. However, the nursing literature particularly described how organizations with different mandates, purposes, histories, organizational structures, cultures, and membership responsibilities experienced competition, conflict, diminished ability to speak as a collective voice, and policy inertia [37,39,47,81,84,86,88,89,94,98,99]. Challenges to collaborations were partly attributed to a rise in specialty nursing organizations that ignored issues outside their specialties. Diminished collaborative efforts

[7] Mission statements were conceptualized as part of governance structures by some authors (Lararai et al.). For this review, missions were included as part of legislative authority discussion.

were also attributed to difficulties setting priorities for issues separate from their primary organization affiliation [49,51,84,88].

*3.4.1.3. Professional mandates.* Professional mandates were described in the nursing literature and referred to the beliefs held by members of the profession about their social obligation or "contract with society" (i.e., what the profession ought to do) [39,56]. Authors argued that nursing had a moral and political responsibility to address health and social issues, often referring to nursing's broad interpretation of health, code of ethics, standards of practice, and historical practices as evidence of positions and action the profession should take [28,29,34,38,41,47,50,76,80,100,101]. In addition to advocating for public welfare issues concerning social justice, equity, and human rights [34,47,49,50,76], authors argued that advocating for professional issues that led to improved conditions for nursing practice was necessary to improve the public's health [34,102].

The professional mandate articulated by the nursing profession left ample room for nurses to interpret the most appropriate issues of concern to the profession. Arguments were made by authors for nursing organizational roles not only in health, but also in other sectors such as housing, employment, education, transportation, agriculture, and economic and environmental sustainability [34,41,80,101]. However, authors also noted that barriers might prevent nursing engagement or interest in public policy. With the growing number of nursing organizations (e.g., association, regulatory, union, specialty), the range of issues that compete for nursing attention continues to escalate. Diminished policy engagement was also attributed to incongruence among underlying assumptions, ideas, and beliefs about socio-political activism articulated in higher order documents (e.g., scope of practice) and practice realities [47]. Harwin suggested that some nursing associations may not aspire to public policy due to concerns that this might detract from other important organizational activities [59].

*3.4.1.4. Jurisdictional mandates.* Both the nursing and non-nursing literature suggested that organizations had to direct their efforts at different political levels and tailor their advocacy tactics accordingly [64,71,76]. Organizations at state/provincial levels were more likely to direct efforts at their respective jurisdictional level of authority (i.e., provincial organizations target provincial policy). However, organizations were not restricted in the target of their efforts and some attempted to influence multiple levels of government, often by working through jurisdictional networks [71,76]. The non-nursing literature reported that organizations operating at various jurisdictional levels experienced different supports and challenges. State and national organizations were "better placed to take on direct advocacy roles than local groups who were often constrained by resources and limited networks" (p. 73) [71]. On the other hand, national organizations attempting to influence federal policies faced greater challenges to work in collaborative policy efforts as the number of partners, interests and logistical challenges increase and make it more difficult to initiate an sustain relationships [64,73]. The non-nursing literature also reported that organizations targeting various levels of government policy tended to use different advocacy approaches, with national organizations more likely to engage in "insider tactics" such as lobbying and electioneering, as opposed to "outsider tactics" that generated publicity and molded public opinion [64].

*3.4.2. External factors*

*3.4.2.1. Legislated mandates and mission statements.* Legislated mandates, in the form of government acts, provided the legal authority for the existence and purpose of NGOs, NPOs, and nursing associations. Mandates were often represented in organizational mission statements and served as guides for the establishment of priorities and the development of strategic plans to meet the needs of the public served [26,32,48,76,83,100]. The non-nursing literature specifically identified that inclusion of policy roles as part of organizations' mandates or missions increased organizations' willingness to set policy priorities and take action [26,56,79]; promoted their public image as policy players [26]; and facilitated the delineation of potential roles for leading, supporting, coordinating, or providing advice [67]. One American study reported that the legal mandates of some professional organizations were conducive to advocacy work as they allowed considerable latitude in the amount of money used to support advocacy efforts, and in lobbying and communicating with members about partisan matters [26]. The organizations studied included unions and associations, which have very different mandates. However, differences in advocacy work that may have existed between these two types of organizations were not identified in the report of findings.

Both the non-nursing and nursing literature reported obstacles for policy work attributable to legislated mandates. Legislated boundaries for advocacy were not always understood and thus policy advocacy was sometimes avoided for fear of violating one's legislative mandate [26]. Chan argued that confusion may exist between mandates legislated by law and mandates gained through membership endorsement [52]. For example, while a national organization can assume a lead in the development of regulatory guidelines, their affiliate members were only bound to the regulations promulgated by law and could choose to accept or not accept the recommendations. Organizations with 'two-pronged' mandates (e.g., professional and public interests) also faced more challenges. Their advocacy efforts often competed with other demands of the organization, such as improving work conditions of its members [24,26,39,58]. In other cases, advocacy work was an add-on responsibility that resulted in ad hoc and reactive approaches to policy issues [56]. Similar findings were noted in the nursing literature. The nursing literature reported that although the imprimatur to self-regulate was understood as critical to facilitate the highest standard of nursing practice, the implications of such authority were often not perceived as favorable for public policy action [39,100]. Multi-purpose nursing organizations were thought to be left in positions of trying to balance the needs

and interests of the association, the profession, and the public [39].

*3.4.2.2. Credibility.* Both the nursing and non-nursing literature reported that the degree and nature of organizations' participation in policy work were linked to their credibility as perceived by the public, government, and other stakeholders. Confidence in organizations' competence, expected performance, or anticipated contributions to solve a problem facilitated organizations' participation in policy initiatives and increased their political power [30,42,64,66,81,94]. The non-nursing literature suggested that organizations perceived to be credible by external parties were more likely to use direct advocacy tactics (e.g., direct negotiation), while indirect advocacy tactics (e.g., influence public opinion) were used when organizations had been ineffective in getting a response from government or were excluded from decision tables [71].

The non-nursing literature reported that an organization's participation in policy issues was diminished when views about a policy issue were framed narrowly, were inconsistent with dominant stakeholders, or were not articulated within the prevailing context [65–67]. On the other hand, framing issues broadly enhanced the ability for stakeholders to envision the roles and contributions to be made by various organizations [65,67]. Phaladze suggested that involvement in policy decisions might require nursing associations to more clearly define their orientation to broader institutional and social policies [28].

*3.4.2.3. System disruptions.* System disruptions, extensively described in both the non-nursing and nursing literature, and variably referred to as shocks or jolts [60], posed both barriers and opportunities for policy action. System disruptions were described as environmental shifts or events that occurred outside of the organization and its control, and that triggered organizational actions, reactions, or inactions. These disruptions took multiple forms but generally included milestones, catastrophes or crises, emerging health issues, government legal and administrative turns, changes in the socio-economic climate, stakeholder activity and relationships, or prevailing public views [23,60,78].

System disruptions enhanced organizations' actions for a policy issue for which they were already committed. Government restructuring, receptivity, or interest, demonstrated ministerial support [54,59,65,79,86,89,90,103], and public demand or needs [48,76,79,85] were suggestive of supportive environments that inspired enhanced responses. Media attention gave greater political urgency to policy issues [64], while anniversaries of milestones (e.g., Earth Day), the release of key documents such as government reports or research, governmental elections, and the introduction of legislations were used as opportunities to remind governments about organizations' policy positions [57,60,86,90]. Health and social reforms signaled opportunities for organizations to step up efforts for a policy concern [27,30,39,51,58,84–86,89,103]. Increased actions were also motivated by invitations from political leaders, who sometimes solicited involvement from organizations that could bring expertise and deter backlash aimed at the government [54].

Advocacy efforts were also enhanced through the formation of new collaborations, networks, and partnerships. Working with others served to protect organizations or offset opposition when in conflict with advocacy targets (e.g., government or industry) [56,69,71]; enhanced access to resources and diversified political actions [26,40,44,46,52,56,62,63,79,81,94,104]; created common and meaningful positions or frames [26,32,73,78]; and increased visibility, credibility, trust, and political clout [23,62,69,71,102]. Those in health did not always have the necessary mandate or supports required to influence change outside the health sector [73]. In these cases, collaborations provided access or short-cuts to various government departments, provided opportunities for action on health determinants that were under the authority of other sectors, and enhanced efforts across sectoral, jurisdictional, and geographical boundaries [48,65,67,71–73,94].

Crises, economic instability, and political transitions were reported to create possibilities for new roles or partnerships. In these cases, organizations reacted by taking action for a new policy or changing their course of action [36,65,85,92]. Environmental catastrophes, such as oil spills, instigated changes in beliefs, values, rules, and players leading to opportunities to address new or emerging policy issue [60]. Unexpected legislative changes or passing of legislative bills also inspired reactions by organizations to take up efforts in a particular area [85,92].

While crises, economic instability, and political transitions were reported to support opportunities for actions, these events also sometimes diminished policy actions. Major crises and economic downturns left fewer financial resources and shifted attention, thus diminishing efforts or creating conditions for political inaction [23,79]. In some situations, legal or administrative events (e.g., elections) overshadowed organizations' policy work [37]. Lack of independence, fear of government retribution, and ideologies in conflict with government diminished organizations' advocacy efforts [23,25,71,79]. Changes in legislation and turnover of key political leaders affected the ability to build relationships and to influence policy decisions [105]. Interprofessional conflicts, particularly when organizations' views were opposed to powerful groups, also hampered organizations' advocacy efforts [54,60,67,86].

## 4. Discussion

A lack of empirical evidence constrains our ability to describe how nursing associations manage conflicting priorities or how they conduct their policy work. This review indicates that several internal and external factors determined how organizations succeeded or failed to set achievable priorities and advance their advocacy goals. Internally, the type of governance model, the cohesiveness and breadth of membership, how organizations viewed their professional mandates, and the scope of their perceived jurisdictional authority affected policy choices and initiatives. Externally, legislated mandates, organizational credibility with external stakeholders, and system

disruptions shaped decisions and the actions taken. These are important characteristics of the decision context in which nursing organizations undertake their policy work.

The findings from this review challenge us to consider how we might understand, plan, and manage policy work in nursing associations with these complex decision contexts. It is evident that organizations display ambiguous responses even when they seemingly share similar structural features or are exposed to common events and conditions. For instance bureaucratic organizations were reported to both facilitate and hinder policy work. While diversity among membership enhanced policy efforts, it also contributed to policy inertia. Similarly, various system disruptions created opportunities to act, but other times led to policy inaction. To understand these ambiguous organizational responses, a holistic approach that explores the relationships and interplay among internal and external factors is required. This would include attention to both nursing associations' diverse structural and legal organizational arrangements and the systemic context in which choices and actions are taken.

Understanding nursing associations' policy work also requires attention to the dynamic of their relationships and partnerships. The findings indicate that organizations face particular challenges when addressing complex health and social policy issues that requires cross-disciplinary, inter-sector, and inter-jurisdictional efforts. For instance, while cooperative and collective leadership across all sectors and between levels of government are proposed [2,106], there is often less opportunity for organizations to build relationships with government or to be perceived as credible by external stakeholders when they advocate from outside their recognized domain of authority. Furthermore, the importance of framing and contextualizing issues and considering the roles for other stakeholders in a sufficiently broad manner is apparent. Although the narrative accounts included in this review provide insight into an array of public policy issues addressed by nursing associations and the supports and obstacles they face in their broad policy work, research is required to confirm the learning and insights gained. In addition, understanding complex public policy issues requires attention to the networks of stakeholders across local, subnational, national, and international boundaries and the interplay of ideologies, interests, amenities, and power dynamics.

Approaches that consider multi-strategy and multi-targeted approaches and the constellation of factors shaping organization change are also necessary to understand the nature of nursing associations' policy work. Organizations' attempts to influence public policy include efforts aimed at members, the public, media, and political leaders. These efforts entail, for example, awareness and education campaigns, mobilization tactics, and lobbying. Furthermore, the types of strategies and the intensity of efforts are often inspired or altered in response to system disruptions. Thus, understanding nursing associations' choices and actions requires attention to the dynamic of their efforts within their professional–legal–social–economic–political–ecological environments across time.

To understand the array of factors and their interplay, the dynamic of relationships across disciplinary, jurisdictional and sector boundaries, and the changes that occur at varying times and across various targets that shape nursing associations' priority setting and policy advocacy, we propose that some form of systems thinking is required. Various forms of systems theory have been applied in organizational studies to understand strategic and organizational decision-making [107–109], and to develop knowledge for human and health care problems that involve cross-disciplines–sectors–jurisdictions [55,110–113]. Organizational systems theorists conceptualize organizations as "collections of human and physical capital that exchange and process information, transform physical objects, and make decisions for the purpose of achieving some set of objectives related to their external environment" (organizations are open systems section) [108]. While people make decisions, the sharing and convergence of interpretation among members characterizes organizations' decisions [107].

The concept of social and other forms of capital is also relevant in socio-ecological theory introduced by the interdisciplinary field of ecosystems management [110,114] and can guide our thinking about the implications of our findings for future research. This systems theory approach was applied to a recent analysis of Canadian nursing associations' joint policy efforts over several decades to introduce and sustain the use of nurse practitioners across Canada [111]. In this form of systems thinking, whole systems change is defined as "uneven, nested cycles of adaptation that evolve within closely coupled, complex socio-ecological systems over time" (p. i) [115]. Human systems (including organizations) and natural systems are viewed as co-evolving over time through an "interplay between processes and structures that sustains relationships on the one hand and accumulates potential on the other" (p. 102) [110]. Using this form of systems thinking to interpret nursing association policy work may mean that their capacity for effective policy work is critically shaped by their ability to adequately target variable resources during overlapping phases of longer periods of growth and conservation, whereby capital such as relationships and networks are accumulated, and shorter periods of restructuring and reorganization, whereby opportunities for innovation are created.

The scale, duration, and non-linear nature of this kind of co-evolution also mean that a variety of structures and processes can serve as leverage points or blockages for systems change at any given point in time [111]. Leverage points, defined as "places within a complex system ... where a small shift in one thing can produce big changes in everything" (p. 1) [116], can be used to foster resilience, sustainability, or change. Identifying blockages that hinder, scale down, or create inertia is essential for finding ways to manage them [110,111]. Furthermore, the paradoxical presence of both leverage points and blockages to change within a given organization that we noted in our findings is consistent with the paradoxical system dynamics that are well described in ecosystems management case studies [110,114]. This suggests, as Best et al. [117] argue, that understanding health systems as complex systems

may be aided by building whole pictures of the system. Gaining insight about nursing associations' policy priorities and actions must therefore include both attention to the organization and to closely coupled professional, legal, social, economic, political, and ecological systems whose features may incorporate any number of leverage points or blockages to specific policy initiatives at varying points in time.

Overall, a systems perspective would provide an important underpinning for future research that aims to examine how nursing organizations set public policy priorities and advocate within their various contexts. Case comparisons would be particularly useful for identifying cross-cutting themes that contribute to, or constrain nursing organizations' public policy efforts at different systems levels. Furthermore, as case exemplars in ecosystems management [110] and health systems change [111] illustrate, longitudinal studies are also needed to understand changes that occur at different time scales. Data collection requires tracking change from multiple perspective and multiple levels in order to identify patterns and ambiguities, and to identify where different changes may occur. Data sources could include, for example, the perspectives of various stakeholders and data from organizational documents and archives. Analysis would include plotting external events (e.g., crises) and change/advocacy processes implemented by organizations [110].

This scoping review bridged research, narrative accounts, and theoretical nursing and non-nursing literature. The inclusion of narrative accounts allowed us to identify innovative policy work undertaken by nursing associations that have not been the focus of empirical inquiry. By drawing on a strong empiric base from the organizational literature we were able to map organizational and systemic factors that influence organizations' policy choices and actions. The inclusion of theoretical literature allowed us to identify important dimensions and processes of priority setting and policy advocacy and their potential relationships. Incorporating policy experiences from diverse policy contexts and international experiences contributed to insights gained and, as explained by Gilson et al. [69], facilitated an understanding of what might be applicable in another context. These findings identify processes for leaders of organizations to consider in their priority setting and policy advocacy work. However, further investigation is needed to understand the best approaches within various contexts.

The results for this review are subject to limitations. Our focus on nursing associations' cross sectoral public policy work excluded other bodies of literature that may have provided additional insights related to professional organizations (e.g., only NGO and NPO research for public policy related to social determinants of health included). Papers were scrutinized for their relevance based on their description of priority setting and policy advocacy, and the findings largely drew from narrative accounts. All papers that met the inclusion criteria were included in the analysis regardless of methodological rigour. While this approach is consistent with the aims of a scoping review, the variability in the methodological rigour of included studies limits conclusions regarding the relative importance of internal and external influences on organizational priority setting and policy advocacy.

## 5. Conclusion

There is limited research investigating how nursing associations make choices among competing public policy priorities, how they advocate for public policy and systems change, and the supports required or challenges faced when they attempt to address social and environmental public policy issues that involve cross-discipline–jurisdiction–sector collaborations. A socio-ecological systems perspective can inform the development of theoretical frameworks and research to understand leverage points and blockages to guide nursing associations' public policy initiatives at varying points in time.

## Competing interests

The authors declare that they have no competing interests.

## Authors' contributions

Jo-Anne MacDonald: Conceived of the scoping review question and design; conducted all searches, screening, and analysis.

Nancy Edwards: Assisted with framing the question and design of literature review, analysis and interpretation of data, and application of socio-ecological approach. Suggested revisions made to earlier drafts and the final manuscript.

Barbara Davies: Assisted with framing the question and the design of the literature review and analysis and interpretation of data. Suggested revisions made to earlier drafts and the final manuscript.

Patricia Marck: Review of search strategy, review of findings, and substantive contributions to theorizing and discussion of findings. Suggested revisions made to earlier drafts and the final manuscript.

Judith Read Guernsey: Assisted with framing the question, provided comments and text edits to manuscript drafts, participated in general discussions about application of population health approaches and organizational theory to substantiate the work.

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## INTRODUCTION TO CHAPTER 3

This chapter presents the development of a conceptual framework that guided this doctoral research. The framework depicts nursing associations' priority setting and policy advocacy for community environmental health (CEH). The manuscript was published in the journal, Aporia February, 2012[2]. Aporia is a peer-reviewed, bilingual, and open access journal dedicated to scholarly debates in nursing and the health sciences. The journal is committed to a pluralistic view of science and to the blurring of boundaries between disciplines.

[2] MacDonald, J., Davies, B., Edwards, N., Marck, J. & Read Guernsey, J. (2012). Priority setting and policy advocacy for community environmental health by nursing associations: A conceptual framework to guide research. *Aporia, 4*(1), 18-29.

2

**Abstract**
Nursing associations' choices to engage in community environmental health transpires in a complex decision-making context in which a number of issues compete for their attention and a number of factors influence their choices. Given the complexity of this decision environment, theoretically informed research can lead to understanding about the dynamics, supports, and constraints shaping nursing associations' decisions. We propose a conceptual framework to guide research to understand whether and how nursing associations' take action for community environmental health. The framework depicts nursing associations' priority setting and policy advocacy for community environmental health embedded in a policy decision-making context in which internal association factors and external factors at all system levels (local to global) influence the organizational choices and actions taken.

**Key words** community environmental health, conceptual framework, decision-making, nursing associations, socio-ecological systems change

# Priority Setting and Policy Advocacy for Community Environmental Health by Nursing Associations: A Conceptual Framework to Guide Research

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## Introduction

Nurses and other health care professionals have the ability to influence system and policy change for improved community environmental health.[1] Influencing system and policy change requires that nurses organize, speak, and act as a united front provincially/territorially, nationally, and internationally.[2] Nursing associations provide vehicles through which nurses, as a collective and with partners, can take political action across system levels.[3-5] However, environmental health is one of many policy issues that are of concern to the nursing profession.[6] Thus, nursing associations are charged with making choices about which policy issues should take precedence and what strategies should be taken. Little research is available that explores how nursing organizations chose among competing priorities, and in particular social and environmental public policy issues that involve cross disciplinary, jurisdictional, and sector collaborations.[7]

This paper proposes a conceptual framework that depicts nursing associations' priority setting and policy advocacy for community environmental health. The framework was developed for the purpose of guiding doctoral research. We begin with a background that provides conceptualizations of what we refer to as community environmental health and community environmental health policy. Descriptions of the community environmental health policy context and the need for a nursing presence in shaping policies are provided. We examine and report the evidence that describes nursing associations' policy work for community environmental

health. Using socio-ecological whole systems change lens, we then propose ways forward for understanding nursing associations' policy choices and actions. We conclude by proposing a conceptual framework that depicts nursing associations' priority setting and policy advocacy for community environmental health. The implications of the framework for research and nursing associations' priority setting and policy advocacy are discussed.

## Background

### *Community environmental health*

In its broadest definition, behavioural, social, natural, and physical components make up the total human environment.[8] In relation to health, Pruss-Ustun & Corvalan[8] suggested a practical definition, whereby environment is more narrowly conceived as "all the physical, chemical and biological factors external to the human host, and all related behaviours, but excluding those natural environments that cannot be reasonably modified".[p21] Recent nursing literature underscores the reciprocity of human and natural systems that co-exist and co-evolve. For instance, Laustsen proposed that the term ecosystem more accurately depicts human-environment health as it encompassed "the dynamic, interrelating, and relational nature of organisms and their environments".[9 p44] Attention is drawn to the intricate relationships among biotic and abiotic relationships that comprise the human-health ecosystem. Scholars have argued that healthful human-environments are produced by people participating within their surrounding environments in ecologically sound ways.[10-11] Furthermore, human-environmental health is shaped by practices, conditions, and relationships at the local, sub-national, national, and global scales.[12] Building on this work, we use the term community environmental health in this paper to refer to human-ecosystem health, generated through human participation with natural, physical, chemical and biological systems and supported through ecologically sound practices and policies at different levels of geographic scale and time (note this conceptualization does not include occupational environments).

### *Community environmental health policy*

Multi-disciplinary, multi-sector, and multi-jurisdictional public policy responses are needed in order to address the complex and multi-causal nature of community environmental health issues.[13-14] Broadly, public policy refers to both action and inaction by public authorities to address a problem or interrelated set of problems in the interest of larger groups, organizations, or communities (distinguished from case advocacy that aims to solve problems for individuals or families)[15-16] When applied to community environmental health, public policies refer to those that address human-ecological health. More specifically, community environmental health policies aim to promote healthful practices, conditions, and relationships for improved human-ecological health.

Three categories of community environmental health policies for which nursing could advocate: those that affect the healthfulness of settings, such as homes, workplaces, schools, or communities; those that influence the quality of ecological systems such as water, air, land; and those that target the local, sub-national, national, or international governments that are responsible for policies that influence the health of human environments.[11,17] These policies employ a number of mechanisms, referred to as policy instruments, including regulations and standards, taxes and charges, voluntary agreements, subsidies and financial incentives, information, and research and development.[18] Most often packages of policies are required to address community environmental health problems along "multiple points of interaction or multiple points in the chain of cause and effect".[14 p24]

### *Community environmental health policy context*

Stakeholders engaged in community environmental health issues are immersed in a complex policy field involving diverse and policy arrangements, multiple actors, multiple sectors, and multiple jurisdictions with varying constitutional authorities. Community environmental health policies are created and administered by various government departments, agencies, and sectors, often with shared constitutional authority but diverse mandates.[17] In addition to political leaders, and depending upon the community environmental health issue, a number of other stakeholders could also be involved including the public, media, scientists, industries, and non-profit organizations.[19-20] Ambiguity and disagreement about the problems, their solution, and the evidence, as well as incomplete evidence add complexity and challenges for those attempting to influence community environmental health policy.[14,21]

### *Need for a stronger nursing association presence in community environmental health*

Recent reports suggest nursing associations should

have a stronger presence in advocating for community environmental health and propose a range of ways they could contribute.[22-26] Nursing associations are encouraged to provide education and share information with nurses, the public, and other professional groups;[22-23,27] to join coalitions for improved environment conditions (e.g. reduce air pollution, urban redesign, increased public transit; caps on emissions);[23] to develop position statements;[24] to conduct research[24], to lobby legislators and governments for stricter environmental legislation and policies and investment in renewable energy,[23-24,27] to encourage other international professional bodies and their members to lobby their governments to promote sustainable environments,[27] and to advocate for governments and international agencies to mitigate the impact of industrial and economic policy on the environment.[24] The International Council of Nurses[25] suggested national nursing organizations could play a strategic role in reducing global environmental health hazards and be part of multi-sectoral measures to mitigate the impact of climate change on populations, particularly for those most vulnerable.[26] Thus, there are a number of community environmental health issues, strategies, and targets for which nursing associations could take action.

## Examining the evidence for nursing associations' engagement in community environmental health

We conducted a literature review to identify research that explored or explained how nursing associations were engaged in community environmental health policy setting and advocacy. Using a search strategy designed with the assistance of a professional librarian, six electronic databases from the years January 1999 to October 2010 were searched (Refer to Table 1 for further details about search terms for database searches). In addition to the database search, a manual search of reference lists was conducted for retrieved articles (e.g. editorials, commentaries, reports) that were directly related to nursing organizations involvement in environment. The search also included a grey literature of websites for Canadian and international nursing organizations, nursing academic institutions, the Canadian government, and health organizations (Refer to Table 2 for search terms used for grey literature search). The combined search yielded 1,864 papers.

Table 1: Search terms for databases

| SH Terms for Nursing Organization | MESH Terms for Environment |
|---|---|
| (MH "Nursing Organizations+") or (MH "Student Nurses Organizations+") or (MH "State Nursing Organizations+") or (MH "Nursing Organizations, International+") or (MH "National Federation for Specialty Nursing Organizations") or (MH "New Zealand Nurses Organization") or (MH "Nursing Organizations Alliance") or (MH "State, Provincial and Territorial Nursing Organizations+") or (MH "American Organization of Nurse Executives") | (MH "Natural Environment") or (MH "Environment") or (MH "Work Environment+") or (MH "Environment, Controlled+") |

Table 2: Search terms for grey literature search

| Key word searches | Sites searched |
|---|---|
| a) Environmental health in nursing based websites<br>b) Nursing organization or nursing association in other websites | Nursing websites examined:<br>13 Canadian nursing organization; the International Council of Nurses; the American Nurses Association; and several state nursing organizations that had publications related to environmental health (e.g. newletters, position statements) including the Maryland Nurses Association and Texas Nurses Association, and specialty organizations such as the American College of Nurse-Midwives and Oncology Nursing Society.<br>Other websites examined:<br>EnvirRN University of Maryland School of Nursing; Canada's Department of Health and Department of Environment; Friends of the Earth; and Canadian Physicians for the Environment; World Health Organization |

Screening entailed a three-stage process using pre-determined inclusion and exclusion criteria starting with titles, followed by abstracts, and then full text review of papers. (Refer to Table 3 for further details about inclusion and exclusion criteria.) Papers that did not meet inclusion criteria were eliminated. When uncertainty existed about the eligibility of papers based on either the title or abstract assessment, full articles were retrieved. A total of 162 papers were retrieved for abstract or full review. (Refer to Table 4 for further details about yields from literature search.) These articles were then screened using the inclusion and exclusion criteria.

### *Findings from literature review*

Only one study[28] was identified that reported nursing associations' work for community environment health. This extremely low yield suggests this is an underdeveloped area of study. However, the literature review also revealed the substantial public policy work undertaken by nursing associations for community environmental health, which is primarily charted in editorials or commentaries, discussion papers, reports, reflective reviews, and historical accounts (with no formal research methodology). This anecdotal evidence described nursing associations' involvement in a broad array of community environmental issues including green health care, pesticide legislation, green energy, climate change and Kyoto Accord commitments, and environmental carcinogens and exposures.[19,22-23,29-32] A number of tactics have been employed to address community environmental health. For instance, nursing associations have conducted surveys to identify public concerns, and to explore nurses' needs related to their community environmental health practice.[5] They have responded to concerns by developing background papers,[22-23,31] position statements,[25,27] and environmental health principles.[33] Some nursing associations have lobbied for pesticide and carcinogen legislation, environmentally responsible activity in the health sector, and safe drinking water.[17,25-26,28-29,32,34] Some have participated in interdisciplinary and government committees (e.g. Friends of the Earth, Environment Canada)[22] and engaged in community environmental health initiatives involving many partners (e.g. medical associations, industries, and scientists)[31] as part of their community environmental health efforts. However, the absence of empirical research to investigate this work leaves minimal opportunity to understand the factors that support or hinder their choices or actions.

This anecdotal evidence further points to the complex environment in which nursing associations' make choices

**Table 3: Inclusion and exclusion criteria**

| Inclusion criteria | Exclusion criteria |
|---|---|
| a) Described work undertaken by a nursing organization<br>b) Original research including qualitative and quantitative research and systematic reviews<br>c) Described community environmental health issues<br>c) Published in English<br>d) Published between January 1999 and September 2009 | a) Studies about independent nurse priority-setting or policy advocacy efforts<br>b) No research design or methodology described<br>c) Theses, dissertations, discussion papers, commentaries, and editorials |

**Table 4: Yields from search**

| Database | Total finds | Yield |
|---|---|---|
| CINAHL | 481 | 77 |
| PubMed | 276 | 23 |
| HealthStar | 102 | 9 |
| ABI Inform/Global | 762 | 43 |
| Cinoebdex | 243 | 10 |
| Greenfile; Web of Science/ BIOSIS; Scopus | Yields to specific earth, physical, and chemical sciences (links to human health not part of research) | 0 |
| Total | 1 864 | 162 |

and take actions for community environmental health. There are a number of issues for which nursing associations could take action. Addressing community environmental health entails a series of independent and collaborative efforts. Tactics may include direct (e.g. lobbying) or indirect (e.g. developing position statements) efforts. Collaboration for community environmental health, in turn, may involve any number of actors from diverse disciplines and sectors and involve efforts with national, sub-national, and local governments. In this context, understanding the dynamics, supports, and constraints shaping nursing associations' community environmental health work would benefit from a socio-ecological lens.

## Understanding choice through a socio-ecological systems change lens

In a recent scoping review,[7] it is argued that given the considerable intricacies of nursing organizations structural arrangements and systemic environments, the particular challenges encountered when addressing cross sector health and social policy, and the paradoxical responses by organizations exposed to common events and conditions, a socio-ecological whole systems perspective would be appropriate to understand their policy decision-making processes. Exploring nursing associations' decision-making from this perspective views whole systems change as "uneven, nested cycles of adaptation that evolve within closely coupled, complex socio-ecological systems over time."[35 p2]

More specifically, whole systems socio-ecological thinking as described by Gunderson and colleagues[12,36] and as applied to understanding and managing health systems change[37] could facilitate the exploration of contextual factors and their interplay in shaping individual and organizational choices, and dynamic changes that occur at varying times and across system levels. Furthermore, nursing associations and related systems (e.g. legal system) are believed to co-evolve over time through "interplay between processes and structures that sustains relationships on the one hand and accumulates potential on the other."[12 p102] MacDonald and colleagues[7] further argued that attention to closely coupled professional, legal, social, economic, political, and ecological systems may lead to the identification of any number of leverage points or blockages. This socio-ecological perspective is complemented by the decision-making literature, which identifies decision-making as a social process embedded within complex systems. We consider this literature in the next section.

## Decision-making: A social process embedded in complex systems

Vroom and Jago[38] suggest decision-making by organizations is a social process that can be understood through examination of both its prescriptive and descriptive dimensions. The prescriptive dimension looks to the rules that are applied to rational groups to facilitate decision-making. [38-39] Understanding the prescriptive dimension of nursing organizations' decisions for community environmental health, for instance, would require attention to the types of problems the decision-makers identify, to the types of data used to make judgments, and to the set of decision rules used to adjudicate among alternatives. The descriptive dimension, on the other hand, is concerned with how decision-makers actually decide (not how they ought to decide) and the patterns, regularities, or principles in the way groups chose in given situations.[38-39] Understanding nursing organizations' decisions for community environmental health would require an examination of the processes of decision-making and the determinants that shape choices and actions. These determinants include both "hardware" and "software" components.[40]

Authors[40] have argued that questions related to health policy decisions have been skewed by a focus on a system's "hardware" such as levels and types of human resources and organizational structures and legislation. However, human activity systems (such as organizational decision-making for public policy) that include human actors who have foresight and intentionality, can attribute different meanings to what they perceive, can communicate, and can use technology[12,41] would benefit from more attention to "software components" or the social processes, practices, and ideas that drive decisions. Software components include "ideas and interests, values and norms, and affinities and power that guide actions and underpin the relationships among system actors and elements."[40 p 2] Software components are evident in institutional theory, which contributes to systems theory by drawing attention to institutional influences that operate to support or constrain organizational behaviour and choices.[42]

## Institutional theory: Attention to the software context for decision-making

According to institutional theorists and researchers,[19,43-46] institutions are established when actions are repeated, given

similar meaning, and become widely accepted. These institutions may not be readily apparent or known, but operate to regulate behavior, and to shape goals, priorities, standards of practice, and codes of conduct.[43] While institutions are often resistant to change, scholars further contend that organizations possess the autonomy to make purposeful, strategic, and opportunistic choices.[44]

More specifically, Scott[43] contends that three broad forms of institutional factors help explain organizational behaviour and decisions: regulative, normative and cognitive institutions. First, regulative factors refer to formal rules, policies, laws, or regulations, which exert their pressure through forms of coercion, threats, or inducements.[45] Organizational behaviours are thus driven by a need for expedience or compliance. Examples of regulatory factors potentially relevant to nursing associations' choices include governance models, by-laws, codes of ethics, and government regulatory or corporation acts.

Second, normative factors refer to traditional mores, informally sanctioned obligations, and rules-of-thumb, which exert their pressure through informal rules that structure expectations, standards of performance, and expected relationships. Organizational behaviours are thus driven by perceived social obligations. Normative factors are reflected in nursing associations' professional mandates, certifications, intra-professional relationships, and collaborative partnerships.

Third, cognitive factors are shared understandings, logics, and cultural meanings about how things work or should be done. They exert their pressures by encouraging the adoption or mimicking of other successful organizations in an effort to gain legitimacy. In this case, organizational behaviours are often taken for granted.[47] Cognitive factors potentially relevant to nursing associations' choices include beliefs about why community environmental health problems exist and the roles of government in solving public problems. Institutional theory has contributed to organizations, professions, and policy research[47-50] and holds promise to inform research exploring factors and their mechanisms that influence nursing associations' policy work.

## Dev elopment of a conceptual fr amew ork

### *Complementary theoretical perspecti ves*

Socio-ecological whole systems change explains the broad context and processes for change across all system levels.[12,35-36] Institutional theory draws more detailed attention to specific contextual regulative, normative and cognitive institutional factors and their mechanisms for influencing organizational decision-making. Using these complementary perspectives, research approaches would include efforts to gain knowledge related to: a) the nature and scope of nursing associations' engagement in community environmental

health; b) the perspectives and beliefs leaders hold about how nursing associations make decisions or how they conduct policy advocacy; and c) the social context or institutional influences (i.e. from related professional, legal, social, economic, political, and ecological systems) in which choices are made and action is taken; and d) the interplay of internal and external factors and their mechanisms that operate across discipline, jurisdictional, and sector boundaries and at different time scales. Based on tenets of whole systems thinking and institutional theory we propose a conceptual framework to guide such research.

### *Overview of conceptual framework*

The conceptual framework depicted in Figure 1 represents nursing associations' priority setting and policy advocacy leading to engagement in community environmental health. Major components of the framework include decision-making processes and influencing factors, which constitutes the decision context. A recent scoping review[7] undertaken to investigate priority setting and policy advocacy by nursing associations identified several factors both internal (governance and governance structures; membership; jurisdictional mandate, professional mandate) and external (legislation, credibility, system disruptions) to the nursing associations that influence their policy choices and actions. Concepts from these findings informed the development of the framework.

Nursing associations' decision-making for engagement in community environmental health is embedded in a policy decision-making context in which internal association factors and external factors at all system levels (local, sub-national, national, and global) influence the organizational choices and actions taken. At the core, decision-making includes priority setting for competing policy issues and policy advocacy (represented by overlapping ovals with broken lines in the figure). Priority setting and policy advocacy choices are interdependent (represented by overlapping ovals). The outcome of these choices (represented by the square) concerns whether and how nursing organizations are engaged in community environmental health policy issues. Decision processes are shaped by internal and external factors (represented by half-moon crescents with broken lines to indicate their ability to influence decision-making). Regulatory, normative, and cultural factors within the internal and external environment are interrelated (represented by overlapping ovals with broken lines). Within this context nursing associations retain the autonomy to take deliberate, strategic, and opportunistic action to influence priority setting and policy advocacy.

Together the framework proposes factors internal and external to nursing organizations that can both create opportunities or narrow options for their choices of policy, for ways they advocate, and for the outcomes from their policy efforts. A more detailed explanation and supporting evidence for the components of the framework are described in the following section.

## Framework components

### *Decision-making*

**Priority setting.** Part of the decision-making process includes setting priorities among competing policy issues. Priority setting refers to the ways in which decisions by nursing associations are made for the allocation of its human, financial, and/or material resources. This includes the identification and selection of relevant stakeholders; the selection of criteria and values upon which to adjudicate decisions and ways to weight those decision criteria; ways to identify, gather, manage, and synthesize evidence; and mechanisms for reviewing and evaluating decisions and their consequences.

**Policy advocacy**. Policy advocacy processes are the ways in which nursing associations attempt to influence structural and system-level decisions. This involves working across discipline, jurisdictional, and sectoral boundaries. Policy advocacy processes include stakeholder analysis and inclusion processes; the use of multiple types of evidence; navigation through various stages of the policy change cycle; deployment of efforts in various settings, and use of a range of strategies and tactics.

**Engagement in community environmental health.** In this framework, the outcome from decision processes includes engagement (or not) in community environmental health. Engagement includes both the choice to address community environmental health issues and the actions taken to influence policy decisions for human-ecological health.

### *Decision context: Internal organizational factors*

**Governance.** Governance represents the set of organizing and monitoring activities that describe how nursing associations' boards or councils do their jobs. Structures required for the board / council to do their job include designated authority and division of tasks, operating procedures, rules, bylaws, strategic plans, and goals. The degree of buy in from governing bodies, the formality of decision structures, lines of authority, and supporting organizational documents influences the choice and degree of engagement in policy initiatives.

**Membership**. Membership represents nurse registrant and other supporters (e.g. individuals, corporate, group membership) and their contributions to nursing associations' policy efforts. The homogeneity or heterogeneity of membership influences associations' access to resources and their ability to reach consensus or speak in unity. While advocacy efforts may be enhanced when resources are pooled, conflicting interests and mandates may diminish intra-professional collaborative efforts for community environmental health.

**Jurisdictional mandate**. Jurisdictional mandate represents the associations' territorial responsibility across local, provincial/territorial, national, or international boundaries. Nursing associations operating at various jurisdictional levels target different levels of the political system and vary the use of direct (e.g. lobbying) and indirect (e.g. public awareness campaigns) approaches. National and sub-national nursing associations will experience different supports and challenges in their collaborative endeavors (e.g. opportunity to intimately know political leaders).

**Professional mandate**. Professional mandate represents the beliefs members of the nursing associations hold about their social obligation (what the profession ought to do) to address community environmental health. Community environmental health will compete for attention or for preferential treatment in nursing associations' that attend to broad policy interests.

### *Decision context: External system factors*

**Legislative authority**. Legislative authority represents government regulations, policies, or legislation that provides the legal authority for the existence and purpose of the nursing associations. Nursing associations articulate their potential contribution and roles and engage in community environmental health initiatives when policy advocacy is included as part of their mandate and mission statements. Fear of violating the law or dual mandates (e.g. regulatory and professional) diminish policy advocacy for community environmental health.

**Credibility**. Credibility represents the perceptions or assumptions held by the public, government, and other stakeholders from outside the nursing association or the profession about the expertise or contributions nursing associations can appropriately make to community environmental health. Associations that have the confidence of those outside the association have increased political power, opportunities for participation, and use direct advocacy tactics. Indirect tactics are used when nursing associations advocacy efforts are ineffective or they are excluded from decision tables.

**System disruptions**. System disruptions represent environmental shifts or events that occur outside of the organization and its control that create opportunities for engagement, change the nature of relationship among stakeholders, shift resources, and alter the urgency of issues. Nursing associations may respond to system disruptions by enhancing actions for policy issues for which they were already committed, by taking action for new policies, or by diminishing or withdrawing efforts.

## Contributions / implications for nursing research

The framework offers a depiction of concepts and their relationships regarding nursing associations' engagement in community environmental health. The framework draws particular attention to internal organizational factors and to external system factors, and provides a starting point to identify institutional factors and their mechanisms (e.g. coercion, compliance) that shape nursing associations' choices and actions for community environmental health. The framework provides an opportunity to inform research to understand how nursing associations make choices among competing professional/practice and public policy priorities, how they advocate for public policy and systems change, and the supports or challenges they may face when attempting to address public policy issues.

One way forward would be to conduct case comparisons across nursing associations with diverse organizational features (e.g. mandates, membership configurations), across various jurisdictional settings (e.g. provincial/territories and national boundaries), across geographic boundaries (e.g. Canada and United States countries), and involving diverse actors (e.g. government, industry, non-governmental organizations) to identify cross-cutting themes that contribute or constrain nursing associations' public policy efforts. Identifying patterns and ambiguities would require exploration of change from multiple perspectives and sources including, for instance, the perspectives of staff and directors and data from organizational documents and archives. Exploration should span time scales to understand diverse and differential rates of responses that may result from multiple smaller and bigger changes moving at different speeds across different levels of the system.

## Implications for nursing associations' priority setting and policy advocacy

This conceptual framework draws attention to the need to

understand how nursing associations set policy priorities and factors and mechanisms that support or restrict their efforts. Understanding the factors and mechanisms that support priority setting and policy advocacy can underscore leverage points and blockages, which in turn can be used to plan the most receptive time to address a policy issue, the stakeholders who need to be involved, and the most appropriate targets and strategies.[51-52] Drawing on these opportunities can help nursing associations meet their vision, mission and goals, and lead to successful policy choices/efforts.[52-56] Failure to acknowledge leverage points and blockages may undermine nursing associations' attempts to meet their objects or prevent associations from implementing their policy preferences. Priority setting choices and actions may be made in reaction to past experiences, rather than in response to the most pressing needs of the communities they serve. Opportunities may be lost to maximize organizational efforts and subsequent health gains for the resources available.[51,57]

## Conclusion

We argue that nursing associations' priority setting and policy advocacy occurs within a complex decision-making context whereby there is a dynamic interplay of internal organizational and systemic external factors that influence whether and how they take action for community environmental health. Given that organizational responses can vary and change over time within this context, research approaches are required that permit an in-depth exploration of these dynamics. We provide a theoretically and empirically informed conceptual model rooted in tenets of whole systems thinking and institutional theory to guide research investigating how nursing associations makes decisions and factors that influence those choices. In constructing this framework, we have provided a way to consider how social influences and their mechanisms may operate to shape nursing associations' engagement in community environmental health. Future research guided by this framework can lead to better understanding of decision supports and constraints and thus areas for potential action to enhance priority setting and policy advocacy.

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## INTRODUCTION TO CHAPTER 4

This chapter presents the research design and methods. I begin with a description of the study design. Details about the study setting, case selection, and participant sampling are discussed. Data collection methods are provided, followed with a description of the analyses. Information is provided about a small group discussion. The chapter ends with a presentation of actions taken for trustworthiness and ethical considerations.

# CHAPTER 4 - METHODS

## Research Design

This study was a qualitative comparative case study (Yin, 2009). Yin defines case study as "an empirical inquiry that investigates a contemporary phenomena within its real life context, especially when the boundaries between the phenomena and context are not clearly evident" (p. 18). This case study design supported an in-depth exploration and description of three Nursing Associations' engagement in CEH policy in their natural setting in which the organizational, federal, and provincial context was highly pertinent to understand the choices and actions taken. The comparative design permitted comparisons among the Nursing Associations to identify cross-cutting patterns and build a more powerful understanding about factors that contributed to and constrained the Associations' priority-setting choices and policy advocacy actions. The qualitative approach allowed me to gain access to the types of information, both spoken and written, which collectively informed an understanding about the reality of the Nursing Associations' policy work. More specifically, an understanding of decision processes and factors that shaped choices and actions were gained through the experiences of those who lived it and organizational materials that documented it.

## Study Setting

This study was undertaken in two Canadian provinces and encompassed both provincial and national jurisdictions. Canada operates as a federal system. Constitutionally, the responsibilities for health and the environment primarily rest with provincial/territorial governments. The federal government assumes legislative responsibility for issues with national implications (e.g., Canada Health Act, Canadian Environmental Protection Act). Municipal governments assume responsibilities granted to them by their provincial/territory government authorities (e.g., pesticide by-laws). The number of acts, regulations, and administrative agreements and range of sectors, government agencies, departments, and stakeholders contribute to a complex and diverse policy field.

## Case Selection

The cases were purposefully selected based on variations in both their organizational attributes and their degree of CEH policy work. To identify associations with varying mandates, I used website information that described associations' legislative and

jurisdictional authorities. To assess the degree of engagement in CEH, I examined the associations' resolutions, position papers and policy statements, and resources (e.g., educational material) that were available on the websites. The assessment for engagement in CEH was rudimentary, with associations classified as either high or minimal degree of involvement. Associations with resolutions, policy documents, and resources related to CEH were considered to have a high degree of involvement. Associations with resources or references related to CEH, but no evidence of resolutions or policy documents, were assigned the category of having a minimal degree of involvement.

Four Associations were invited to participate that had a healthy public policy mandate and exhibited some involvement in community environmental health. Three of these Associations agreed to participate. One Association declined the invitation. The reason was not disclosed. The first case, the Canadian Nurses Association (CNA), is a national association with member-granted regulatory functions. CNA was involved in community environmental health initiatives since 1990 and was considered to have a high degree of involvement. The second case, the Registered Nurses' Association of Ontario (RNAO), is a provincial nursing association with no legal or member-granted regulatory functions. RNAO was involved in community environmental health initiatives since 2010 and was considered to have a high degree of involvement. The third case, the Association of Registered Nurses of Newfoundland and Labrador (ARNNL), is a provincial nursing association with legal responsibility to regulate nurses in the province. Initiatives taken by ARNNL related to community environmental health were considered minimal.

**Participant Sampling**

All Association staff and members of the Board were eligible to take part in the study if they also met the following criteria: a minimum of one-year experience with priority-setting and policy advocacy during the past 5 years with their Association and/or had experience working in the area of CEH policy, and spoke English. Sixty-three participants were eligible to participate.

Out of a total of 63 potential participants across the three organizations, forty-one individuals were interviewed. Approximately 34.1% (14/41) were from CNA, 19.5% (8/41) from ARNNL, and 46.3% (19/41) were from RNAO, reflecting the range of employees and volunteers of the Associations. Of these, 39 were current employees or volunteers, 35 were

female, 31 were registered nurses, 35 held a minimum of a Master's degree, and 27 practiced their profession for over 20 years. Few participants had formal training (courses or certificates) related to community environmental health issues. Thirty-nine of the participants held senior management and decision-making positions (e.g. Chief and Assistant Executive Officers, Executive Directors, Directors of policy departments, Board of Director members, and Chairs of committees). Thirty-two participants had a minimum of two years experience with their associations. Twenty-two reported a minimum of 10 years policy experience, with having over 40 years. Table 4.3 provides additional participant attributes.

Thirty-five percent (22/63) of participants who were invited did not participate. Nine percent (2/22) of those who did not participate were current staff members and 91% (20/22) were Board or Council members. Of the Board/Council members that did not participate, 40% (8/20) were current members and 60% (12/20) were past members. Seventy-percent (14/20) of Board/Council members who did not participate were from CNA, 10% were from ARNNL, and 20% were from RNAO. Individuals who did not participate did not respond to any of three invitations, thus the reason for not participating remained unknown.

## Data Collection

Data collection occurred from June 2010 to December 2010. Site visits lasting 7 to 9 days were made to each Association . Data were collected from two primary sources. First, face-to-face or telephone interviews lasting 30 to75 minutes were conducted to explore participants' perceptions about priority setting and policy advocacy for CEH by their Associations. Participants completed a demographic profile (Appendix B). An open-ended interview guide directed the line of inquiry (Appendix C). The interview questions focused on priority setting and policy advocacy processes and the factors that contribute to or constrain its policy choices and actions. More specifically, participants were asked how concepts identified through the literature reviews[3] and represented in my conceptual framework (Chapter 3) influenced the Associations' priority setting and policy advocacy. In addition, participants were asked more abstract questions that provided an opportunity for additional factors to be identified (e.g. Would you describe an example of when your

[3] A scoping review examining factors that influence organizational priority setting and policy advocacy and a second literature review exploring nursing associations' engagement in CEH informed the development of a conceptual framework. These reviews are published in Health Policy (2012) and Aporia (2012) respectively.

organization decided to address a community environmental health issue and/or when they decided not to address a community environmental health issue?). Questions were asked in a conversational and unbiased manner to facilitate a non-threatening line of inquiry. This approach gave me the latitude to follow up on interesting points made by the participants and ask questions in response to issues raised. I used probes to as a way to fully explore the issues under investigation, to explore participants' views, and to clarify meanings. All interviews were audio recorded and transcribed verbatim. All interview text were imported into NVivo 8 qualitative data analysis software, which was used to assist with data management.

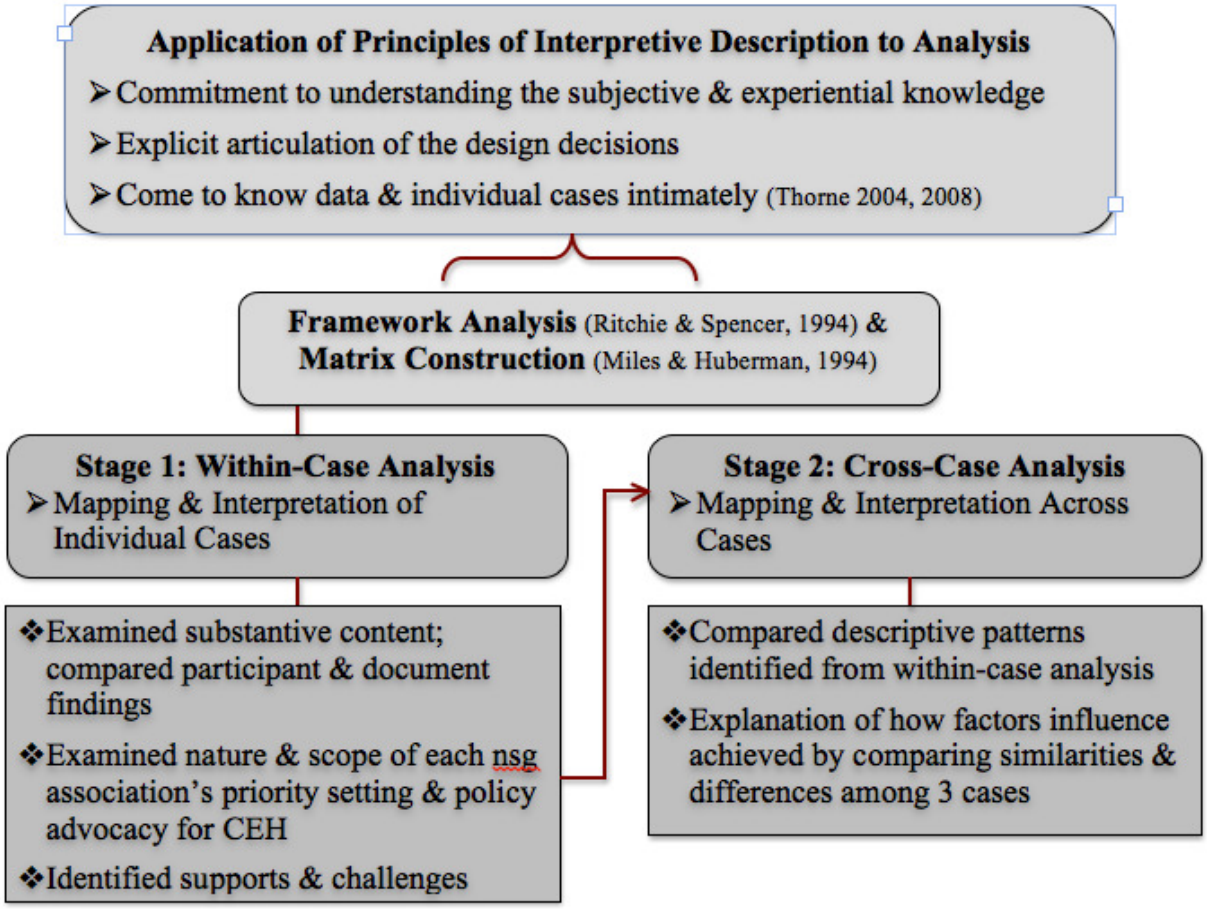
Document review served as a second source of data. Data collection from documents occurred simultaneously with interviews. To corroborate and augment information gained from interviews, and to guide further areas for inquiry, documents were purposefully selected for review that met the following eligibility criteria: (a) one of five types of organizational documents including policy documents (e.g., Constitution and By-Laws, flow charts for decision-making), strategic plans, communications (e.g., media releases to nurses, the public, or politicians), minutes including Board of Director or Council and committee, and reporting documents (e.g., annual reports); and (b) dated from January 2005 until December 2010. All documents specifically related to CEH were included regardless of date (e.g. resolutions for CEH). These documents were in the public domain with many accessible through the Associations' websites. Participants from the Association retrieved additional documents that were not accessible through the website. Data extracted from the documents included the date and type of document (e.g. position statement), the intended audiences (e.g. nurses, politicians), and salient points related to decision-making processes, policy advocacy, and factors that supported or posed barriers for priority setting and advocacy work related to CEH. The data was imported into NVivo 8. An estimated 80-110 documents for each Association were reviewed.

## Data Analysis

The analyses proceeded through two phases: (a) Phase One: Within-Case Analysis; and (b) Phase Two: Cross-Case Analysis. The analysis was guided by framework analysis (Ritchie & Spencer, 1994; Ritchie, Spencer, & O'Conner, 2003), which supported an inductive, iterative, and systematic analytic process. In addition, matrices were constructed

as described by Miles and Huberman (1994). This analytic process entailed a series of interrelated stages: (a) Familiarization – to learn about the data and gain a sense of the whole; (b) Development and refinement of a descriptive coding framework; (c) Charting – to organize and visually display data in matrices so that substantive content could be viewed and compared across the data; (d) Mapping and interpretation of individual cases – to examine relationships among descriptive categories and identify case patterns; and (e) Mapping and interpretation across cases – to examine similarities and differences across the cases in order to identify cross-cutting patterns. The following section describes Phases One and Two. Figure 4.1 depicts an overview of the analysis process. Appendix D provides additional details about the stages of framework analysis, the application of principles of interpretive description, and the analysis outcomes.

**Figure 4.1 Overview of Analysis Process**



**Phase One: Within-Case Analysis**

Phase one, the within-case analysis, began with an in-depth familiarization process. Data were reviewed to get a sense of the whole, to explore data beyond the original conceptual framework, and to challenge preliminary interpretations. Interviews and text from documents were read, transcription errors corrected, and personal identifiers removed. A sense of the richness, depth, and diversity of the data was gained by systematically re-reading all the information and using the annotation feature in NVivo to make notes about what the data referred to, why data seemed important, and messages that were repeated. Repetitive categories were identified that included ideas based on verbatim text (e.g., policy screens) and summaries of the text meaning (e.g., leadership strategies). Organizing the data into these initial bundles provided a way to look at data from different angles and to develop ideas about ways to begin to code the data.

During the second stage of within-case data analysis, a descriptive thematic coding framework was developed that included an initial list of descriptive codes and their links. Key concepts for the framework were developed by reviewing data organized under the bundles and by consulting memos. Concepts were organized into groupings judged to be conceptually linked; for example, concepts related to policy advocacy were placed together.

Stage three of within-case analysis included the application of the descriptive thematic coding framework to data. Sentences, phrases, and paragraphs from interviews and

documents were examined and coded under the relevant descriptive codes, with text coded under more than one descriptive code if applicable.

The fourth stage of within-case analysis entailed the construction of descriptive and conceptually-oriented matrices (Miles & Huberman, 1994). The development of matrices was an iterative process that involved systematically reading and judging the meaning of the text within each descriptive thematic node and determining key patterns. The entries in the descriptive matrices retained substantial original language extracted from interviews and documents. The descriptive matrices were used to construct conceptually-oriented matrices, which entailed a higher level of abstraction represented by labels that moved beyond the original text (conceptual interpretation). For example, the matrix for priority setting included three column headings: criteria to decide if policy was in or out; criteria to decide order of importance; and processes and rules for decision-making. Memos were written directly into

the matrices to serve as visual cues for follow-up and to note conceptual overlap or relationships with other matrices. This phase of analysis provided a way to examine the substantive content, compare participant and document findings, and build a foundation for cross-case comparisons.

**Phase Two: Cross-Case Analysis**

The second phase, cross-case analysis, compared descriptive patterns identified from the within-case analysis for each case. To begin this process, matrices were constructed that plotted the patterns for descriptive case findings. The matrices were comprised of four columns; the Associations were represented in three columns and similarities and differences among the cases were tracked in the final column. The rows represent key features of the descriptive patterns identified from the within-case analysis. Row headings in the priority setting matrix, for example, included organizational values, the Board decision-making tasks, and criteria for screening priorities. Summaries of key findings were plotted under the respective column and row headings.

The matrices were systematically interrogated to compare similarities and differences across the cases and to identify patterns or conceptual links among the matrices. Interpretation of factors that influence the Nursing Associations' priority setting and policy advocacy was achieved by following up on hunches, referring to memo and journal notes, writing the findings, and re-visiting the case findings for clarifications and elaborations. The final findings were based on explicit factors described by participants as well as those inferred by me.

## Small Group Discussion

A final phase of the study included a one-hour teleconference, in 2012, with the Executive Directors from the participating Associations. The purpose of this discussion was to provide an opportunity for the Executive Directors to reflect on and respond to the integrated cross-case findings.

Two weeks prior to the telephone conference, the participants were given the integrated cross-case findings in point summary form and a draft conceptual framework that emerged from those findings (Appendix E). A six-page summary accompanied the framework, which explained the main findings and the relationships in point form. The participants were requested to consider three questions in preparation of the meeting: (a) do

these findings resonate with your experiences? Explain; (b) are you surprised by any of the results? If yes describe; and (c) do you have any additional comments or suggestions? Only a verbal response to the questions was requested. This phase of the study was intended to enhance the credibility of the findings.

## Trustworthiness

To enhance the trustworthiness of this study, including the *"truth value"* and the quality, the evaluative criteria for credibility, auditability, and fittingness were applied (LoBiondo-Wood, Haber, Cameron, & Singh, 2009). Credibility refers to the match between the data and my interpretation of that data (LoBiondo-Wood et al.). Steps taken to enhance credibility included making the researcher's assumptions explicit (e.g., assumptions represented in a conceptual framework); using participants' words; reflecting through journaling and memoing; and receiving feedback from committee members on coded transcripts and constructed matrices. The truth-value of the data was also enhanced through triangulation that included interviewing participants from different locations within the Association (e.g., staff, Board Directors), by collecting data from the different Associations, and by using different sources of information (e.g., interviews and documents). Further validation of the findings was supported through a small group discussion with the Executive Directors from the participating Associations, who reviewed the integrated cross-case results and a draft of a final integrated conceptual framework. This feedback led to the refinement of concepts (e.g., regulatory functions, support of regulations, and public protection and interest) and clarification of decision processes (e.g. who had the authority to develop 'ends' policies).

Auditability refers to the ability for another reader to follow the logic of the methods used and conclusions reached by the researcher (LoBiondo-Wood et al., 2009). To allow a reader to follow the steps of the research process, an audit trail was kept. The audit trail detailed the steps taken, provided rationale for the decisions taken, and identified coherence between the steps taken and the underlying philosophical and methodological principles of interpretive description (Refer to Appendix D). In addition the interview guide was included as an Appendix (Appendix C) and raw data (e.g., quotes) are integrated in the research results.

Fittingness refers to the provision of descriptions that allow readers to judge whether the study findings have meaning for other settings and contexts (LoBiondo-Wood et al., 2009). Detailed contextual information was provided about the provincial and federal context, the Nursing Associations' organizational attributes, and participant characteristics that permit readers to assess the applicability of the findings to other situations.

## Ethical Considerations

Steps were taken to ensure that participation was informed and voluntary and organizations and those participants were protected from potential harms according to the Tri-Council policy statement for the ethical conduct of research involving human subjects (Canadian Institutes of Health Research, Natural Sciences & Engineering Research Council of Canada, and Social Sciences & Humanities Research Council of Canada, 2005). Ethical approval for this study was received from the University of Ottawa, Office of Research Ethics and Integrity (Appendix F). In addition, organizational approvals were obtained from the three participating Associations from where study participants were recruited. A Letter of Introduction and Permission was first sent to the Executive Directors of each site to introduce the study and to invite the organization to participate (Appendix G). Organizational consent was obtained before members from the organization were invited to participate (Appendix H).

Individual participants were recruited in two ways. First, names and contact information were retrieved from the organizational website directories. Second, during site visits participants were asked to identify other potentially relevant participants. For potential participants identified in this manner, attempts were made to obtain contact information from the organizations' directories. When this was not possible, the individual recommending the potential participant was asked, and given the option to either: (a) to give my contact information to the individual or (b) to provide a Letter of Permission to be Contacted (Appendix I).

A Letter of Introduction and Consent Form was sent to the Executive Directors, each of whom were asked to also participate in a small group discussion (Appendix J). Separate consents were sent to current and past employees and Board Directors (Appendices K and L). The letters identified the purpose of the study, what the participant would be expected to

do, and the risks and benefits associated with participation or non-participation. Signatures were obtained from participants prior to their interview.

The participants were informed that their anonymity could not be guaranteed because of the small number of staff and BODs belonging to the organization. Steps to protect participant identity included the use of anonymized and aggregated results in thesis reports and publications, the removal of personal identifiers, and the replacement of names with codes so that quotes could not be linked to participants.

Several steps were taken to protect participants' confidentiality: (a) a code was assigned to all information provided by participants so that it could not be linked to them; The list of participant names were kept separate from the data collected; (b) the interviews were conducted in a place of privacy or in a place requested by the participant; (c) participants were reminded that they could refuse to answer any questions; (d) only the researcher, Jo-Anne MacDonald, and the thesis committee members had access to the raw data; and (e) the transcriber, who had access to the audiotapes, signed a confidentiality form (Appendix M). Information was sent to the transcriber using PANDO, which encrypted the data; All audio-recordings were erased.

## INTRODUCTION TO CHAPTER 5

This chapter reports findings from Phase One: Within-Case Analysis. The results from each of the cases are presented. The focus of the within-case analysis was to gain an understanding of the nature and scope of each the Nursing Association's priority setting and policy advocacy for CEH, as well as the supports and challenges they faced.

# CHAPTER 5: PHASE ONE
# WITHIN-CASE RESULTS

The following sections report findings from the independent analysis of the three cases. The results for each case are reported under three broad sections: (a) organizational attributes, (b) priority setting, and (c) policy advocacy. Table 5.1 summarizes key organizational attributes for the three Associations that were the cases. Table 5.2 summarizes priority setting processes and policy advocacy strategies undertaken by each Association for CEH.

## Case One: Canadian Nurses Association

### Introducing the Canadian Nurses Association (CNA)

Founded in 1908, CNA is Canada's National Nursing Association located in the country's capital, Ottawa, Ontario. Since its inception, CNA has served as the national voice of nursing in Canada, influencing public policy for health and nursing issues. On the international front, CNA contributes to international policy, development, and partnerships to advance the contribution of Canadian nurses to global health and equity.

In this case study, I provide an overview of CNA's organizational attributes. Based on participant interviews and document analyses, I describe the Association's priority setting processes and policy advocacy related to community environmental health (CEH). The supports and challenges that influence how CNA sets priorities and takes action for CEH are described.

### Organizational Attributes

#### Member-Driven Public Policy and Support of Regulation Mandate

CNA members have the authority to self-proclaim their objectives and carry out national and international activities under the Canada Not-for-Profit Corporations Act (Bill c-4: Statutes of Canada, 2009 c-423). In its Letters Patent (1996), CNA articulates its mission as, "*the national professional voice of Registered Nurses, supporting them in their practice and advocating for healthy public policy and a quality, publicly funded, not-for-profit health system"*. CNA members grant public policy functions and the support of regulation to the Association. Since 1996, the objects of the corporation have been to: (a) promote high standards of nursing practice, education, research and administration in order to provide quality nursing care in the public interest; (b) perform uniform and high quality regulatory

**Table 5.1. Organizational Attributes of the Selected Three Canadian Nursing Associations**

| | CNA[4] | RNAO[5] | ARNNL[6] |
|---|---|---|---|
| Location of head office | Ottawa, Ontario | Toronto, Ontario | St. John's Newfoundland |
| Jurisdiction | National | Provincial | Provincial |
| Mandates | | | |
| Delegated by legislation | Ministerial approval for self-proclaimed objects under the Canadian Not-For-Profit Corporations Act; BillC-4: Statutes of Canada, 2009 C-4 | Ministerial approval for self-proclaimed objects under Ontario's Corporation Act R.S.O. 1990, Chapter C.38 | Self-regulatory college under Newfoundland and Labrador's Registered Nurses Act of, SNL2008 Chapter R-9, R.S.N. 1990; Amended: 2009 c30 s14 |
| Delegated by governing body | Public policy and support of regulation | Public policy | Public policy end[7] |
| Criteria for membership | Voluntary (jurisdictional registrants[8]) | Voluntary | Mandatory (required to practice in the province) |

Note: [4] CNA=Canadian Nurses Association.
[5] RNAO=Registered Nurses of Ontario.
[6] ARNNL=Association of Registered Nurses of Newfoundland.
[7] A bifurcated mandate whereby legislation permits professional interests to co-exist with a regulatory mandate (Bryce & Bayne, 2010).
[8] Quebec is the only province without jurisdictional membership in the national Association, however nurses in the province can become members by registering with RNAO, the Nurses' Association of New Brunswick (NANB), or Yukon Registered Nurses' Association (YRNA)

**Table 5.2 Summary of Priority Setting and Advocacy Strategies for CEH Undertaken by the Three Selected Canadian Nursing Associations**

| | CNA | RNAO | ARNNL |
|---|---|---|---|
| **Priority Setting** | | | |
| Organizational values and beliefs | X | X | X |
| Monitoring and organizing information | X | X | X |
| Adjudicating policy priorities | X | X | X |
| **Policy Advocacy** | | | |
| **Building Organizational Capacity** | | | |
| ▪ Strategic planning | X | X | |
| ▪ Governance restructuring | X | | |
| ▪ Strengthening ways of working | X | | |
| ▪ Knowing and taking a stand on organizational identity | | X | |
| ▪ Attracting the right people | | X | |
| ▪ Strengthening or establishing infrastructure | | X | X |
| ▪ Maintaining a legal right to advocate for public policy | | | X |
| ▪ Tapping into the resources of other nursing associations | | | X |
| **Building Social Capital** | | | |
| ▪ Fostering relationships | X | X | X |
| ▪ Establishing relevance | X | X | |
| ▪ Protecting reputation | X | X | X |
| **Inspiring a Critical Mass of Support for CEH Issues** | | | |
| ▪ Raising awareness | X | X | X |
| ▪ Finding champions | X | | |
| ▪ Creating opportunities for action | X | X | X |
| **Lending Support to and Leading in Policy Change** | | | |
| ▪ Joining allies | X | X | X |
| ▪ Stakeholder analysis | X | X | X |
| ▪ Adjudicating roles in collaborations | | X | |
| **Exercising Political Acumen** | | | |
| ▪ Understanding the landscape and being opportunistic | X | X | |
| ▪ Understanding power dynamics | X | X | |
| ▪ Framing messages | X | X | |
| **Pushing Policy Positions** | X | X | |

practices in the public interest and in collaboration with nursing regulatory bodies; and (c) act in the public interest for Canadian nursing and nurses, providing national and international leadership in nursing and health issues (CNA Letters Patent, 1996). CNA's member-directed public policy functions and support of regulation create both opportunities and challenges related to CNA's community environmental policy work.

The public policy mandate endorsed by members gives CNA the authority to act on a range of sensitive CEH issues, which participants suggested that some provincial regulatory bodies perhaps could not act on. One participant stated, *"and so I think it gives us the freedom to do things for the nurses in [name of province removed] that their regulatory body cannot do because they are not allowed to"* (Participant 10).

The support of regulation by CNA includes crafting regulatory policy, developing the Code of Ethics for Registered Nurses, developing and administering entry-level exams for RNs, offering certification in a number of specialties, and contributing to the development of credentialing standards (CD40). Participants identified the support of regulation as a significant part of their work:

> *Well, as you know, we've been a split regulatory/policy kind of advocacy organization for many years because we have the exam, the national exam. When nurse practitioners came out, we moved into the nurse practitioner exam. We have the certification program, which is not an advocacy piece but is more of a regulatory, if you will, around excellence in practice or promoting continuing competence. We have the Code of Ethics, which is more on the regulatory side. So we've had large initiatives, and have for many, many, many years around the whole regulatory side.* (Participant 2)

Although CNA's support of regulation is not legislated, and thus not accountable to government for this support role, participants indicated that these roles warrant some caution in their public policy choices. For instance, one participant said:

> *We are not a regulator, and we don't register directly obviously. But this is the home to which the Colleges all pay their dues and is the seat of the national standards and the national exam.…So CNA therefore is careful, I think, and has to be careful to not be seen to be doing silly things. I don't mean environment is silly. But CNA has to be more cautious than the union, let's put it that way, in its activities in public.* (Participant 6)

The participant went on to explain that CNA is mindful of the implications their choices and actions might have for their jurisdictional members. Thus, as a participant indicated, CNA *"tried to frame all these things, including the environment, around advancing human health.*

*And I think that legitimizes a lot of it*" (Participant 6). Focusing on the health implications attributable to environmental conditions was perceived by some participants as one way to protect the public. Since the mandates of some the jurisdictional members focused on protecting the public, improving health by advocating for CEH then seemed acceptable and aligned with the support of regulation role.

**Federal Jurisdiction Mandate**

The focus of CNA's CEH policy efforts is at the federal level. One participant explained the delineation of jurisdictional foci between the provincial and national organizations:

> *So typically the provincial associations target community health at a provincial level…. RNAO is concerned with provincial pesticide legislation. CNA is concerned with national pesticide-related legislation or choices at the federal level around greenhouse gas emissions…. So we try to stay at federal legislation, federal policy, federal programming, federal budget around these issues, and let the provinces deal with the provincial.* (Participant 2)

Some participants indicated that CNA deliberately avoids taking action at provincial and municipal levels of polity. This was exemplified by a participant, who stated:

> *But we did not engage in issues at a provincial or municipal level unless we were specifically asked to engage by that provincial member. And I really can't think of any time when we've engaged at a municipal level at all.* (Participant 1)

According to some participants, CNA seeks permission prior to taking action in a jurisdiction member's area. One participant stated:

> *The perception has been that CNA should only engage in national and international matters, and should not have any authority and autonomy to engage on issues at the provincial level. So CNA should not be sending a letter to a Premier unless the jurisdiction agrees to it or the jurisdiction does that.* (Participant 11)

Other participants reported that legislation does not restrict nursing associations from advocating in other jurisdictions. However, as explained by one participant, these jurisdictional boundaries are implicit. Drawing attention to the work of one of its jurisdictional members, one participant described how nursing associations have worked across jurisdictional boundaries in the past:

> *I think there might be a certain implicit understanding that it is just provincial. But certainly when you look at the role that RNAO plays, they do not confine themselves to just provincial policy. I mean RNAO sometimes presents at House of Commons*

> *committee meetings. I haven't looked at their mandate so I really don't know what is explicitly in there. But the interpretation might be not what is on paper. And most certainly, the interpretation probably varies from one person to another.* (Participant 1)

Incorporation Statutes align with this participant's perceptions. While Statutes governing the organizations give them authority within the jurisdictions in which they are incorporated, they are not prevented from acting in other jurisdictions, as long as they are not in violation of jurisdictional laws where the action is taken (Canada Not-for-Profit Corporation Act Bill c-4: Statutes of Canada, 2009 c-23).

Participants indicated that CEH action at the international level was not a focus of CNA. However, they noted some efforts had been made to influence Canada's position on environmental issues of global concern. For instance, CNA wrote an open letter to the Honourable Stephen Harper in advance of his participation in the Copenhagen Climate Change Summit requesting that Canada strengthen its commitment to the Kyoto Protocol (CD15).

Some participants suggested CNA's national focus has advantages. For instance, one participant believed CNA can speak to sensitive issues from a broad perspective. Referring to the federal mandate, the participant stated, "*I also think it gives us the ability to look at the bigger picture as opposed to the smaller picture…. CNA could look at a sensitive issue from a national perspective"* (Participant 10).

On the other hand, some participants suggested that influencing federal level policies had challenges, particularly in comparison to associations that influenced policy at the provincial level. As explained by one participant, provincial jurisdictional members have *"a little more access to where the decision-making happens"* (Participant 6). For this participant, the size of an association's jurisdictional responsibility also might have implications for getting to know decision makers. The participant went on to say, "*I bet it's different if you're in PEI where you know everybody and you can contain some of the variables. Ontario might not feel the same. So size might matter*" (Participant 6). Participants believed the inability to form close relationships meant there might be less opportunity to become involved with federal policy for CEH issues.

**Organization Membership**

CNA is a federation of 11 provincial and territorial associations and colleges. Membership in CNA is voluntary and comprised of organization and group members. Organization members include the jurisdictional provincial associations and colleges, represented by their respective Presidents. Registered nurses (RNs) belonging to one of these jurisdictional members are automatic or "*guaranteed*" members of CNA. At the time of the study, guaranteed members included an estimated 143,843[9] RNs (approximately 54.0% of RN's in Canada). Members also include 35 associate members (groups constituted in Canada that have a majority of regulated nursing members), 3 affiliated members (other national organizations or corporate bodies constituted in Canada), and 4 emerging groups. Organization membership has implications for decision-making (CNA, 2010a; CNA Letters Patent 2008, CD44).

Some participants indicated that organization membership is a factor that diminished their ability to conduct public policy work, including CEH. Organization membership means that CNA primarily works through the jurisdictional Presidents, not individual nurse members, as is the case for some Canadian provincial associations. As explained by a participant:

> *So the membership of CNA isn't individual nurses. The membership of CNA is technically and according to the Bylaws, Acts of Incorporation, etc., etc., the jurisdictional members. So their membership is technically the Registered Nurses' Association of NS, the CARNA Alberta, CRNBC, RNAO. Those are technically the members of CNA.* (Participant 12)

Privacy laws prevent CNA from obtaining personal contact information from the jurisdictional Presidents for their RN registrants. Thus, CNA primarily relies on jurisdictional Presidents to conduct the work or communicate the requests for assistance by CNA to RN members. However, some jurisdictional Presidents of the self-regulating bodies are restricted to communicate only about regulatory issues with their members. As explained by a participant, "*[name removed] say we can't send it to anybody that doesn't have anything to do with regulation [….] So that's been the biggest problem around us being successful in any advocacy is access to individual nurses"* (Participant 3). RNs across the country are able

[9] Canadian Institute for Health Information [CIHI] (2010) reported an estimated 266,253 registered nurses in the Canadian workforce in 2009

to gain access to information about ways to get involved with CNA *vis-a-vis* their website. However, participants indicated that RNs do not often contact CNA. Referring to RN's across the country, a participant stated, *"it's just that they are not writing to us very often"* (Participant 8). Another participant suggested that because RNs do not self-initiate membership, they are not necessarily interested in the work of CNA. "*There's a certain inertia in a place that has a guaranteed membership"* (Participant 6).

**Federated Corporate Structure**

The federated corporate structure was described as both supporting and hindering decision-making for public policy issues such as CEH. According to some participants, jurisdictional representation on the Board allows policy concerns to be heard from across the country and also brings together a group of "*extremely seasoned nurses"* (Participant 9) who could deal "*with complexity in the way that they look at work, with the way that they look at nursing and the way that they value and wish to promote nursing"* (Participant 9).

However, challenges in reaching consensus for policy issues, including CEH, were noted within the federated corporate structure. These challenges were partly attributed to the number and diversity of provincial/territorial issues brought to the CNA Board. A participant stated, *"from a national perspective, I think it's more difficult because you're trying to deal with multiple different jurisdictions who are structured in very different ways, who may have very different policies"* (Participant 12). This participant went on to say that reaching agreement *"is probably more difficult at a national level because you are trying to bring together so many different players who are trying to meet their own memberships' requests and needs"* (Participant 12).

Reaching consensus is further challenged by tensions that exist about whether CNA should be addressing provincial/territorial concerns or federal concerns. The assumption by many of the participants is that the National Association exists to address issues of federal concern. As explained by one participant:

> *So when discussions at the Board table get pulled into things like let's talk about the tar sands, CNA's job and the job of the governance folks as well as the operational folks should be to say okay, what is the national?* (Participant 4)

According to these participants, jurisdictional Board Directors are interested in addressing issues of concern within their respective provinces and territories and do not understand the national context. This perspective was exemplified by a participant who stated, *"the Board is*

*not a Board that directs the company. It's a Board that represents the interests of the provinces"* (Participant 6). Another participant attributed the dual roles of jurisdictional Board Directors as contributing to the challenge to agree about national priorities:

> *They kind of in reality wear two hats. I mean one is they are a member of the CNA Board and they are supposed to be thinking about the organization. But most of them are Presidents of a jurisdictional member. So they will often be representing the views of their jurisdictional organization as well.* (Participant 1)

According to participants, reaching consensus and identifying national implications for public policy issues is further complicated because 10 of 11 jurisdictional Board Directors have primary affiliations as Presidents of self-regulatory bodies. Thus, the foci of their concerns are regulatory issues.

A further challenge to reaching consensus within a federated corporate structure includes conflicting mandates among members of the federation. Within a federated corporate arrangement, the governing body is largely comprised of Presidents from the jurisdictional provincial/territorial nursing associations and colleges. Each of these jurisdictional members is governed by their respective provincial/territorial legislations. Thus, their mandates vary and include associations with public mandates, those with regulatory mandates, and those with both a public and regulatory mandate. Particular emphasis was placed on the diverse foci between organizations responsible for legislated regulatory functions and organizations that support or advocate for nursing and health issues, as is the case with CNA. One participant expressed, "*it would be my analysis that the provincial colleges and associations have a mandate that is very different and work in a very different environment than a national organization"* (Participant 4).

Some participants indicated that representing a provincial self-regulatory body prevents some jurisdictional Board Directors from participating in discussions at the CNA Board related to public policy issues such as CEH. A participant explained that some jurisdictional Presidents only spoke to issues related to regulation or registration: *"unless it directly relates to the registration to you as an individual they feel they can't deal with it"* (Participant 3). Another participant stated, *"but there are some sensitivities. So sometimes they [sic BOD] will say we can't go there because of the nature of the business we are in, and therefore we prefer that you go directly to our membership"* (Participant 7).

However, other participants believed that self-regulatory mandates do not necessarily impose limitations for participating in policy work. Rather, they suggested that limited interpretations of regulatory laws prevent self-regulatory organizations from participation. One participant suggested, *"across the country there is a lot of divergence with the way that the regulatory roles are being perceived"* (Participant 9). Another participant further explained, *"in my opinion and in legal opinion that we sought at CNA, they have broader jurisdictional ability to engage in advocacy than the Councils of some of those jurisdictions interpret it*" (Participant 11). Another participant concurred, stating:

> *I think there is the letter of the law and there is the spirit of the law… If the letter of the law suits the direction you want to go in, that is the line you follow. But if in fact you prefer to go another way, you may follow more the spirit of the law and find a way around things to make them happen. So I'm going to be very blunt here [….] [name removed] for an example have interpreted their legislation to mean that they are not allowed to do any advocacy work, nor could they be associated with a group that does advocacy work.* (Participant 10)

These differing views contribute to divisiveness, tensions, and subsequent challenges among provincial and territorial organization members when they are expected to engage as Board members of the National Nursing Association. Participants indicated that the incongruence between a regulatory and public policy mandate had grown so serious that one jurisdictional member called for an evaluation to determine the relevance of a continued relationship with CNA. The final report (Bryce and Bayne, 2010) concluded, "*legal and policy research and analysis leads to the conclusion that the CNA function of 'lobbying government' creates perceived, if not an actual, conflict for the College, given its public protection mandate under section 16 HPA [sic Health Professions' Act]"* (p. 16). During the time of this study, this jurisdictional member announced its intention to disaffiliate from CNA.

According to some participants, a further challenge for operating within a federated corporate structure is an imbalance of the jurisdictional Association/College Board Director representation, which disproportionately weights the outcomes of decisions. As explained by a participant, "*the biggest influence is [….] the number of Presidents from the jurisdictions continues to be the greatest [….] so the Presidents from the jurisdictions still outnumber all the rest of the Board members who can vote"* (Participant 3).

**Operational Structure**

CNA's policy work is operationalized through its home office, comprised of seven departments. These include four separate policy departments (Public Policy, Regulatory Policy, Nursing Policy, and International Health and Development Policy). The policy departments appear to work independently, each having its own administrative support, Director, and assigned staff. CEH is the responsibility of the Public Policy Department.

Staff roles in the home office are highly specialized, with each employee having assigned policy portfolios. One staff person is assigned the CEH portfolio. However, participants reported there is minimal time to do the research and prepare policy papers for respective policy issues, including CEH. Referring to CNA's investment in CEH, one participant stated, *"we are not making a crack at it. We also don't have resources dedicated to it. So I think [name removed] did an admirable job among the 50 other things she had to do"* (Participant 6). The participant went on to explain that more investment is required in order to seriously address CEH. "S*o if CNA wanted to really impact the environment, you'd probably need a quarter of this organization working on that all the time. Not one person doing an hour a week"* (Participant 6).

**Summary of CNA's Organizational Attributes**

Overall, the organizational member-endorsed mandate permits CNA to take action on a range of sensitive CEH issues. Operating as a national body, CNA is in a position to influence CEH related to federal policy, but also is able to support jurisdictional members in their efforts to influence provincial/territorial CEH policy. However, CNA experiences several challenges for setting policy priorities for public policy including CEH. Because of their support role in regulation, CNA is guarded in its choices of CEH issues that might be considered improper by government. Different interpretations of public protection (i.e., patient protection by ensuring safety through enforcement of standards and discipline or population protection by addressing social and environmental determinants of health) lead to disagreement about whether nursing associations have a role in public policy advocacy. In addition, CNA avoids action for some CEH issues because of the potential political implications for their jurisdictional members.

CNA has less opportunity to form close relationships with federal government officials compared to some leaders of provincial/territorial associations, who have developed close

ties with government officials in their provinces. Lack of close relationships can diminish CNA's inclusion in CEH discussions and initiatives. In addition, there are implicit expectations that CNA will not take action in provinces and territories without the permission of the nursing organization in that district.

Organizational membership means that access to individual nurses by CNA is limited. This contributes to diminished engagement by nurses to carry out the policy work of the Association. Minimal resources are dedicated to CEH, with one staff person given some time to address those issues. Highly specialized departments and staff assignments, providing minimal opportunity for staff to work collectively on any one issue, further limit the capacity for CEH work.

While a federated corporate structure permits the identification of CEH issues from across Canada, this orientation presents several problems for priority setting and policy advocacy. Reaching consensus within CNA is more challenging because of the number and diversity of issues brought to the table, a disparity amongst members of views about needs that should be met (e.g., provincial or national), and different foci of mandates among jurisdictional members of the federation.

## Priority Setting by CNA for CEH

Analysis of participant interviews and organizational documents indicated that priority setting for CEH is guided by core organizational values and beliefs and follows from monitoring, screening, and adjudication processes. The following section describes CNA's priority setting related to CEH. The supports and challenges that influence the way CNA sets priorities for CEH is described in this section.

### Guiding Organizational Values and Beliefs

Decisions about whether CEH issues will be addressed by CNA are anchored in a core set of organizational beliefs related to both the environment and health and roles for government and nursing. Participants indicated that CNA supports the view that the environment is a critical determinant of health and that action can lead to improved health. This was exemplified by a participant, who stated, "*I think environmental health is a key determinant of health. So there's real potential to have a positive impact on the health of Canadians by addressing environmental health issues"* (Participant 1). There was agreement

that nurses and their Associations exist to address issues affecting nursing and health, which includes environmental health. As described by a participant:

> *…If you say why does an association or an organization exist, it exists to deal with issues that are relevant to health and nursing. And if some of those environmental issues are relevant to health and maybe not even to nursing but it's relevant to the health of the population then we have an obligation to deal with it.* (Participant 11)

Some participants believed that nurses look to nursing associations to provide leadership for community environment health efforts. One participant explained:

> *I think individual nurses are looking for knowledge, are looking for support in this area; and turning to their organization is somewhat of a natural fit, I would hope. So I think there's a lot of individual interest by members. And they are looking somewhere to get the tools and resources that can enhance their knowledge, support them in their practice around this area.* (Participant 2)

Another participant suggested that their Association should be involved in CEH because "*CNA legitimizes issues for nurses*" (Participant 8). Participants further indicated CNA supports the belief that protecting citizens from conditions that compromise the natural environment and human health, particularly for those most vulnerable, is a duty of governments. Thus, influencing government policies for improved environmental conditions and addressing health inequities is considered a role for nurses and their Association. Support for this view was exemplified by a participant, who stated:

> *As nurses, we have a role to advocate for health. We have a role to try to keep people healthy. We have a role to address inequities or risk factors. So for us, I think it's our contribution to humanity by being involved. And I think that advocacy is a big role of nurses at all levels. So you get to influence policy legislation, influence the environment*. (Participant 7)

**Monitoring Policy Issues**

When asked how CNA identified CEH issues of concern, participants described formal and informal scanning and monitoring processes that generate an extensive list of provincial, national, and international nursing and health issues of potential interest. A participant explained, "*we now use the PESTM model [sic political, economic, social, technology and management]. And I think we get probably the most valuable information out of that in terms of what's coming. Because it not only looks provincially and federally, but it also looks globally"* (Participant 3). Issues are brought to CNA's attention by frontline nurses and members, BOD members, other nursing organizations, the Association staff, network

members, government officials, and media personnel. In addition, networks, listservs, websites, news media, legislative happenings, and parliamentary events are routinely audited. Attention is paid to government departments responsible for environmental issues. As recalled by a participant, awareness about CEH policy *"was identified by public policy [sic department] in their usual scanning process"* (Participant 3).

However, inconsistent reporting about jurisdictional concerns by jurisdictional members and the lack of a user-friendly format to synthesize the diverse policy issues contributes to a long list of disjointed policy issues that Board Directors are expected to screen. Referring to the way jurisdiction members report policy issues of concern, a participant stated:

> *At this point in time, they [sic jurisdictional Presidents] complete these tables that talk about what is going on in your region in relation to these goals and how does it affects CNA. So they are done with a whole lot of inconsistency. From one organization, we get kind of lists of what they've done in the past month- so nothing in terms of what the issues are. From another organization, we do get some really good issues. But then we've got a 20 page document full of issues with no mechanism to really bring it together in a way that synthesizes or really enables us to take something, an issue that we are working on, and build it from their evidence or their experiences and so on.* (Participant 9)

Consequently, CEH issues are lost. As a participant noted, "*So the environment could fall into that in a huge way, but it doesn't often come up" (Participant 9).* Another participant concurred that CEH does not rise to the top of the priority list among the many issues of concern:

> *Like we just came out of a Board meeting where, as I said to you, environmental determinants of health didn't get narrowed down among any of the other things. You came away with 50 or 60 things we have to do in a year, each of which would take a team a decade to do*. (Participant 6)

**Screening Policy Priorities**

Screening policy priorities requires judgment about whether a policy issue is of interest to CNA and then judgment about the policy's order of importance. Analysis of participant interviews and a review of organizational documents indicate that CNA follows an explicit screening process that leads to decisions about whether a policy issue, such as CEH, is of interest and relevant to the Association. This decision process is clearly depicted in a policy and program framework that illustrates how "*priorities were set in due consideration of the*

*Association's purpose, values, and resources" (CD Social Justice Gauge)*. The use of the mission and values outlined in the policy-screening tool was confirmed by a participant who remarked, "*we definitely think about the mission and vision and the goals in order to think about what is in scope and what is out of scope"* (Participant 1). Capacity is also used to determine whether CNA would address a policy issue, including CEH. As explained by one participant, capacity is not limited to available funding and human resources, but also knowledge capacity:

> *So staff themselves, based on I guess their experience and their capacity to - not capacity to work. That also affects, I guess. Capacity to take on more work or workload can cause you not to take on an issue. But capacity to see it as an issue, to understand these kinds of convergences or this branding or this whatever, the trends and so on.* (Participant 8)

These relevancy-screening criteria support decisions for CNA's involvement in a CEH.

Unlike the explicit screening criteria used to judge the relevance of an issue, there is no documented formal screening criteria to judge the order of importance of policy issues. However, examination of participant interviews and organizational documents suggested that the order in which policy issues, including CEH, receive attention is guided by an implicit set of criteria. Among these criteria was opportunity for success. Perceived government receptivity and media interest are considered supportive opportunities to advocate for CEH issues. Recalling CNA's choice to address climate change, for instance, a participant stated:

> *And I think we partly have engaged on that issue more than others that we might have because it was one of the three themes, and also because it's been in the media. It's been in Parliament. The Copenhagen meeting occurred last fall.* (Participant 1)

Another participant suggested government funding and reactions were opportunity signals:

> *We know that there are a gazillion issues out there, and we can't address all of them. And that any that we try to address is probably going to improve the situation but it's better to choose one that you know is going to get government funding support and reaction.* (Participant 10)

Issues perceived to be urgent also get priority attention and include those perceived to have an impact on nurses and the public, as explained by one participant, *"I think urgency is your biggest one. What are the issues most affecting nurses in Canada and the public in Canada"* (Participant 14)? Another participant emphasized that as a *"membership-based organization*" (Participant 9) urgent issues include *"member needs and priorities, and their*

*sense of urgency"* (Participant 9). On the other hand, lack of interest by nurses meant CEH would not get priority. Using an example, the participant stated:

> *The whole Gulf being filled with oil hasn't provoked us to do one thing….So no groundswell from nursing. The environment around us being what it is, you know, heating and flooding and oil and everything, it doesn't prompt any comment on the environment*. (Participant 6)

Previous progress also guides choices about policy areas that receive attention first:

> *They look at what they've already done. So some of it, you know, there's been a lot of work that has historically been done. So if the work has been done in that area, if it doesn't need to be revised, they can resurrect some of those things and bring those things back to the forefront again.* (Participant 12)

CEH issues for which there is definitive research identifying the human health risks are also considered to be more deserving of attention. One participant used the example of tailings ponds to illustrate how one CEH issue receives attention over another based on available evidence and the impact on human health:

> *The tailings ponds at the tar sands is one. But for us to get out making a lot of statements about it, you know, the stuff is obvious there. I'd rather look at other things like pesticides from the fields and herbicides that are running into the water supply that affect a big part of the population. And the research is available so I would rather take on an issue like that than the tailing ponds.* (Participant 14)

The participant went on to suggest that CNA is also less likely to be involved in CEH issues that are already being addressed by other stakeholders. Continuing with the example of the tailings ponds, the participant stated:

> *Because there's too many people already involved in the tailing ponds. That issue is before the public. They all know it's a problem. So it's not worth spending a lot of energy on that one. I would rather spend energy on ensuring that we have clean drinking water for everybody.* (Participant 14)

However, participants suggested that the absence of explicit and weighted priority criteria means decisions could still be ad hoc. One participant claimed, *"how it really happens, I think, you get a Board that kind of says yes, we're interested in all that. It then often falls to what is the abilities and interests of the staff"* (Participant 6). The participant recalled that it was the personal interest of a CNA home office individual that served as the impetus for the Board's choice to dedicate resources to CEH issues:

> *So you know [name removed] is a health nut. [identifying information removed]. She*

> *was interested in it. That is where it came from. I don't think there was any other big impetus. And it fit as an interesting visible project for the Centennial year, and it was a determinant of health. (*Participant 6)

Another participant explained that a CEH policy issue might get attention simply through a staff members' persistence:

> *So the staff actually have quite an influence in that they will, I find, keep bringing an issue forward. Even though I have given them, or [name removed] or [name removed] has given us our assignment, these are your deliverables, it's in the work plan. But still, if somebody is really determined that they want to go to that meeting [....] you really want to go, if you really think it's important, if you really think you should be there, if you can get all your other work done, like do what you want to do.* (Participant 8)

**Adjudicating Policy Priorities**

CNA uses a modified Carver Model of Policy Governance© to guide priority setting. These modifications were explained by a participant:

> *We do a modified Carver Model - a very modified [sic version]. We try and abandon most of Carver's language [....] We don't use ends, we talk about goals. We don't talk about executive limitations. We talk about expectations and parameters. Carver's language spells out what the CEO will not do, they've [sic BOD] abandoned all the negative language and talk about what the CEO will do.* (Participant 3)

Thus, CNA's 'executive limitation' policies include a list of what the Association and CEO can do. The Board holds ultimate responsibility to decide whether a CEH will be chosen as a priority issue. These decisions are made in close consultation with the home office staff.

The primary decision tasks for home office staff are to determine best approaches to address the policy priorities, which are considered "operational" decisions. Home office consults the Board when issues arise that are not on the list:

> *So that we have our goals and our main focus that is determined. The Board determines the big main goals [....] And if the issue falls within one of those goals, for the most part we wouldn't have to consult with the Board [....] If it fell outside of what they've identified as the things that CNA should be working on and should be involved in, then certainly the CEO would have a discussion probably initially with the President of the Board. And then if it is, again, a big enough issue, it would wait until the next Board meeting.* (Participant 10)

Participants reported that although the governance policies aim to delineate roles between the Board and home office, these roles are often blurred. One participant expressed this concern stating, "*we really have red flags when the Board tries to delve deeper into business that is really operational [....] And CNA sometimes doesn't have those boundaries*

*as much or they are blurred. I guess they are not as clear" (Participant 13).* Another participant concurred stating:

> *Because I mean the Board is supposed to be a policy Board. So not operational. So they should just be giving us broad priorities, not saying you should do a survey kind of thing. But they often do do that. They often say you should do something specific.* (Participant 1)

The participant went on to explain inefficiencies result when the Board involves itself in operational decisions, such as directing the way policy issues should be addressed:

> *I've had the Board say develop a position statement with this particular organization. And that might not be the best organization. Like maybe you already have a relationship with another organization that could equally get you to that goal. So it's a lot more efficient to tap into that existing relationship. But if they say it has to be with this organization, I am not in a position to say I am going to ignore you.* (Participant 1)

The added layer of approvals by the BOD for operational decisions was another problem identified by participants. Gaining BOD approval for operational issues results in the absence of, or a delay in, decisions about specific issues. One participant emphasized this concern stating, *"the problem is you get back to the Board table and it's supposed to be a Policy Governance© Board, and it's at the table with 500 other things and it just gets mired"* (Participant 6). The analysis suggested the use of a modified Carver approach may contribute to the need for extensive Board consultation since issues that are not on the 'can do list' need to be reviewed by the Board.

Delays in decision-making also result when new issues are spontaneously raised during Board meetings. According to one participant, this sets off a long process that results in further delays as new requests require consideration and review of workload by the Chief Executive Officer (CEO):

> *Like sometimes they throw out specific suggestions, that you should do this or that, or that CNA should be doing this or that. But then that will have to come back to Directors [sic home office Directors] to think about.* (Participant 1)

Before more direct or visible action can be taken on a policy priority, formal positions need to be developed (e.g., mobilize nurses or directly advocate government officials). The development of policy documents involves a series of inclusive and iterative steps that begins with home office staff preparing policy background papers and position statements

and the Board providing feedback. Revisions and reviews continue until the Board gives final approval, as explained by a participant:

> *Well, you just report that back to the Board, and then the Board decides whether they can then agree on a consensus statement at that meeting. And that has been my experience that they were able to agree. But it's very possible that they would say, no, you need to go back and try to achieve consensus from this angle. And then you would continue the process.* (Participant 1)

However, this process can result in delays since the Board Directors are volunteers who have limited time dedicated to CNA. One participant called attention to the many demands required of the Board Directors:

> *It's that the Board might take a longer period of time to decide to take a step into it or to take visible action, to take action and leadership on something. They might hesitate a bit longer. And as we know, this is only their job a certain number of days of the year.* (Participant 8)

Additional time is also required following approval from the Board of Directors, as other stakeholders then have an opportunity to provide input. One participant described the long process of gaining approval:

> *You do an initial draft of the position statement and then you make it available along with some consultation questions. And it has to go out to all of the jurisdictional members for at least a six-week period. They have to respond back to your questions…. And so then when you get all of that feedback, and at the same time, you've asked your relevant stakeholders externally, and you also ask people within CNA in the policy department to provide some feedback. And then you need to revise your draft position statement based on that feedback that you get.* (Participant 1)

Before action could be taken by CNA for CEH, approval for these policy documents were required as they articulated the official position the Association took.

**Summary of CNA's Priority Setting**

Alignment with CNA's mission and values, evidence of inequity and/or social justice dimensions, and organizational capacity (manpower, finances, expertise) are key criteria that lead to the decision that CEH is an area of interest. CEH gets more attention when there is opportunity; urgency in terms of members, nurses, and public demand and impact; government receptivity; capacity within the organization (e.g., human resources; builds on previous investments); evidence linking the human health impact from environmental conditions; and lack of attention by other stakeholders.

With many issues of interest to CNA and lack of a clear mechanism to order priority

areas, CEH issues get lost or do not often come up. In the absence of explicit screening criteria or mechanisms to order priority areas, setting priorities for CEH can be ad hoc. While priority setting processes entail an inclusive and iterative process that involves the governing body, home office staff, members, and other stakeholders, decisions often span extended periods of time.

## Policy Advocacy for CEH

Analysis of participant interviews and organizational documents indicate that CNA engages in a range of strategies related to CEH that aim to build capital, as well as to influence policy decisions directly. CNA's policy advocacy for CEH is described in the following section. A summary of advocacy strategies undertaken by CNA related to CEH is provided in Table 5.2.

### Building Organizational Capacity

Many of CNA's policy efforts are dedicated to building their organizational capacity. Analysis of participant interviews indicated that efforts taken to build organizational capacity were not necessarily related to any one-policy issue. Instead, efforts aimed to establish infrastructure and ways of working that then served as a foundation for involvement in various policy initiatives. Building organizational capacity includes efforts to develop a functional and relevant strategic plan and governance structure, and to secure resources that are critical to carry out policy work.

#### Strategic planning.

At the time of this study, CNA was in the process of revamping its strategic plan, which included enhancing efforts to address environmental determinants of health. Participants suggested that organizational capacity necessary to engage in CEH requires a strategic plan that provides focus, direction, and long-term commitment. As explained by the following participant, a gunshot approach is not conducive to advancing policy:

> *I think we need to be focused. There are a gazillion priorities that people would like to see action about. You cannot do the gunshot approach when you advance policy. So you need to decide what are the areas that we want to focus on and stay the course. A change in policy can take anywhere between 5 to 15 years or it never happens. So I think CNA needs to decide what is the focus*. (Participant 11)

Some participants indicated that inaction or insufficient actions for policy work in areas like CEH is attributable to a strategic plan that is outdated and in need of "*reaffirmation and*

*rejuvenation*" (Participant 10). One participant explained:

> *I think you can always tell in an organization when a strategic plan is out of date. So in the years, the two or three years leading to this strategic planning session, the Board on an annual basis scratched their head and said what are our priorities anyway*? (Participant 9)

The new plan is intended to address these problems. Participants indicated that strategic planning includes a long-term investment in policy issues. As noted by the participant, you cannot *"shape and influence policy in a year"* and *"an investment in influencing policy is a long standing relationship"* (Participant 9).

A revised strategic plan includes efforts not only to provide support to their jurisdictional members, but also *"to advocate provincially"* (Participant 3). The ability to advocate provincially means action can be taken in provinces where CEH efforts are not being taken and these efforts could span multiple system levels.

**Governance restructuring.**

Governance restructuring is another tool CNA planned to use to build its capacity for policy work. Plans for a new Board structure include the addition of four nurses at large who will have selected expertise based on the needs of CNA. One participant stated they *"might want someone with expertise in environmental health for instance"* (Participant 3). Other capacity building plans aim to inspire commitment and provide support for Board Directors in their roles. As another participant explained, jurisdictional members:

> *…sit on the Board, largely as advisors [....] there perhaps needs to be some ways of building buy-in around some of these issues at a jurisdictional level so that the advisors to the Board are prepared to engage them on this [sic CEH]* (Participant 9).

The participant went on to explain:

> *Because they are volunteers. They work full-time. They come in four times a year for two days. There's a lot of reading related to this. There's a lot of complex issues. If they don't have a background, it's hard to get up to speed maybe [....] So it means that at times the Board is less adept at really having good critical discussions or achieving that ah-ha mood or recognizing the relevance of these things to them in way that translates into how they play out their leadership role in jurisdictions or even on the Board.* (Participant 9)

Governance restructuring also includes plans to strengthen the orientation of Board members. In addition, CNA is continuing to investigate ways that jurisdictional members with diverse mandates (i.e., regulatory and/or public policy functions) and provincial

concerns can work more cohesively as a governing body. As a participant explained:

> *We were trying to look at, as part of the governance structure, what other structures have national organizations chosen and how do they work? [....] Not every profession has national and provincial [sic organizations]. And many of them are completely separate regulatory bodies and professional associations. Many of them are completely joined. And so we were trying to figure out is there a gold standard or best practices.* (Participant 10)

**Strengthening ways of working.**

Building capacity further entails efforts to strengthen the ways in which home office staff work. For instance, participants indicated that a tactic to enhance capacity includes the creation of opportunities for policy departments to work more cohesively. As a participant explained, "*they [sic Board] rejigged the goals and made them more concise, but have also encouraged across departmental work to address them"* (Participant 10). At the time of the study, discussions were continuing about the new departmental structure.

Strengthening ways of working includes plans to find ways to link with individual nurse members. A participant explained:

> *We need the nurses also to be involved; so that effort certainly will be striving based on the Board's directions. In this revised strategic plan for the next four years, is that we need to engage nurses because nurses as individual members of a profession can also lobby, advocate and actually position themselves to try to influence environmental laws or environmental best practice and so forth.* (Participant 7)

One way forward includes plans to engage nurses through expert commissions that will call upon nurses to provide input into key issues. A participant explained, *"a lot of it has come from the Board's strategic planning around engagement. And I'm thinking about how to engage nurses within regions, within local settings, and through these groupings that we're calling expert commissions"* (Participant 9). Overall, part of CNA's policy work, including efforts for CEH, is to build the Association's capacity by revamping its strategic plan, by investing in ways to support the BOD in its decision work, to engage individual members in the policy work, and to work more cohesively to influence change at multiple points of the system.

Despite CNA's renewed commitment to environmental determinants, some participants were not optimistic that further efforts would be forthcoming. Participants pointed to several reasons for this. For instance, participants indicated that although there is agreement that CNA needs to change, uncertainty remains about the new directions:

> *There's lots of uncertainty out there. And I think we have to redefine ourselves and kind of almost create a new identity. So yes, we've been status quo for too long. It's time to move on. And that doesn't happen easily or quickly.* (Participant 13)

Buy in for CEH is also a concern for some. One person recalled that some participants involved in the strategic planning sessions considered CEH to be peripheral to overriding concerns of many nurses, and perhaps even to the mission of the Association:

> *So then you end up with how come we are marching on the Hill about water in China? Which may seem like a very obscure long disjointed journey from advancing the professional voice of nursing in Canada, which is our mission. And that is what she was kind of saying. Like you are about health, and that is where people tie you and that's where your high trust is. Why are you way out there on that other theme? Even though we understand it's related to human health, maybe you can't do all those things.* (Participant 6)

Others remained concerned about the capacity for staff to address both planned and unplanned issues. Many participants stressed that CNA is dealing with too many issues, as exemplified by the following statement, *"we are pretty much of consensus here that we are doing too many things. And yes, we have good products. But we are not being as successful in getting say these products out because we are doing too many things"* (Participant 8). Participants indicated that in the past they had not always been successful in getting their policy work completed in a timely manner. Having the surge capacity to address emerging issues remains a concern. One participant noted:

> *I was just saying to staff yesterday as we were thinking about our work planning that it is going to be very important to make sure that we are not extending ourselves beyond 80% for our normal day to day work so that we can remain 20% responsive for those kinds of things that will come up. In Ottawa, the nation's capital, things are going to come up all the time. So we've got to be able to be ready to respond.* (Participant 9)

Though efforts are also directed at longer-term investments in policy issues, skepticism remains as to whether efforts will be sustained. Recalling historical patterns of changing goals, one participant stated, "*they [sic BOD] can adjust after two years. I am going to suggest that we hang onto them for two years and don't add unless we take away"* (Participant 9). Another participant suggested that lack of investment for the long term is partly attributable to changes in leadership positions. The participant explained, *"you basically can't wander too far into the next president's term"* (Participant 6). The participant went on to explain that incoming Presidents tend to change plans made by previous Presidents. Another participant similarly noted, "*it's a real challenge. The staff have to be*

*very patient and persevere. And especially god forbid the Board changes over on you as you are partway through the process"* (Participant 12).

**Building Social Capital**

A second key strategy related to CNA's CEH policy work is building social capital. Building social capital entails a series of relational and communication efforts that aims to establish CNA as a valued player in CEH policy dialogues and decision-making by fostering relationships, establishing relevance, and sustaining its reputation.

**Fostering relationships.**

Participants described how creating trusting and supportive relationships with CNA members and government officials is a prerequisite for involvement in various policy initiatives, including CEH. Fostering relationships includes being responsive to member and government official needs and managing conflict.

***Being responsive.*** Being responsive to the needs of the members is a primary focus of CNA. Participants reported that CNA is concerned that members might not see the Association as relevant and able to meet their needs when dealing with issues such as CEH. The following participant exemplified this concern:

> *And so they [sic nurses] look at the national organization that is going on and on and on about community environmental health, and they will think you are irrelevant because it doesn't match what most of our members [....] So there is a risk that the organization doesn't seem relevant to our actual membership base. And then they have ways of withdrawing their support from us.* (Participant 1)

Thus, CNA emphasized the rationale for their choices to avoid losing membership support. As another participant explained:

> *There might be some risk with members who might see their investment as being poorly spent if they don't align. So we have to be very careful that we are creating the rationale and motivating and being compelling with our rationale to our members and so on.* (Participant 9)

In order to be responsive and inclusive of members' needs, CNA also engages in routine consultative processes across the country. A participant explained that, *"our president and CEO, [....] one or the other attends all of the jurisdictional AGMs. So we try to listen to the conversation that goes on there as well, and what nurses are saying is what they see as priorities"* (Participant 2). This tactic is intended to maintain friendly, collaborative, and cooperative working relationships. However, one participant suggested this creates an

expectation among provincial/territorial jurisdictional members that CNA would then be responsive to the concerns raised at the meetings *"because their job is to support all Association things*" (Participant 14).

Attempts to meet different jurisdictional needs can invite conflicting expectations with respect to CNA's efforts for CEH. For instance, some participants believed CNA efforts should remain at the national level. As one participant noted, *"when you need to leverage provincially, sometimes you go nationally"* (Participant 14). CNA is also perceived to *"have more control over the environmental issues*" (Participant 14) at the national level compared to many of the provincial/territorial bodies and, as the participant went on to explain, can serve *"as our mouth piece for things that will get the government excited here"* (Participant 14).

On the other hand, some participants emphasized that CEH is neither within the mandate nor a priority for some provincial/territorial associations/colleges. For these members, talking about CEH, for example, detracts attention from issues that are of greater concern in their provinces/territories. In some cases, meeting the needs of members also means not speaking about particular issues. Participants indicated that provincial/territorial jurisdictional members make requests for CNA to avoid speaking out about specific or controversial CEH issues. As a participant explained:

> *But they have said to CNA on the environmental health issues [....] please don't come out and say anything about the tar sands because as a member of CNA the moment you do that I am going to get a phone call from the Minister of Health and the next time I want something in terms of changes for regulation the answer is going to be no [….] I need them to cooperate with me to get changes for, they were negotiating to have their Act changed around what nurse practitioners could and couldn't do.* (Participant 3)

Another participant called attention to a recent catastrophic environmental crisis to illustrate the limits placed on CNA in terms of speaking to CEH issues:

> *The whole Gulf being filled with oil hasn't provoked us to do one thing. So when I said do you think maybe this is the time that we should ramp this up, do you know what I got told? [Name of province removed] member doesn't want us to do anything because it will embarrass them, the government [identifier removed]. So we can't say much about the oil and the tar sands and the ducks dying in the oil. And the whole Gulf, it's not water any more but it's oil now. We can't say that. [word removed], what is it going to take.* (Participant 6)

CNA seems to be left in a precarious position, trying to balance the requests of those wanting to invest in CEH with those that expect they should not.

Fostering relationships with government officials is a key tactic for CNA. As explained by a participant, *"when you work with the government, like if they did not respect what we were doing or did not work with us on the issues then obviously we wouldn't have a good enough relationship to do stuff"* (Participant 14). Efforts to build and maintain amiable relationships with all government parties across jurisdictional levels are considered critical. A participant emphasized, "*because government will change and you have to always be influential. And often if you want to be successful, you've got to work at all levels, like all party government"* (Participant 7). In order to establish and maintain those relationships CNA meets with government officials routinely. As a participant described, *"I spend a lot of time at government events and meet with the minister three to four times a year in the province here"* (Participant 14). At other times, CNA members attend events to convey interest in government issues, to enhance their visibility, and to create opportunities to speak with decision makers about issues of concern to CNA. As explained by a participant:

> *So if there's going to be Members of Parliament or other decision-makers there, and we think that that will provide us with an opportunity to engage them either directly or on the side about that issue or even another issue, then of course we want to have somebody* there. *If it's like all of the important people on that issue are going to be there then of course CNA doesn't want to look like it's not interested in the issue.* (Participant 1)

Building relationships with government officials includes efforts to accommodate their requests such as providing testimony at hearings or giving feedback on impending Bills. Maintaining non-partisanship ensures government officials are aware that CNA is driven by strategic direction, not party politics. Participants believed that this kept doors open for their involvement in policy issues, including CEH. As explained by a participant, *"you don't want to align with one party and piss the other party off"* (Participant 12).

***Managing conflict.*** Another tactic used by CNA in fostering relationships includes managing conflict. Participants recognized that when dealing with policy, particularly highly charged and controversial issues, conflict is inevitable. There was wide spread agreement among participants that non-confrontational approaches are essential to maintaining a working relationship with government officials. One participant explained:

> *This government does not like to be criticized. And if you criticize, you will pay the*

> *price. You will not get [sic invited] to meetings. You will be left out of the federal budget consultation invitations. I mean they make it very clear [….] when you start to just blatantly criticize them then you politically can pay the price.* (Participant 2)

Another stated, *"so you don't go marching up there all the time and literally march with a sign that says we hate the government, and then say, 'By the way, can you cough up a couple of million dollars to fund all our work'"* (Participant 6)? Participants suggested exclusion from policy discussions or branding were potential consequences of using confrontational approaches. For instance, one participant said, *"you might run into a government that just really doesn't like that issue, and then they kind of brand you with that particular issue"* (Participant 1).

Part of CNA's approach is to thus to *"tow a respectful line"* (Participant 6). The participant went on to say, "*in this case around environment, you can't just sort of go all Suzuki and think it's going to work. You have to frame it around what is the best thing for the public"* (Participant 6). Another participant indicated the use of evidence and provision of solutions is a more appropriate route to advance a position when differences of opinion exist between CNA and government:

> *We are pretty clear on the fact that we don't want to get up their [sic government] noses [….] there are lots of groups who are doing that. We don't want to do that. We want to bring them evidence. We want to bring compelling arguments. We want to be seen to be solution providers as opposed to marching on the streets.* (Participant 9)

Overall, analysis suggests that when CNA's policy positions do not align with those of government, meeting with decision makers to explain positions and provide evidence, rationales and potential solutions are key tactics used rather than confrontational approaches.

**Establishing relevance.**

Establishing relevance as a knowledgeable and key player regarding CEH issues is a second tactic in building social capital. Spotlighting what nurses know and underscoring their motivations for engaging in CEH are primary efforts employed to establish their relevance as potentially valuable contributors.

***Spotlighting what nurses know.*** Some participants believed that lack of understanding, particularly by government officials, about health risks from environmental conditions and the potential role for CNA to inform those, limits their involvement in CEH initiatives. This was explained by the following participant:

> *One of the things we do hear though from one of our government relations' staff in my department is that the people on the Hill, Parliament Hill, still don't get what nurses are doing in the environment. So we think we have, you know, some credibility [….] And nurses are very trusted in terms of even environmental health by the public. But the politicians don't quite get what we are doing in environmental health, in the environment. Like why would we be concerned about tar sands and greenhouse gas emissions? They don't make the link to health.* (Participant 2)

These participants suggested that spotlighting what nurses know and drawing attention to the successful contributions made by CNA to issues such as climate change, pesticides, and environmental hazards are key tactics to enhance understanding and to raise awareness about the value added by a nursing presence. One participant recalled a call made to a stakeholder to emphasize what CNA could bring to a CEH discussion:

> *There were some issues that were being discussed that the nursing community wasn't involved in. So part of what we did at CNA was to phone whoever was leading the exercise and say nursing probably has some knowledge to bring to the table. Would it be possible to intervene or to talk to you about where you are going, and make sure that we are sharing the information with nursing?* (Participant 4)

Because of these approaches, some participants thought CNA gained visibility for CEH and those government officials increasingly looked to CNA for information and advice. For instance, one participant stated:

> *But we've noticed that as we have developed those materials and let nurses and governments know that we are interested in supporting our nurses to get involved and telling them that nurses have a role, that they have in turn then been coming back to us and asking us for our opinions on particular issues. And that is happening a little bit more frequently, I'd say, in that two-year period.* (Participant 1)

Another participant suggested that other partners, members, and the public are also taking notice of the role CNA plays in CEH:

> *Our partners that we work with, like the [names removed of two Canadian advocacy organizations], all those partners all talk about the role we've played in environmental health. So we hear it from not only our members, but our peers.* (Participant 2)

However, not all participants believed the increased visibility or credibility was all significant. Once participant stated:

> *It's not clear to me that CNA has done a massive amount of work on one environmental issue versus another that it is perceived to be an authority. I would say it does not perceive to be an authority, but it has credibility because it is a very credible and highly respected organization.* (Participant 11)

Some participants suggested that neither CNA nor the profession is perceived to have new knowledge that will advance policy discussions related to CEH. For instance, one participant stated:

> *What could CNA possibly say about the tar sands in a position statement [….] And then where is the nursing community going to stand when everybody who is employed in the tar sands start complaining that they are losing their jobs, and it's on the backs of nurses? At a certain point, you do the analysis and say so what is it that nursing can do about the tar sands? And is nursing ready to do that kind of thing?* (Participant 4)

For this participant, simply summarizing existing evidence does not underscore the contribution nursing or CNA can bring to policy discussions, nor does it warrant involvement in these discussions. Instead, nursing and CNA need to be able to, *"articulate what it is that they bring to the table"* (Participant 4). The participant further explained that gaining relevance requires nursing and the Association to develop and translate that new knowledge:

> *…CNA would then, or some other organization, would then have to put money into researching and projecting. And then being active, seeking out opportunities to position itself to present papers, to intervene, to engage the environment community at different levels so it begins to position itself on the issue. So people will say, "Oh, yeah, I remember the nursing community came. I remember they talked about that." And then you start establishing yourself. And it's not by shouting. It's not the one headline wonder. It's sustained, important and value-added kind of research that will position an organization at the national level on an issue, and make that issue policy-relevant. (*Participant 4)

Unless CNA is willing to invest in such efforts, the participant did not see a substantial role for the Association in shaping CEH policy. Another participant similarly noted that CNA representatives have to think about what it is they could bring to policy discussions stating, *"I don't think people would say we shouldn't talk about these issues, I just don't think we've built that base yet [….] I don't think the public at all, in any place, would turn to nursing when they think about environmental health"* (Participant 6). Thus, while some participants thought that CNA should raise awareness of the link between CEH concerns and nursing and promote their role, others thought CNA must first identify their role advancing CEH policy discussions.

***Underscoring motivations for involvement.*** Making explicit that motives for involvement in CEH are non-self-serving was perceived to lend relevance to their interest for involvement. This was exemplified by a participant who stated, if *"all they do is yell at you*

*or accuse you of being more concerned about nurses than the public then it's very difficult to make any headway in anything"* (Participant 14). Participants believed that nurses and their associations do not have anything to gain professionally by addressing CEH issues. As one participant stated, *"it's not like nurses are going to have a lot to gain by it. It's not going to make a lot of jobs for us fighting for better water sanitation"* (Participant 8). The public would likely see that nurses' interest in CEH is to enhance population health and thus would be supportive of their involvement.

**Protecting reputation.**

Protecting their reputation as a knowledgeable and trustworthy source is a third key tactic for building social capital to facilitate CNA's engagement in CEH. There was widespread agreement among participants that CNA has credibility for CEH, partly owed to their reputation held as the National Nursing Association:

> *I think CNA has a credibility of being the national voice of nursing. And nursing has a huge credibility across the country. Whether it is recognized as an expert in environmental health, I would say it's probably not. So the credibility comes from the legacy and the importance of being a nursing organization. And people would listen to that in that context.* (Participant 11)

To protect this credible image CNA only uses current and reputable evidence. This was explained by the following participant who stated CNA had to:

> *… have the background to make the decisions that you are making. You know, if I don't know anything about environmental health, it's very easy to make assumptions and they could be so wrong. And if they are wrong and people know they're wrong, they talk. And pretty soon you have no credibility [....] Like we have to do our research.* (Participant 14)

Another participant similarly stated CNA has to ensure that it is *"not dispensing unfounded information. You know, things that will harm your credibility. So it's to do the policy work carefully"* (Participant 8). Others suggested that CNA aims to deal with CEH issues in which the evidence and link to health and nursing is explicit, otherwise the Associations' credibility can come into question:

> *We have to be very careful that we maintain that coveted position and use it wisely. So I think going forward, if we can link our position to health, I think it's credible. I don't think we can be fanatical. We have to be aware of trying to maintain the respect that we have.* (Participant 10)

Some believed the public is reaching a tipping point for recognizing the connection between

environmental conditions and health. The development of evidence and acceptance of the public is opening doors for CNA to speak to community environmental issues that at one time seemed irrational:

> *And we maybe have reached a tipping point on that. So that you are not seen now as being irrational. It's not an irrational argument. And lots of people have seen cancers that are environmentally linked. You know, right from the Love Canal forward, people are seeing it now more asthma, the air. So maybe it's because we have gone sadly so far into environmental degradation that people can see it. It's more obvious. So the health connection is becoming clearer.* (Participant 8)

**Inspiring a Mass of Support for CEH Issues**

A third strategy taken by CNA is to inspire a mass of support to influence CEH policy. Participants indicated that in order to influence policy, efforts should include a critical mass of people working in many geographic settings and jurisdictional levels. One participant explained, *"the most effective work comes when you have people at all levels talking, and nurses in all areas speaking"* (Participant 8). Another stated, *"The more that spreads the message, the same message, the more the politicians are apt to listen"* (Participant 7). Inspiring a mass is primarily managed by raising awareness. Other efforts include finding champions and creating opportunities for individual and collective action.

**Raising awareness.**

A significant portion of CNA's policy advocacy efforts for CEH is dedicated to raising awareness. Press releases, position statements, background papers, and videos were developed about climate change, green health care, pesticides, and toxic chemicals and publically shared via the media and CNA's journal, website, and the NurseOne Portal[10]. Through these venues, nurses, the public, nursing organizations, and government are provided with rationale for needed change to promote more healthful behaviours for CEH and to reduce harmful environmental exposures, for the role of nursing in CEH, and for the types of efforts that can be taken as citizens or as professionals. As acknowledged by one participant, a key role for CNA is to serve as a knowledge broker for CEH issues among nursing associations:

> *One of the things we try to do is play a knowledge broker role at the national level. So for example, when RNAO has done a lot of great work on influencing pesticide*

[10] Note: NurseOne is a personalized interactive web-based resource designed to support nursing practice.

> *legislation, we've tried to put their tools and resources and links to their information on our website so the other jurisdictions as they go forward with similar legislation per se can benefit from those who have gone before.* (Participant 2)

Participants indicated that many of these efforts occurred as a result of CNA's decision to select CEH as one of three celebratory themes for its centennial celebrations. However, some participants suggested that instead of creating an opportunity to invest substantively in CEH, the issue got lost amid the celebrations. One participant stated:

> *Well, the centennial was basically a celebration of nursing. Trying to put something else in there is confusing. It's sort of like having a birthday party while it's Christmas day [….] So it just gets lost. It's just another thing going on.* (Participant 4)

There is a sense that while the centennial celebrations provided an opportunity to enhance efforts for CEH, the celebrations became the focus and an opportunity to plan for sustained efforts for CEH was missed.

**Finding champions.**

Unlike others, one participant believed, "*the public is fairly well informed about a lot of these issues [sic CEH]"* (Participant 6). Instead, this participant attributed disinterest to an overall apathy for policy in general and CEH issues more specifically. The participant went on to explain:

> *So part of it is because there's a group of nurses out there who, and I think it's a lot, who are completely disconnected from nursing, never mind from broader health policy [….] I don't know, two-thirds of nurses don't give a [word removed] about anything more than the current shift [….] I don't know if it's gender and fatigue and women and kids and multiple responsibilities, and let me just get it done and get out of here. I don't know. I've watched it my whole career.* (Participant 6)

Another participant similarly noted, *"nurses were multi-roled, multi-committed individuals with only so much time in the day"* (Participant 3). Apathy towards CEH is thought to exist in the broader community as well. One participant stated, *"but there's this kind of inertia that when you say let's just do it different, let's just do something different, it's almost like it enrages people even if it will be better. So the environment is caught in that too"* (Participant 6). Therefore, part of CNA's efforts is to identify champions that will speak to community environmental efforts. One participant stated, *"so we rely on the groups that are activists. They exist in every province. We need to identify who the activists are in every province and work with them"* (Participant 3).

**Creating opportunities for action.**

In order to inspire efforts for CEH, CNA also creates opportunities for individual and collective action. Opportunities for individual action are facilitated by creating tools and resources that can be used in nurses' everyday practice, as noted by a participant, *"what I could give that nurse or what CNA can give the nurse is some confidence and some tools"* (Participant 8). CNA supported the establishment of a national nursing environmental health special interest group comprised of CNA nurse members and other stakeholders with a vested interest in CEH. The group was registered as one of CNA's emerging interest groups at the time of this study. However, one participant suggested there is a lack of uptake in the group noting there are only *"30 or 40 members of that group. I mean it's a very small movement at this point"* (Participant 6).

**Lending Support to CEH Policy Change in Partnership with Others**

A fourth strategy taken by CNA is lending support to CEH policy change in partnership with others. This entails working collectively with those outside of nursing and health in order to address CEH issues. Lending support to policy change is managed by joining allies and stakeholder analysis.

**Joining allies.**

Both participant interviews and organization documents described how CNA works with allies inside and outside the health sector in order to address CEH issues. Allies include diverse players from various levels of the system and from various geographic regions. These players include government officials, advocacy and environmental groups, coalitions and organizations, industry, and other professionals and their associations. Forming partnerships sometimes requires CNA to approach potential partners to let them know the role they can play. One participant stated, for example:

> *Now, with the air quality health index, we heard about that initiative. And it was kind of new and it was clear that Environment Canada was trying to find external stakeholders that could help raise awareness about this index. So we approached them saying that we thought nurses could use this index and that they should know about it.* (Participant 1)

The role assumed by CNA is primarily to lend support to these collaborations. For instance, CNA offers a nursing perspective about community environmental issues to the coalitions, government advisory groups, action committees, and commissions with whom

they participate. In many cases, the participants' spoke to reciprocal benefits that CNA and their partners receive by working together. Partnership approaches are used to create a synergy of expertise and knowledge, to increase a pool of resources for more intense advocacy efforts, to strengthen arguments, and to increase the power and legitimacy of group efforts in the eyes of the government:

> *So on environmental health, CNA has really, on their policy advocacy worked with other organizations in the health sector and then also the [name removed of Canadian advocacy organization] and the environment sector. But it's helped to work with organizations like the [name removed of Canadian advocacy organization] that have resources. Then you can kind of move issues forward a little bit quicker, easier by pooling those resources. And then also just working with others that maybe don't have resources. But if you can pull together ten organizations all saying they want the same thing, policy-makers are more receptive to having a message that is coming from more than one organization because then they know there is some consensus there.* (Participant 1)

Working in partnership opens doors for CNA's involvement in CEH issues and provides a way for the Association to navigate barriers. For instance, working through the Minister of Health can become a way to influence the Minister of Environment:

> *It's whoever will play ball [….] Environment says, "Oh, that is a Health issue." So when we write the Environment guy about how it affects health, sometimes he'll say, "Fine. Thanks very much. I appreciate it." And sometimes he'll say, "Well, that is really for the Minister of Health" [....] They try to toss the ball, really. No one wants to pick it up and respond to you. But clearly if it's things like greenhouse gas emissions, we're speaking with the Minister of Environment, not the Minister of Health. But we try to work through the Minister of Health to say can you try and influence the Minister of Environment or bring our voice to that table in Caucus or whatever in the House?* (Participant 2)

However, participants suggested that developing and working collaboratively was challenging. For instance, one participant described how partnership becomes a dance when stakeholders share similar views with CNA on one issue, but hold different views on others. Referring to an organization with whom CNA frequently partners, a participant cautioned they cannot assume their agendas always align:

> *I certainly think it lends well if you are in the same room lobbying for the same thing and for the same outcomes. However, the agendas are different. And that is the challenge. So once again, it's a dance. So you want to be able to stand up alongside*

*and lobby, but you have to make sure your agendas are the same as well. And I think sometimes the agendas are a little bit different.* (Participant 12)

**Stakeholder analysis.**

CNA engages in stakeholder analysis to assist with the identification of appropriate partners. One participant explained, "*there is a whole activity looking at where is the expertise and can we bring that expertise together? Is there energy to put together a network, I guess, of experts? And let's plumb that to see where the potential is"* (Participant 4). Some participants reported that working with those both in and outside the profession is essential. One participant stated:

> *We all know that any advocacy works when you have a good solid stakeholder representation. And sometimes as a nursing organization as well, we need to not just also get coalition from nurse or nurse members or jurisdictions (sic jurisdiction members) but also other partners that have vested interest. That is also powerful. And you build yourself a coalition with other health or environmental organizations.* (Participant 7)

Some participants claimed that CNA tends to partner with groups and organizations representing broad health issues and with those comprised of professional representatives. This approach was explained by a participant, who stated:

> *I think our Board and I think our staff is a little bit leery of becoming too much affiliated with kind of a one-issue organization needing to, I don't know, show that we are taking a broad view of all these things rather than one thing ….] But we do feel more influenced, for example, when you start to have discussions at [name removed of Canadian health advocacy organization] where there's 32 professional groups are there, and people are saying, "What are you doing with toxic waste in your organizations? Have you guys got anything about this or said anything about reusable equipment and so on?* (Participant 8)

Participants tended to agree that shared views and values are essential qualities in a partner. One participant stated:

> *So maybe you collaborate with another stakeholder like [Association name removed] and they go off and say something really crazy in the media or to government. And then because you've been working together, you kind of get painted with the same brush so to speak.* (Participant 1)

Participants further suggested that CNA is more likely to achieve its goals by avoiding involvement with extremists. One participant stated, *"but you certainly don't want to be perceived as being an extremist. And I mean I've seen, I've worked with groups that are*

*extremists. And that extremity is not necessarily the most conducive to positive results"* (Participant 7).

However, one participant disagreed, suggesting opportunities to push policy agendas may be lost if some stakeholders are uncritically dismissed as potential partners:

> *So some of that is what we need to modernize and change the kind of people we partner with [….] I think we just need to partner differently. And I think we also need to really look hard at who is the enemy, the traditional enemy.* (Participant 6)

The participant went on to suggest that sometimes joining with *"strange bed-fellows"* (Participant 6), which includes organizations and governments whose positions do not necessarily align with those of the Association, is an effective way to move a policy agenda forward.

**Exercising Political Acumen**

A fifth strategy used by CNA is exercising political acumen, which entails the application of political skill to secure a nursing voice in CEH policy decisions. Exercising political acumen includes understanding the landscape and being opportunistic, understanding power dynamics, and framing and positioning key messages.

**Understanding the landscape and being opportunistic.**

Assessing the political, economic, socio-cultural, ecological, and professional realities and determining the most appropriate targets, approaches, and forums for action are political strategies employed by CNA. According to a participant, CNA's ability to influence policy requires knowing *"all about that right person, the right voice at the right time and the right place"* (Participant 12). CNA assesses shifting contexts and adapts the strategies used, the target for change (e.g., public or government), and the timing and intensity of the efforts. A participant explained:

> *So it's not like black and white. I think it is a blend of [sic strategies]. And depending on the issue that you want to advocate or influence, you adjust your mechanism and figure what stakeholders or who should be involved. So you adapt your strategy based on what it is you are trying to do. So that it's fluid.* (Participant 7)

Participants cited examples of events that lead to the intensification or reduction of efforts. For instance, a participant recalled circumstances that led to the ramping up of efforts for CEH:

> *So when the environment started to come on the radar, people like Al Gore, the United States scientists talking about the impact of greenhouse gases, it started showing up on*

> *political platforms of parties, in their election platforms, CNA said okay, there's an opportunity here. Because when the government is interested, you know, you jump for it.* (Participant 2)

Work being done within the broader nursing community also stimulates enhanced interest and action by CNA for CEH:

> *And that there was work that had been done through the [name of country removed] Nursing Association, through the [name of a government joint commission[11] removed], linking health and environment. That there was some research work that had been done that looked at roles of nurses, and particularly public health nurses but other nurses as well. And there was evidence of nurses, individual nurses, being active on some local environmental health issues. One of the sort of things that brought this all out was a paper that was published in the Quebec Order of Nurses Journal by a prof at [name of school removed] who is a nurse. And she had produced a paper that sort of summarized nursing involvement in environmental health issues. A nice general kind of thing that captured knowledge and expertise. And my analysis was jeepers, if this is happening in Quebec, is it happening elsewhere?* (Participant 4)

Changes in government priorities, for instance, sometimes lead to the reduction of efforts. One participant provided an example, stating:

> *If you had been building your case for a research program around environmental health, you might have to go back to the drawing board and think about an option that relates to public awareness campaigns in order to get any successful movement.* (Participant 1)

**Understanding power dynamics.**

CNA's political know-how includes understanding power dynamics and weighing risks and benefits. For instance, a participant recalled an environmental crisis that should have inspired action by anyone invested in the environment. "*I mean when you have an episode of an oil spill, it's a prime opportunity to push your environmental issue"* (Participant 2). However, action was not taken. The participant went on to explain that unless the government is receptive, efforts by CNA would be futile. In addition, the topic of oil and oil sands is a contentious issue among members of CNA. Thus, deliberate choices are made to avoid topics that are in opposition to government or the Association membership to avoid potential losses in other areas (e.g., support). A participant spoke to this tactic, stating:

> *Because we are no good if we are not at the table. And there might be a point, if you think of governments becoming extremely extreme, there may be a point where you just*

[11] Government commission charged with monitoring transboundary environmental agreements

> *cut your losses holistically. But as long as you want to be at the table with them, we want to be. Not so much moderate. This is not about a compromise to our position. It's about being as strategic and thoughtful about what it is that we are doing.* (Participant 9)

Another participant concurred, stating:

> *They [sic CNA] want to move six things forward. Well, maybe three of them only get moved forward this way, and they maybe have to take a step backward in something to be able to get those three things, or a step sideways in something to be able to get those three things moved forward. So it's really all about a dance.* (Participant 12)

**Framing messages.**

Participants indicated that the strategic framing of an issue could affect the amount of attention it receives. A participant expressed, *"if you can brand it in some way, people start to, or it may or may not get onboard"* (Participant 8). Thus, efforts are taken to position CEH issues in ways that will make them more attractive to governments. Participants believed that emphasizing the health impact is the most common frame that gains attention for CEH. This belief was reflected by a participant, who stated:

> *CNA has been strategic around how they've approached those issues. So when it comes to things like pesticides, there's a lot of people you can piss off when you start putting policies out there around things like pesticides. A lot of the corporations and stuff that back those. But if you position in the lens of what is in the best interest of the health of Canadians then I think they've positioned it properly.* (Participant 12)

Using the example of greenhouse gas emissions, another participant emphasized the polite "politicalness" used by CNA:

> *Their targets they've [sic government] set for greenhouse gas emissions are quite conservative and we'd like more aggressive targets. So we say we urge you to consider more aggressive targets, or we are in favour of more aggressive targets. But you don't come out and say you guys are idiots. You are never going to get there if you set those targets. It's all in how you word it. So it's the politicalness of the wording, how you frame it that gets them to either respond or not respond, and how you present the issue.* (Participant 2)

Another participant suggested skill is required to frame issues in ways that government may be receptive to and that do not compromise CNA's fundamental values:

> *The bottom line is that we want governments to be receptive to what it is we have to say, notwithstanding what their ideological position is or what they are talking about. We always have to adapt and adjust so that we can find a way of getting our messages in - which means that we need to change our messages. We don't need to change what*

> *it is we're trying to say but we also have to adapt our messages so that they can be framed in a way that governments understand them and are ready to listen to them.* (Participant 9)

However, one participant suggested that CNA should consider expanding and align its vocabulary in a way that speaks seriously to government:

> *Basically, where this government has paid some attention is looking at toxics and the management of toxics. So instead of talking about environmental health, CNA has to adopt a vocabulary when it is speaking to government that says, "You know your toxics program. You are investing $2 billion in it in the next 10 years. This is what the nursing community is talking about, and this is what we are seeing [….]" So there needs to be an effort made and investment made by CNA if it's going to pursue that to adopt language that is relevant to the particular government.* (Participant 4)

Attaching CEH to political agendas that already have the government's attention is another approach that gives prominence to those issues. One participant provided an example, stating:

> *So let's use water. The Prime Minister announced it in his leadership, they were going to tackle maternal child and newborn health [....] we issued a press release saying that we want both an international strategy and a Canadian strategy to address maternal, newborn, and child health in Canada. And in particular, we wanted to address determinants of health like water and access to clean water and housing. Because you cannot have maternal and newborn and child health without clean water.* (Participant 2)

**Pushing Policy Positions**

A sixth strategy taken by CNA is pushing policy positions that aim to get a CEH issue on the government's radar and agenda, or to change or strengthen existing policy. Efforts described included directly advocating the government, aiming to influence legislation by meeting with and writing to senior government officials and their staff.

For CNA, advocacy is an incremental process that requires the development of a knowledge and resource base before other strategies such as inspiring a mass of support or advocating government, can be undertaken. These materials are then used to articulate CNA's official stance on the CEH issue. One participant stated:

> *I worked on getting those resource materials completed and out to nurses. But then we shifted. And then I also worked on the position statement around each one of those themes. And then we shifted to doing the advocacy because we had the background materials and then we had our policy statement. And then that gives you information to be able to then express the Association's views.* (Participant 1)

Once materials are developed and approved, leaders of CNA meet directly with members of parliament to communicate their CEH concerns, to go on record about issues on behalf of the Association, and to share their analysis of alternatives and recommendations for action. One participant described these direct advocacy efforts undertaken by CNA:

> *So as a national organization, our advocacy is going to be with MPs, Members of Parliament, or with federal government departments – Department of the Environment and so on. And we would meet with their staff or their committees and be supporting various kinds of legislation, speaking for things or monitoring, speaking for environmental protection laws and that kind of thing.* (Participant 8)

Another stated:

> *So we meet with Health Canada, Environment Canada and talk about issues. We've written letters to the Prime Minister. We've met with the staff to talk about our greenhouse gas emissions, our targets.* (Participant 2)

The participant further recalled a meeting that took place with a senior government official to discuss Canada's role in an international CEH issue:

> *We had also been meeting with Minister [name removed] around international, around that whole if you want to do something in these countries, help them get access to clean water and housing and whatnot.* (Participant 2)

At times collective direct advocacy efforts are undertaken, as described by the following participant:

> *And we've had nurses write their MPs on the issue. Or a Bill before the House on the environment, the Canadian Environmental Protection Act. When they write their MP then the MP, when he gets so many letters in his box, he has to bring it to Caucus. That is their kind of internal policy. So he has to bring it to their Caucus meeting and raise it. And so if a bunch of MPs say, "Yes, I'm getting lots of letters from nurses," they start to put it on the list of the issues that they need to talk about at their Caucus meetings around policy setting.* (Participant 2)

However, some participants indicated that CNA, along with other provincial/territorial associations, does not have a visible presence in terms of CEH. As one participant noted, other than the media attention given to RNAO for pesticides, no nursing association plays a visible role for CEH. Furthermore, the participant believed there is risk involved when claims for involvement are not supported by substantive efforts:

> *There is always a risk of claiming to be present on an issue when your only presence is a press release or a one-night stand media statement or event or whatever. Because basically people who are involved in the policy workings of government will be*

> *dismissive. 'Oh, yeah. That's CNA. They are just mouthing off again. They won't follow up. Don't worry about it'.* (Participant 4)

Of interest was participants did not identify criteria that signaled when no further attention would be given to a CEH policy issue. When asked what indicators were used to identify when policy goals are reached, one participant responded:

> *That is a very good question. I guess we don't. I guess we just kind of go until we're tired of the issue. That is a very interesting question. Or maybe it gets resolved, which is an unusual thing. But sometimes things do get resolved.* (Participant 6)

### CNA's Overall Pattern of Engagement in CEH

Attention given to CEH issues by the CNA can be described as sporadic and ad hoc. As explained by a participant, *"over the years, the level of intensity that we have been involved has fluctuated"* (Participant 7). CNA's formal involvement with CEH issues was traced to two resolutions first proposed in 1990. These resolutions directed CNA to actively promote the use of cloth diapers as an alternative to disposable diapers and to work with the International Council of Nurses and the World Health Organization to decrease and eliminate the use of chemicals and pesticides that contain contaminants, surfactants, and solvents.

Significant attention was then given to CEH during CNA's 2008 centennial year celebrations. Several background papers, position statements, and resources to support nurses were developed related to environmental health principles, climate change, and greening of health care. However, investment in these issues waned considerably in the years following and up until the time of this study.

## Case Two: Registered Nurses' Association of Ontario

### Introducing the Registered Nurses' Association of Ontario (RNAO)

Founded in 1904, RNAO is Ontario's Provincial Nursing Association located in Toronto, Ontario. During its early years RNAO developed standards for education, secured funding for nursing education and research, and supported collective bargaining issues. The Association relinquished its regulatory functions in 1963 to a newly established College of Nurses of Ontario[12]. In 1974, responsibility for collective bargaining issues was also given

[12] The College of Nurses of Ontario is the regulatory body for registered nurses and registered practical nurses of Ontario. Registration with the College is mandatory to practice nursing in the province.

over to a newly formed union body, the Ontario Nurses Association. At the time of the study, RNAO stood as the only provincial/territorial Association in Canada with a sole mandate to advance public policy for nursing and health (i.e., no regulatory functions). RNAO is a long time jurisdictional member of Canada's national body, the Canadian Nurses Association (RNAO, 2009a).

In the following case study I provide an overview of RNAOs' organizational attributes. I describe the Association's priority setting processes and policy advocacy related to CEH. I further describe the supports and challenges that influence the way RNAO sets priorities and takes action for CEH.

## Organizational Attributes

### Member-Driven Public Policy Mandate

RNAO has the legal authority to exist and carry out its business under Ontario's Corporation Act R.S.O. 1990, Chapter c-38 (Ontario Canada, Ontario Ministry of Attorney General, n.d. 2009). Incorporation under this Act awards the Association and its members the ability to self-proclaim its objects within the provincial jurisdiction of Ontario. Thus, RNAO is considered a member-driven organization. Under their Letter Patent, RNAO articulates the mission as, *"speaking out for health and speaking out for nursing; to pursue healthy public policy and to promote the full participation of registered nurses in shaping and delivering health services now and in the future"* (Bylaws 2010, RD53). RNAO aims to cultivate knowledge-based nursing practices, promote quality of work-life, and ensure excellence in professional development services (Bylaws 2010, RD53).

The mandate endorsed by members gives RNAO the authority to take action towards a range of policy issues, which includes CEH. As explained by a participant, "*I think being a policy organization gives us more depth with which we can look at many of the issues, including environmental health, that are brought by its members"* (Participant 24). Referring to the mandate, another participant stated, "*that becomes a real leveraging point for us to be able to. Because it is such a broad vision and mission, that we are able to approach a number of different things that otherwise we may not be able to"* (Participant 23).

Participants suggested that because RNAO is member-driven, as opposed to regulation-driven, the Association has flexibility to address policy issues deemed to be important to the members and the public. One participant stated:

> *Our decisions and our priority setting to address issues on the environment come back to membership issues, media issues, general public issues or health of Ontarians, I suppose if you want to keep it limited. We've got the privilege of not being confined by regulations. You know, we need to work within the law but not confined by the ability for nurses to have a voice on the issue. As long as we are not breaking a civil law, we are well within our ability to decide whatever environmental issue we want to work on. We'll work on as a membership-based organization.* (Participant 28)

Another participant emphasized that policy priorities are not dictated by legislative mandates that require regulatory issues to take precedence:

> *We are not regulating the profession. We are not distracted by looking at credentials of people and disciplining them for malpractice and things like that, and providing legal advice. So I mean we are here to advocate for nursing and to advocate for health. So that directs our action. And you can see that in our platforms.* (Participant 30)

Participants drew attention to the "*unique*" position RNAO holds in terms of its sole public policy mandate compared to other provincial/territorial nursing bodies with regulatory functions. According to one participant, this gives *RNAO "a lot more freedom to advocate on a policy level"* (Participant 21). Another participant concurred stating:

> *I mean so if you think of the other provincial jurisdictions in nursing, because they have such a strong regulatory component, their ability to actually spend the time and effort and dollars to focus on broader policy issues is limited. And in some jurisdictions it's actually, legally they can't do it.* (Participant 27)

While a member-driven mandate frees RNAO from restrictions associated with regulatory functions, sorting out which policies are a priority for action is a challenge:

> *And I think it's because the public or the membership demands it. How? Not always for the better. Just because they demand it? It could be the nursing group responding to an issue, demanding this membership organization do the same. And we will because we are membership-based. But it doesn't mean it's the right response.* (Participant 28)

Selecting policy issues based on membership direction means that CEH may not be an issue supported by all members. One participant stated, "*so you want to make sure that you are always listening to members and working on the issues that are important to them. And for some people, that doesn't mean the environment"* (Participant 21).

**Provincial Jurisdictional Mandate**

RNAO's CEH policy efforts are directed at Ontario's provincial government: "*we tend to focus on provincial legislation and provincial issues. But that really covers most of the environmental health issues"* (Participant 16). Another participant suggested that working on CEH at the provincial level "*might force us to look at the bigger issues, like the pesticide by-law, phasing out coal, that sort of thing"* (Participant 18).

Participants emphasized that although RNAO "*tended to focus on provincial legislation and provincial issues"* (Participant 16), effectively addressing CEH requires policy change at various system levels. For instance one participant stated, "*so I think there is a critical role for nursing in influencing change at all levels of government, from municipal up, around public policy"* (Participant 32). Another indicated they believed action at one level could have ripple effects across other jurisdictional and geographic boundaries:

> *…when we advocate at the municipal level, it may have ripple effects, as the pesticide campaign did at the provincial level. And the success in Ontario had ripple effects because a number of other provinces had pesticide legislation modeled on Ontario. And it ripples across the border as well.* (Participant 16)

Pesticide legislation is an example of multi-level system efforts whereby RNAO lobbied provincial Ministers, as well as supported advocacy efforts by coalitions and communities for pesticide by-laws in as many as *"30 to 40 municipalities in Ontario*" (Participant 16). While RNAO occasionally advocates at the federal level, participants believed a more effective approach to influence federal policy is to work collaboratively through the National Nursing Association. A participant explained:

> *We do get into federal submissions and so forth where there are sort of major environmental things going on that we haven't covered off already. I mean we are not nervous about doing that but we don't start stomping on someone else's turf. But I don't think like the CNA or our partners really feel that we are speaking out of turn when we do that. But it would be ideal if we could go with the CNA on a national issue.* (Participant 16)

While RNAO did work across system levels, influencing system level change outside their primary provincial jurisdiction was perceived to be more challenging. According to some participants, influencing provincial policy, compared to federal policy, is likely easier. As explained by one participant, *"I mean certainly it allows us to sort of narrow our focus to issues that directly affect Ontarians. And that is important because we are focusing our*

*arguments on people within a smaller backyard"* (Participant 21). The participant went on to suggest there are *"fewer variables"* when addressing provincial policies and that, *"it's a smaller landscape, and you can better determine who might be onboard or off-board on a particular issue. So you don't have those regional disparities to deal with"* (Participant 21). However, one participant questioned whether it was the greater size and diversity of opinions at various jurisdictional levels that created challenges for influencing policy at higher levels of jurisdictional authority. This participant noted conflict exists at all levels:

> *And in fact, we saw the conflict that occurred when it was a primarily municipal level and then it became primarily provincial. There's a tension there [sic municipal level] too. The same thing plays out at the provincial and national level, particularly around issues where different provincial governments may have their own want.* (Participant 32)

For this participant, the key success for influencing policy at any level was the relationships established with government decision-makers:

> *I think it is much easier to influence change on a provincial issue at a provincial level because you are dealing with it in your own turf. And you can get to know the folks. They are right there. You can build those relationships in a different way with the decision-makers.* (Participant 32)

**Voluntary Membership of Registered Nurses and Other Supporters**

RNAO is a comprised of voluntary registered nurses (RNs) and other supporters of RNAO's work. At the time of the study membership included almost 30,000 registered nurses, about 30% of Ontario's registered nursing workforce[13] (RNAO, 2009a). RNAO members also include 30 independent interest or affiliated groups, out-of-province associates (registered nurses in other Canadian jurisdictions or any person who wishes to support the work of RNAO), and friends of RNAO (any person who wishes to support the work of RNAO who does not meet the requirement as a member or associate) (Board Orientation Manual, 2010 RD52).

Participants believed that voluntary membership has important implications for the choice and the action taken for public policy issues such as CEH. For instance, one participant stated, *"being a voluntary body creates a very important accountability and a*

[13] CIHI (2010) reported an estimated 94,296 registered nurses in the Ontario workforce in the year 2009

*mechanism. To be a voluntary organization like RNAO, you 'ought to' be relevant because if not, people don't join"* (Participant 15). Other participants believed that voluntary membership is indicative of support for RNAO's policy directions, as explained by the following participant:

> *The voluntary membership, that is impactful as well. Because it means that the nurses that are members have made that choice and have made that financial commitment too. They put their support behind what the policies are. And if they didn't support the policies that we had then they wouldn't become members.* (Participant 22)

Voluntary membership is also perceived to enhance the power of RNAO's voice, as stated by the following participant. "*I think politically the power of being able to say, you know, that there are 30,000 members here that have chosen to, they don't need to, but they have chosen to join"* (Participant 15).

In addition to the contributions to decision-making, volunteer members also engage in the advocacy work of RNAO, "*bringing the platform themes to life"* (Participant 18). Nurses working on the front lines are reported as "*leaders*", "*progressive*" and "*innovative*", who collectively exert an important influence on the issues taken on by RNAO. One participant stated, "*the members carry a lot of weight with the politicians, particularly if they do it in person"* (Participant 16). Another stated:

> *Our members work all across Ontario as well. So they can really present the voice of Ontario nurses, which brings 30,000 numbers when they talk at the table to politicians. We are not just talking about one nurse, we are talking about 30,000 nurses.* (Participant 20)

Members' attend political events, respond to action alerts, and present at meetings and government submissions alongside RNAO staff in order to push CEH policy issues. One participant stated, *"if there is an environmental issue that affects their community, it is a good chance that one of our members is involved somewhere"* (Participant 17). Another stated, "*and you see how many nurses we had that took initiative over five, eight years ago at the municipal level in pushing the ban on pesticides"* (Participant 15). In addition members are RNAO's "*eyes and ears on what is really happening out there"* (Participant 17).

**Functional Corporate Structure**

RNAO represents a functional organization, structured to meet the geographic and domain specific interests of its members. Geographically, RNAO is divided into 12 regions,

some of which have Chapters[14] (Bylaws, 2009, RD53). Aligning with its functional model, RNAO's governing body includes twelve Chapters/Regions without Chapters Presidents; five members at large (representing nursing domains of practice, education, research, administration, and socio-political affairs); and an Interest Group (IG) representative. In addition to the core decision body, RNAO has an advisory structure referred to as an assembly. The assembly includes elected members responsible to discuss the RNAO's work, exchange information, share provincial viewpoints, and make recommendations to the Board on a regular basis (RD53 Bylaws, 2010). Voluntary membership and geographic- and domain-specific representation have implications for RNAO decision-making for public policy issues such as CEH.

The geographic- and domain-specific representation allows nurses concerns to be heard from rural and urban areas across the province and from various domains of practice (e.g., research), or from specialty areas (diabetes). One participant stated, "*our Board represents different regions. So it means that we are in touch with what is happening out there much better than we would if everyone came from [name removed of city] certainly"* (Participant 17). Another participant similarly noted the representative assembly structure means RNAO can rely *"on about 100 key nurse leaders across the organization who are geographically across the province in different domains to raise issues"* (Participant 30). Participants suggested that policies can then be considered "*from the multiple perspectives of nursing"* (Participant 32) and RNAO has the potential to impact *"the province as a whole"* (Participant 22). To emphasize the value of a functional model, a participant suggested the alternative federated model poses more challenges for policy work:

> *It's much easier to play in the provincial environment for a provincial association. I would argue that the National Association which was structured for the purpose of creating national change and focusing on national change would be less constrained than is the situation when you take provincially-based people and try and stuff them into a national framework.* (Participant 32)

However, functional representation is not without its challenges. One challenge is to bring experts and the right skills to the decision-making process. For instance, one

[14] Nine of RNAO's regions are comprised of 3 to 5 local Chapters. Three regions do not have local chapters and identify as Regions without Chapters. Chapters and Regions without Chapters act as the voice for the nursing profession across Ontario, provide a network of professional resources and support, and maintain the unity of the association while serving the interests of RNAO members (RNAO, 2009c).

participant called attention to the difficulty to secure representation for some elected positions, stating:

> *Sometimes I also have observed too that there was only one contestant. So this person is acclaimed. So how strong this person is I think it affects the outcome. Even the President's position, if there is only one person competing for it, this person would be acclaimed.* (Participant 29)

Another participant noted, "*a lot of the people that participate in the organization, in the higher levels of the organization, tend to be a certain type of person or tend to be a certain individual"* (Participant 22). As explained by the participant, a lack of competition in elections means that individuals can be re-elected many times or positions can go uncontested, which can be potentially problematic "*if they have views that are opposing their membership that they represent"* (Participant 22). According to some participants, high demands placed on volunteers are a potential risk for members. One participant stated, "*I think this organization has to be careful about what it is expecting from its members. It can't expect us to do everything. They are a very high bar to reach"* (Participant 30). Some participants drew attention to the time and energy required to meet the diverse needs of members. As one participant explained:

> *So if you take a position, you are committed to talk about it with everybody if you really go the whole nine yards. And that takes a lot of time and energy. It's going to generate conflict and disagreement and differences of opinions. It takes a lot of effort. So I think those are risks.* (Participant 30)

**Operational Structure**

RNAO's policy work is operationalized through its home office, comprised of one centre and six departments, including a Health and Nursing Policy Department. The Health and Nursing Policy Department provides *"leadership for the analysis of data and information, and monitoring of government policy and legislation*", and develops *"a variety of tools to support the political action activities of members*" (RNAO Board Manual 2010, RD51). According to participants, the department is well equipped to address CEH issues. As described by one participant, *"it is a well staffed department. A department that requires strong credentials, strong academia, strong understanding of policy, and certainly has some expertise particularly in one or two members on environmental policies"* (Participant 28). Another participant claimed, *"in terms of the environment, it's constantly on RNAO's mind.*

*Just having two people in the policy department out of five who are heavily involved in that, in moving forward any initiative they can speaks to me"* (Participant 26).

Staff within the policy department appear to work interdependently, with assigned leads for specific public policy issues. For instance, one individual is assigned the environmental health portfolio and is responsible to lead the policy team in actions related to CEH. Other staff and departments (e.g., communications department) work along side each other, particularly when opportunity presents to push one of RNAO's policy priorities forward. For instance, one participant explained how staff and departments collaborated:

> *The policy analysis committee will do submissions to different legislative committees at Queens Park. So we'll ask one of them to do a presentation on it, for instance, about toxics and pesticides. One of them will go and talk about why it is important. But we don't work in isolation.* (Participant 20)

**Summary of RNAO's Organizational Attributes**

Overall, the member-endorsed mandate permits RNAO to take action towards a range of sensitive CEH issues across multiple levels of polity. In the absence of restrictions imposed either by a regulatory mandate or support of regulation, RNAO is free to address any CEH issue deemed important by either members or the public. However, RNAO is held accountable by the members and thus requires their support to advocate for CEH issues. No evidence was found to suggest that a CEH issue was not supported because of a lack of endorsement by members.

Operating as a provincial body, RNAO is in a position to influence CEH related to provincial policy, but sometimes aims to influence municipal and federal level CEH policies. While RNAO does occasionally advocate at the federal level, the Association is mindful of doing so given CNA's role. Some participants indicated a better approach for influencing federal policy would be to more often work through CNA. In addition, influencing system level change outside their primary provincial mandate is more challenging since stakeholders are not as well known.

RNAO's functional structure allows for geographic, domain specific, and specialty interests of RNs and public interests to be represented, which includes their CEH concerns. Voluntary membership also creates an accountability mechanism that motivates RNAO to ensure relevance to members. However, meeting the diverse expectations of members mean RNAO has to balance efforts for CEH with the other demands expected by members. While

voluntary membership partly accounts for membership support and willingness to conduct policy work, participants indicated there are substantial expectations placed on volunteers. However, membership continued to grow and members continued to contribute to the decision-making and advocacy work.

Substantial resources are dedicated to CEH issues of interest. In addition to a full-time expert in CEH issues, another staff also has experience with CEH. In addition, one large policy department permits staff to work interdependently to address and quickly respond to CEH issues.

## Priority Setting for CEH

An analysis of participant interviews and organizational documents indicates that priority setting for CEH is guided by core organizational values and beliefs and follows from monitoring, screening, and adjudication processes. The following section describes RNAO's priority setting related to CEH.

### Guiding Organizational Values and Beliefs

Decisions as to whether CEH issues will be addressed by RNAO are anchored in a core set of organizational beliefs related to the environment and health and roles for government and nursing. Analysis of participant interviews and organizational documents indicate that CEH is perceived to be a critical determinant of health as well as a social justice, equity, and human rights issue. For instance, one participant stated, "*I think that environmental health affects all of our health. It's one of the key indicators"* (Participant 24). Organizational documents describing RNAO's work also reflects these values. For instance, RNAO's policy platform document articulated, "*environmental protection is not only a matter of health, therefore, but also of social justice and equity. Environmental rights – clean air and safe water – must be recognized as human rights"* (Policy Platform 2010, RD12). RNAO's policy platform to government is based on the premise that RNAO *"believes this is the time for government to step up with policies that support vibrant communities and all the social and environmental determinants of health"* (Policy Platform 2010, RD12).

There was widespread agreement that the reason RNAO exists is to address issues affecting nursing and health, including CEH. One participant stated:

> *Environmental issues are health issues. People have a right to a clean environment. And if the environment is not clean then you have health issues that arise from that. In that we as an Association and nurses on the groundwork for healthy communities, then*

> *it's fundamental to our raison d'être that we work for environmental health.* (Participant 17)

The participants emphasized that the nursing profession and RNAO ought to be involved in shaping CEH public policies because of their broad-based vision of health, skill and experience, and first-hand know-how about the impact of environmental conditions affecting health.

RNAO is considered particularly well positioned to address CEH issues as they can bring voice that perhaps individual nurses cannot do alone, or cannot do as effectively. One participant stated, "*I think as an organization, what their role is to really have a voice that maybe me as an individual can't do alone or would be very small"* (Participant 24). Addressing CEH policies collectively through RNAO also has the advantage of enhancing impacts, increasing strength through numbers, supporting individual action, and improving chances to overcome potential roadblocks. For instance, a participant stated, "*an organization like the RNAO, when it speaks out on environmental issues, has a much more significant impact as an organization and can support individual members and nurses in that articulation"* (Participant 27). Moreover, if RNAO was absent from environmental health policy discussions, participants believed there would potentially be negative consequences for health and equity issues. For instance, on participant stated, "*and it's more of a risk not providing a voice to people who can't speak out about environmental policy or who don't have the ability to speak out. And I think that is really crucial because often there's voices lost*" (Participant 20).

Participants also reported that protecting citizens from compromised environments and promoting healthful environments, particularly for those most vulnerable, is considered a duty of governments. Upstream preventative action and policies that preserved a social safety net are proposed examples of appropriate actions that should be taken by government. This position is supported in RNAO's policy platform:

> *Progressive, fair taxes ensure we have sufficient resources for all Ontarians to live equally in health and dignity with access to a decent income, affordable, good quality housing, clean air and water, and public health and education. Environmental taxes, such as carbon taxes, help both to achieve environmental objectives and strengthen public programs and services.* (Policy Platform 2010, RD12)

**Monitoring and Organizing Evidence**

When asked how RNAO identifies CEH issues of concern, participants described a formal and informal scanning and monitoring process that generates an extensive list of nursing and health issues of potential interest to RNAO. Although RNAO primarily focuses on influencing provincial policy, the participants indicated that events occurring at other systems levels have potential implications for the province of Ontario. Thus, their monitoring extends to national and international events as well. One participant stated, *"so RNAO has taken positions that I think represent national concerns, and in some ways present global concerns"* (Participant 26). For instance, participants described how RNAO monitors the government's response during the Copenhagen Climate Change Conference.

CEH issues are also brought to RNAO's attention by frontline nurses and members, BOD members, other nursing organizations, RNAO staff, other stakeholders with vested interests in CEH, government officials, and media personnel. In addition, networks, listservs, websites, news media, legislative happenings, and parliamentary events are routinely canvassed. Government departments responsible for environmental issues, as well as the environmental activity of corporations and industries are also monitored. One participant simply stated, *"well, I think it's fair to say that we just have a lot of feelers out there, if you will, with our link to members, our link to a variety of topic and project areas"* (Participant 33). Another stated:

> *And so we also monitor a lot of issues that relate to our political platform in terms of toxics, pesticides. And we really monitor, you know, what is happening in the environment, especially with politicians, MPPs at the provincial and federal level.* (Participant 20)

Deliberate monitoring means RNAO stays attuned of current and emerging community environmental issues. One participant recalled that the issue of pesticides came to the attention of RNAO through their frontline line staff. "*But we had nurses on the ground in municipalities already involved before RNAO was doing it. And then we learned from them"* (Participant 15). As explained by another participant, a member of the policy team *"was someone who is quite interested and aware of environmental issues" (Participant 21)*, who then kept the rest of the Association informed. Suggesting that RNAO is aware of emerging environmental concerns, another participant stated, "*I know if there's a nuclear reactor being built or ones that are being dismantled or if there's certain protests about the environment"*

(Participant 20).

Information gathered is organized according to RNAO's key policy priorities, referred to as *"policy pillars*" (Participant 15) in RNAO's policy platform. As described by one participant, the policy platform is developed through an iterative process that involves consultation with the BOD, home office staff, and RNAO members:

> *We [sic policy department] would collect up all the issues that have been brought forward. The staff would do this. All of the issues that had been brought forward by Board, by individual members, through our Chapters, through our Interest Groups. Our Interest Groups are very good at raising emerging issues. We would look at those. We would create a structure. Then staff would bring that initial document to the Board, which they did in September 2009…Well, we spent the better part of one full day actually going through that initial document, looking at what should be there, what was missing, what fit, what didn't. And then that goes away, all that feedback goes back to staff and is re-worked into the platform document*. (Participant 32)

The policy platform includes a list of overarching policy priorities, under which more detailed lists of specific policy issues or *"drill downs"* (Participant 15) are identified. CEH is one of six policy pillars. Thus, information related to CEH issues is collated and contrasted with other policy issues of interest that are represented in the policy platform. This information is then presented to the Board for consideration.

**Screening Policy Priorities**

Screening policy priorities requires judgment about whether a policy issue is of interest and relevant to RNAO and then judgment about the policy's order of importance. RNAO does not have formal explicit screening criteria to judge whether a policy issues is relevant to or to judge the order of importance of policy issues. As explained by a participant:

> *One thing that we could argue is that priority setting exercise is not necessarily substantively criteria-based. I mean I think everybody uses some criteria and there is some discussion on criteria. But there isn't like a well-established scoring system that as a Board, we can apply on an annual basis.* (Participant 27)

However, participant interviews and organizational documents suggest the choice and order of policy issues is guided by an implicit set of criteria. Implicit criteria are those not formally articulated by RNAO, but are understood to be the standards the decision-makers use to judge policy priorities. For example, RNAO's mission statement serves as the overarching filter for determining the relevance of a policy issue. As noted by a participant, "*the broadest screen is our mission, which is speaking out for health and speaking out for*

*nursing. So it's got to fall within that basket"* (Participant 32*).* Another participant indicated that RNAO's priorities are based "*fundamentally from our values*" (Participant 17). Thus, issues that are judged to have an influence on individual and population health, nursing practice, or the functioning of the health system are considered policy issues for which resources could be appropriately directed. Policy directions cannot be *"in conflict with the law or beyond the power of the Association*" (RNAO Bylaws 2009, RD53). Determining whether to take action on policy issues is also based on the state of the evidence as illustrated in the example of wind turbines:

> *Some people are concerned about the health effects of wind turbines, for instance. And they want us to campaign against that but [….] We agree with the Medical Officer of Health for Ontario that there is no proven health effects of any significance. And so we are not going to jump on that.* (Participant 17)

Policy priorities taken on by RNAO remain closely tied to nursing as a practice discipline, as explained by one participant, "*clinical nursing will always remain there in my view, the priority, because that's what people need"* (Participant 15).

Membership approval is another implicit criterion for policy issue selection. As noted by a participant, RNAO is "*not going to devote significant resources to something without that being more or less approved ultimately by membership"* (Participant 17). Another participant similarly noted, *"resolutions at RNAO are not advisory to the Board, they are binding on the Board*" (Participant 32). Therefore, as explained by one participant, "*often our priorities are nurses, whatever the situation is, because we want to make sure that we are either doing our best to either advocate on the issues and support nurses in their practice*" (Participant 20). This relevancy screening process supports RNAO's involvement in a number of health and nursing issues, which includes CEH.

The order in which CEH gets priority among the policy areas identified by RNAO is also guided by several implicit criteria. Priority is given to members' resolutions. One participant explained, "*the more direct, the higher up and the more directly it is linked to members, the more decisive it is. So I mean the AGM and the resolutions are the thing"* (Participant 16). Ordering of priorities is also determined by the perceived urgency and the potential impact. Government activity and media reports are used as a gauge to monitor the urgency of issues. One participant explained, *"if it's something that we need to address right away because of either a Bill that is being passed through the government or a decision that*

*is hot in the media that also determines how quickly we need to respond"* (Participant 24). An evaluation of government commitments further informs the order by which issues get attention, as explained by another participant, *"we measure actions by government according to what was in the previous platform, and what they [sic government] committed to, and what they may or may not have done since then"* (Participant 17). One participant indicated, *"if it doesn't have provincial implications then it is not as likely to be a high priority"* (Participant 17). Another participant reported, *"I would also say that they would prioritize based on health inequities. Probably the more impacting environmental concerns that impact more of a larger population"* (Participant 26).

An evaluation of the progress made by RNAO on past policy priorities also informs the attention given to issues. As explained by a participant we "*look at what we achieved on previous platform and where stretching boundaries; where to push boundaries next time and what else we want to push; some things continue*" (Participant 15). In some cases, progress means energy could be diverted to other CEH concerns. Using the example of toxins, one participant explained, *"toxics has been the big issue since the pesticide victory. That would be the number one issue"* (Participant 16). Evidence of progress will sometimes inspire more attention to a policy issue, as explained, *"we are looking first of all at our areas where we are already going strong, where you can leverage things further"* (Participant 16).

Resources are another criterion that determines the order in which CEH policy issues get attention. As explained by a participant, "*we don't have the time and the resources to go chasing after everything"* (Participant 17). Another participant similarly acknowledged that capacity factors into priority setting noting, *"there's like a million issues even in environment"* (Participant 16). Therefore, the degree of attention given to some issues fluctuates based on other criteria. For instance, dedicated staff commitment to CEH issues waned temporarily when a more pressing issue emerged. As described by a participant, *"we have relieved [name removed] to do this other piece on the economics of international recruitment"* (Participant 15).

Overall, participants indicated that alignment with RNAO's mission and values, membership directives, and evidence are key criteria that lead to the decision that CEH is an area of interest. A CEH issue gets more attention if it is endorsed by RNAO members through a resolution; there is a need, opportunity for action, and potential for impact; there is

urgency in taking action; there is evidence that action by RNAO is required; and when staff resources are available.

However, the participants further suggested that the current screening processes contribute to challenges for ordering policy issues. Participants noted the large volume of policy issues of interest to RNAO. For instance, one participant noted, *"anything that seems to be something that could affect health or be a determinant of health becomes something that is looked at from the policy standpoint"* (Participant 25). Other participants similarly suggested that at times, there are just too many issues to address, as exemplified by the following participant:

> *In fact, if there is a tiny criticism, is that sometimes we take on too much. And I don't mean that in any kind of negative way. It's just that there are any number of issues, and I think we probably accept these as a challenge as opposed to saying, you know what, that's not our issue. We are not going to do it. We examine whether or not it fits into our mission of speaking out for health. And if it does, if it meets that test then I would say in some shape or form, we've decided to act.* (Participant 21*)*

Another stated, *"we are all sort of over-worked. I mean maybe that is not the right word [….] everybody works hard. And so if we take on something else, it means that something else has to give. And so you have to be careful"* (Participant 16). Another participant cautioned that important issues could fall off the radar of RNAO when trying to juggle so many issues:

> *So the strength of our organization is that we are engaged in many different issues, and they interlock. And they have at their genesis maybe that globalization and neo-liberalism, all that kind of stuff. So I think that is a strength of our organization. But sometimes it can also be a weakness because we are really so busy all the time, and on different issues, that there is a danger sometimes that something that is important can fall off the radar.* (Participant 19)

**Adjudicating Policy Priorities**

The process for adjudicating policy priorities is guided by a Carver Model of Policy Governance©, which a participant stated, *"means we have a policy Board as opposed to one which involves itself in operations*" (Participant 17). RNAO's Policy Governance© articulates decision rules and responsibilities, in addition to what good the Association achieves, for whom, and under what cost. Under this Policy Governance© model, the BOD holds ultimate responsibility for establishing and monitoring 'ends' policies, which articulate RNAO's purpose and explain why the world is a better place because of their work. The ends

point RNAO in the direction to go (RNAO Board Orientation Manual 2010, RD52) and serve as the foundation upon which to select policy priorities.

The primary decision tasks for home office staff are to identify and prioritize specific policy issues falling under the policy pillars and to determine best approaches to address the priority areas chosen. These decisions are considered "operational" and are made by the Executive Director in consultation with senior management and policy analyst staff. More specifically, the Health and Nursing Policy Department provides *"leadership for the analysis of data and information, and monitoring of government policy and legislation*" (RNAO Board Manual Structure 2010, RD51). Staff with CEH expertise are responsible to research, synthesize, and propose key CEH issues of interest, which are then presented to the BOD.

In addition to the planned policy issues, the Executive Director (ED) is also given the latitude to make decisions about emerging issues that clearly align with the mission and fall under one of RNAO's policy pillars. 'Executive limitation' policies establish what activities the BOD finds unacceptable in pursuit of those policy goals (RNAO Board Orientation Manual RD52). If uncertainty exists, consultation with the BOD occurs at the discretion of the ED. A participant explained, *"if [sic the Executive Director] is okay with going in a certain direction, and she has to deal with the Board, she'll deal with the Board. But the rest of us can be quite focused"* (Participant 17). The participant further noted that this freedom means that RNAO can respond to emerging issues *"on a dime"* (Participant 17).

As part of the adjudication process, the 'ends' policies are monitored four times a year and then reviewed annually. A more in-depth review and development of strategic directions and refinement of priorities are undertaken every two to three years. This process corresponds with provincial elections and culminates in revisions of RNAO's policy platform. The final platform serves as a public representation of RNAO's key policy priorities and a "*challenge to Ontario's political parties*" (RNAO Policy Platform 2010, RD13) as politicians prepare for their next provincial election. Building sustainable green communities has remained one of RNAO's policy priorities for over four years. Clean green energy and climate change, toxics, cosmetic pesticide, and clean water are among the list of specific CEH issues (drill downs) of interest to RNAO (RNAO Policy Platform 2010, RD13).

### Summary of RNAO's Priority Setting

Priority setting processes entails an inclusive and iterative process that involves the governing body, home office staff, members, and other stakeholders. Canvassing sources specifically related to CEH keeps RNAO attuned to emerging and current CEH issues. While there is an absence of explicit criteria to judge the order of importance of policy priorities of interest, formal structures to organize and compare progress made by both the government and RNAO provide a gauge to determine RNAO's continued involvement on these issues. The BOD, home office staff, and members have complementary roles that support the identification and adjudication of policy priorities. Broad overarching goals and the latitude for the ED to make operational decisions provides RNAO with a flexibility and capacity to adjust the focus of their policy efforts based on shifting resources, opportunities, and urgency. However, with the number of issues undertaken by RNAO, there are times when staff and volunteers are over-taxed or times when resources are diverted from a CEH policy issue.

## Policy Advocacy for CEH by RNAO

Analysis of participant interviews and organizational documents indicated that RNAO engages in a range of strategies related to CEH that aim to build capacity and influence policy decisions directly. The rationales provided for the types of efforts taken and the supports and challenges encountered point to important influences that shape the actions taken by RNAO. The following section describes RNAO's policy advocacy for CEH. Table 5.2 provides a summary of advocacy strategies undertaken by RNAO related to CEH.

### Building Organizational Capacity

The participants reported that building organization capacity is a key strategy employed to influence all RNAO's policy work, including CEH. As explained by a participant, *"if you don't build the capacity to deliver then you will create huge frustration because you increase the expectations. You got to build at the same time the capacity to deliver"* (Participant 15). Analysis of participant interviews indicated that efforts taken to build organizational was not necessarily for the purpose of getting involved in any one-policy issue. Instead, efforts aimed to establish infrastructure and ways of working that then served as a prerequisite for involvement in various policy initiatives. Building organizational capacity includes tactics taken to nurture the Association's ability to conduct its business and

achieve its goals including taking a stand on organizational identity, developing a comprehensive strategic plan, and strengthening infrastructure to support policy work.

**Knowing and taking a stand on organizational identity.**

According to participants, building organizational capacity for policy work starts with a firm grounding on knowing who you are as an organization and taking a stand on that identity. This tactic was exemplified by a participant who stated, "*so I think the success of organizations is in large part built on knowing who you are as an organization and what do you stand for [….] Otherwise your identity changes every other day. And no one knows who you are"* (Participant 15).

Knowing and taking a stand about what RNAO stood for are essential ingredients for planning and successfully moving policy issues forward, including CEH. Participants consistently suggested that "knowing and taking a stand about you are" means RNAO does not stray from their values and purpose despite external pressures. One participant stated, "*I know just by who RNAO is and what it stands for that we wouldn't change our message if somebody didn't agree"* (Participant 21). Participants were confident that the focus of their overarching policy priorities, including CEH, would not change with shifts in government or ideologies. For instance, one participant stated:

> *But you can't change every year according to who is the government or what's their priority. We have our platform for four years. Tomorrow [sic name removed of politician one] can get elected instead of [sic name removed of politician two]. Right. [sic name removed ] will have probably totally different priorities. We're not going to change that we don't want tax cuts because [sic name removed of politician one] loves tax cuts. We're going to continue to say no tax cuts. We're going to continue to think poverty, environment, etcetera.* (Participant 15)

Another participant emphasized that RNAO's overarching core policy priorities derive from the Association's mandate and are represented in the policy platform, which makes them resilient to external shifts. As explained by a participant:

> *Our mandate is what our mandate is. I mean a new government might wish to introduce a new something but we would assess that new something in our degree of support or opposition based on our existing platform. We would look at it within the values and the principles and the position statements of the organization. Do we change the colour of our cloth because the colour of the ruling party changes? Absolutely not.* (Participant 32)

This resilience was further emphasized by another participant who was confident that changes in organizational leadership in either home office or the Board of Directors would not even distract RNAO from their focus. As the participant explained, *"I mean people [sic Board Directors] keep changing every two to four years [….] But I am actually completely confident today that it would remain because it is in the fabric of the organization at all levels"* (Participant 15).

**Comprehensive strategic planning.**

Participants indicated that organizational capacity to engage in CEH requires a comprehensive strategic plan that is flexible and responsive to a changing policy context, but always keeps a broader vision in mind. This means overall strategic directions or core policy goals do not change. Instead, RNAO is responsive to specific policy issues (drill downs). As explained by a participant:

> *There are certain priorities that are set for the year based on our AGM resolutions. But as an organization, we are also very flexible in that if there are external events that happen which bring up issues that are important to our members and need to be addressed, we are also flexible enough to be able to look at them and make them a priority at that time as well.* (Participant 24)

Participants emphasized that planning CEH policy work is not done is isolation. Priorities are established from a broader vision that sees the interdependencies among issues. As explained by a participant it is "*The entire comprehensive social and environmental and health care grouping that really enable us to deliver what the public needs from us"* (Participant 15). Another participant further explained that:

> *With everything at RNAO, there are always parallel tracks [….] You don't just pick one issue and work on it, and then when that issue is done, you work on another issue. A lot of these are being done at the same time. So different people are assigned, and outcomes or the final piece may get resolved a year or two down the road.* (Participant 21)

A participant shared that the *"Board as a whole understands the importance of addressing nursing in every aspect"* (Participant 15).

**Attracting the right people.**

Participants reported that building capacity includes attracting, engaging, and supporting BOD, home office staff, and members. Recruiting new members is a key tactic employed by RNAO and is articulated as part of an ends policy: "*RNAO inspires every RN*

*and undergraduate nursing student to be a member [….] RNAO increases the number of individuals participating as Friends of RNAO"*(RNAO Board Orientation Manual 2010 End 5, RD51).

In addition to increasing their numbers, deliberate attempts are made to attract members and to hire staff who are armed with the values, passion, knowledge, and skills that align with RNAO's vision and purpose. For instance, a participant stated, *"so the type of people we are trying to get to the Board is people that actually care deeply about one or other or all of those aspects. And more and more people that care about all the broad range of what nursing is"* (Participant 15). Referring to the types of individuals hired by RNAO, the participant went on to say, *"we look for people that actually bring with them that passion and knowledge and we give the space and forum to flourish and make us flourish in the process"* (Participant 15).

**Strengthening infrastructure.**

Building organizational capacity also includes the establishment of infrastructure to support communication and opportunities for policy work. In addition to committees, journals, newletters, and websites, RNAO established network and workplace structures[15] specifically designed to provide a means to keep members informed, to provide member access to expertise, mentoring, and training, to promote the participation of members in policy work, to coordinate activities across membership, directors, and staff, and to enable equitable distribution of work, as described by the following participant:

> *We moved to a new structure where what we wanted was to revitalize the Chapters and region by default. Spread the burden and responsibility of activity from one person the president or chair to more [….] be able to train people in the ground. So we created the structure that mirrored home office [….] Executive Networks. And it is voluntary but everybody has it now. It's not even in the by-laws. And everybody has it so that tells you the success of the structure right [….] And then there is another structure that is the Workplace Liaison Structure, which the goal is to have at least one, or ideally more, workplace representatives in every workplace.* (Participant 15)

Another participant indicated that these structures provide a means for RNAO to *"bring all that knowledge together as a group and be able to discuss as an organization what is important for nurses and what is important for healthcare"* (Participant 24). These networking structures also result in a cadre of nurses who are expected to participate in

[15] Note these structures include executive networks and workplace liaison workers

action taken by RNAO. As a participant explained, *"certainly each representative in the region that is a political action role would be expected to act on any environmental policy alert"* (Participant 28).

**Building Social Capital**

A second strategy related to RNAO's CEH policy work is building social capital through a set of relational and communication efforts. These aim to enhance and sustain RNAO as a valued player in CEH policy dialogues and decision-making by fostering relationships, establishing relevance, and protecting its reputation.

**Fostering relationships.**

Analysis of participant interviews indicated that efforts taken to foster relationships are not necessarily for the purpose of getting involved in any one-policy issue. Instead, efforts aim to sustain and enhance trusting and supportive relationships that then serve as prerequisite for involvement in various policy initiatives, including CEH. Efforts are taken to foster relationships with members and government officials and include being responsive to needs and exploiting conflict.

A focus of RNAO's relational work is attending to membership requests and balancing investment across the range of nursing concerns. As explained by one participant, members need to understand the policy choices taken by RNAO and feel that their needs are also served:

> *Because they may have joined the Association, which is completely voluntary, because they are interested in having nursing issues upheld. And so they may not see the environment or agree that the environment is the priority that we see it as. So you take the time to make sure that you address those concerns. That doesn't mean you shy away. What you do is you make sure that you also spend time on the nursing pieces.* (Participant 21)

Providing the rationale for priority choices is essential to sustaining confidence and support among nurses who may not agree with RNAO's policy choice to address CEH. As a participant explained, *"the members have a vested interest in knowing why we are spending time on the environment because they are saying, well, what have you done for me lately on the nursing front"* (Participant 21)? The participant went on to say:

> *We have to do two things. Number one, we have to educate them about why we are doing this. And it is a very valid question that they are asking us. And we have to take the time to answer and explain so that they do understand.* (Participant 21)

Participants indicated that RNAO has established a long-standing close and respectful working relationship with government officials in Ontario. One participant noted:

> *I think they [sic politicians] regard RNAO quite highly in that there's a lot of visibility at our AGMs. Our Premier attends our AGMs every year. And politicians from the other opposition parties also have attended in previous years as well.* (Participant 24)

Thus, relational and communication work with government officials is intended to maintain RNAO's position as a valued player in policy discussions of broad healthy public policy issues including CEH. Maintaining this position requires regular communication with government officials of all parties. As described by a participant, *"we maintain a very active government relations program. So we are in contact with our provincial government both in power and in opposition on a regular basis. Our policy department is very active in that"* (Participant 32). Participants further indicated that RNAO responds to government needs and requests, which they believe would be reciprocated. For instance, RNAO responded to government requests for assistance during H1N1, as well as to requests to speak to some Bills before the legislature.

Maintaining a multi-partisan or non-partisan position is also essential to sustaining government relationships. A participant explained, *"we are not for a particular party. It's really issue-oriented. And they know too, the politicians"* (Participant 29). In addition, fostering relationships is managed through inclusivity whereby government officials have an opportunity to participate and contribute in meaningful ways. For example, RNAO's strategic positions are formulated through a thorough consultative process involving a range of stakeholders, which includes politicians.

Exploiting conflict with policy decision-makers is another tactic related to fostering relationships. Participants recognized the inevitability of conflict when dealing with policy, particularly highly charged and controversial issues such as CEH. There was wide spread agreement among participants that RNAO is deliberate in exploiting conflict to bring attention to policy issues. A participant explained:

> *The best time to put your organization in the forefront of healthy public policy is when you have an adversary [….] It is much easier to gain profile when you are fighting with someone than when half of the time you are in agreement with someone.* (Participant 15)

The participant went on to say, *"for some of these issues you can do it friendly. For some*

*others you need to be confrontational you need to be out there"* (Participant 15). Another participant concurred, suggesting that overt conflict rather than private discussion is often required to effectively gain attention for some issues: "*If you perceive relationship as only rocking the boat in private then you don't get to the same place that you are going to get to if you are prepared to rock the boat in public*" (Participant 32). Another participant suggested that exploiting conflict not only generates attention for policy issues, but sets a tone for and the type of people that would join and work for the Association: *"If you are averse about being out there at the edge of some of these issues then that is the way you will lead the operations. And that's the type of people you will get"* (Participant 15).

**Establishing relevance.**

Establishing relevance as a knowledgeable and key player for community health issues is a second tactic to build social capital that was employed by RNAO. Spotlighting what nurses know and underscoring their motivations for engaging in CEH are primary efforts to build their relevance as valuable contributors to CEH policy discussions.

There was widespread agreement among participants that RNAO had gained credibility from its past work in CEH. Others suggested that because RNAO is a nursing organization, there is "*built-in credibility"* (Participant 25). As explained by a participant, *"the fact that the name of the organization says Registered Nurses would probably confer credibility because everybody respects that profession [….] So by representing this profession, it makes it a bit easier to have credibility*" (Participant 25). However, one participant suggested, *"it would be a mistake for us to take that for granted. We have to keep earning the respect and the credibility*" (Participant 17). Others suggested that the contributions that nurses and RNAO can make to CEH policy are not always apparent to political leaders or the public. As explained by one participant, *"people often don't understand why nurses are engaging in environment issues [….] and often (sic politicians) don't see the full perspective about what nurses do"* (Participant 20).

Therefore, addressing the potential knowledge gaps by spotlighting what nurses know and do is seen as a key tactic to enhance credibility. As explained by participants, stakeholders need to see the relevance of nursing in policy discussions. Emphasizing what nurses know is particularly important for enhancing opportunities to participate in policy issues such as CEH. This was emphasized by a participant who stated, "*but we need to*

*continue to focus on the whole issue of nurses as knowledge professionals, and that we bring knowledge and skill to the work that we do every day"* (Participant 23). Attention is drawn to nurses' valuable scientific and experiential knowledge and expertise, which can lead to CEH policy discussions. For example, intimate knowledge gained from nurses' frontline experiences is touted as an important piece of evidence that needs to become integrated into policy decisions. As explained by one participant:

> *We do say that as nurses, we see every day the impact of climate change. Whether it's the increase in the kids who have asthma and so on. But we see that in our everyday practice. And it's what we see in everyday practice, it's those stories we want to bring to you.* (Participant 17)

RNAO also draws attention to the successful contributions made by the profession for issues such as pesticides, toxins, green energy, climate change, and environmental hazards as a way to enhance awareness about the value added by their nursing presence. RNAO further underscores the contributions already made by nursing associations from across the globe that operate at different levels of the political system. For instance, the CEH work undertaken by the Canadian Nurses Association (CNA), International Council of Nurses (ICN), and nursing organizations in the United States are frequently cited in policy briefs and letters to government officials (e.g., Position Statement RD06).

RNAO's efforts to underscore their relevance in policy decisions include the articulation of the Association's motives for involvement for CEH. Participants suggested that stakeholders needed to understand the reasons why RNAO would be interested in CEH and to be assured that the Association's work was not self-serving: "*Then also as being seen as an organization that is not self-serving, that does not acquiesce to a certain group in society, and can have an impact on the political system"* (Participant 33). Another participant further explained, "*we have no gain. We have no financial gain from this. We don't have an agenda other than health. So I think we are really well positioned"* (Participant 30). Articulating the links between environmental conditions, health, and the role for nursing also helps stakeholders to see RNAO's motives for involvement. Making that link is a key tactic:

> *I think we do to the extent that we ground it in how you get to that issue. So if we start off as an economic issue then yes, it is true, we sometimes get that quizzical look. "But you guys are nurses. Why are you lecturing us on economics?" But again, if we start with as nurses, we see the impact of the coal plants on the increased number of kids with asthma. The question is what are we going to do about it? Here are some ideas*

> *that we think you should consider. And work from there up to the carbon tax.* (Participant 17)

While underscoring evidence that links poor environmental conditions to poor health is an important tactic used by RNAO, the Association also speaks to evidence for which the human health impacts from environmental degradation are still not well understood. RNAO operates from the precautionary principle. For instance, despite the absence of conclusive evidence, RNAO spoke to pollution, as exemplified in the following excerpt from their policy platform:

> *Given the seriousness of consequences of environmental pollution, it is essential that we take a precautionary approach to protecting human health and the environment. When an activity threatens harm to human or environmental health, precautionary measures must be taken even if a conclusive cause and effect relationship has not been fully established scientifically. (RD13 Policy Platform)*

**Protecting reputation.**

Protecting their reputation as a knowledgeable and trustworthy source is a third key approach to build social capital. Participants indicated that RNAO established a reputation through their role in advancing Ontario's municipal and provincial pesticide legislations:

> *I think RNAO [….] in the pesticide ban, gained a lot of credibility as an organization that would go to bat for something that was in a way targeting big business where people said there is absolutely no way there would be any change made here. Like this is a done deal.* (Participant 33)

Ensuring RNAO's claims are founded on current and trustworthy evidence was consistently identified as a key tactic to sustain this reputation. A participant stated:

> *We know we are responsible for solid research. And whenever we appear before legislative committees at Queens Park, invariably we will hear, "Well, thank you very much for your very thorough and detailed analysis." And that is because RNAO for some time now in fact has had a reputation [….] They may not agree with the arguments but at least they know that the effort and the research and the thought that went into those arguments. And that is important because the last thing you want to be known as is somebody who is out there all the time but can't be relied upon to provide correct and research that would stand up.* (Participant 21)

Equally important is ensuring the claims made by the Association are within the nursing domain. As explained by a participant:

> *As long as we stay within our domain and knowledge, I think we have a high degree of credibility [….] we should not be out there doing basic scientific research and*

> *advocating for the adoption of that basic scientific research. What we should be doing is seeing the conclusions of that basic scientific research, summarizing what that means from a policy direction and what it might mean to nurses in their practice.* (Participant 27)

According to another participant, RNAO is able to maintain an image of being reliable and dependable because *"we deliver on what we say we are going to do"* (Participant 16).

**Inspiring a Mass of Support for CEH Issues**

A third strategy taken by RNAO to influence CEH policy is inspiring a mass of support. Participants believed that changing political will and enlisting a foundation of supporters who worked in many geographic settings and jurisdictional levels are essential to shaping CEH policies. Tactics for inspiring a mass of supporters include conducting broad based awareness campaigns and creating opportunities for individual and collective action. The following section describes these tactics.

**Raising awareness.**

Part of RNAO's policy efforts is dedicated to raising awareness. Gaining buy in is critical, as described by a participant, "*you've got to sell it to both your members and to the public"* (Participant 21). Another stated:

> *So if we give nurses who work in the community and/or the public increased knowledge, knowledge can only be a good thing. So give them knowledge about issues. Give them a voice to that knowledge. That can change political will. That can change community will.* (Participant 28)

Press releases, position statements, background papers, policy briefs, and the Association's political platform publically communicate RNAO's position on green energy, climate change, pesticides, toxic chemicals, and clean water. In addition, information is shared through RNAO's journal, newsletters, and website. Through these venues, members, nurses, the public, nursing organizations and government decision makers are provided with information about the role of nursing in CEH, the types of efforts that can be taken as citizens or as professionals, and the types of policy alternatives necessary to address CEH threats and promote healthful behaviours. For instance, one participant stated, "*we would also try to inspire the membership as to which are the important issues. And hopefully that we are able to guide the membership in thinking that oh, these are the important issues"* (Participant 29). Another stated:

> *That is why we put together the political platform, to state our case to the policy decision-makers but also to educate nurses. But we wouldn't expect nurses to be able to come up with that information themselves. That is why we feed them. But then we expect them to take our information, in whatever way possible for them to incorporate it into their work and to advocate to the Ministry themselves for change, for environmental change.* (Participant 26)

Presenting information in a way that facilitated uptake was also important for creating awareness. One participant explained:

> *I think they have to play a supportive role in more of a general role in bringing to light some of the evidence that is around the research around the impacts that what we are doing to our environment or having on our health. And put it within that context so the people can understand that many of the factors that are occurring to our environment do have an impact on health.* (Participant 27)

RNAO deliberately engaged the media as a way to draw attention to their positions and actions. Sending media advisories and participating in press conferences is also a way to publically communicate nurses' position and the actions RNAO was taking on behalf of nurses. As explained by a participant, *"the other part is hearing our name in media and hearing that the nurses are taking this particular position on this issue"* (Participant 22).

RNAO also aims to enhance understanding and interest about the political process as a way to increase mobilization for political action. For instance, politicians were invited to speak to nursing students, as described by one participant:

> *[sic RNAO]organized a provincial candidate session where university students could come and hear their provincial candidate come and speak about the issues. So we did have four different politicians come. And we asked them questions based on environmental policy, social determinants of health. And there were questions from the audience. So we make sure that they get to hear it. And we try to really engage them and invite them, and say you know what, there is an election coming up. You might want to go speak to your politician about these issues.* (Participant 20)

**Creating opportunities for action.**

In order to inspire efforts for CEH, RNAO creates opportunities for individual and collective action. Creating tools to assist with political activities supports individual efforts. As a participant explained, part of RNAO's role was *"giving tools so people can have something to do"* (Participant 25). Another participant further explained that RNAO gives:

> *…the tools to help in those interventions. So if the tools are political savvy tools. So knowing how to speak to a politician, knowing how to speak to a company that develops or designs products that are hazardous to the environment, knowing how to*

> *speak to their co-worker about what the issue is and what the impact could be. So some of the tools around bringing their voice to the issue.* (Participant 28)

RNAO staff are available to assist members and nurses with their CEH efforts. For instance, one participant described how a member was assisted to develop a resolution related to pesticide legislation. *"So we chatted with a couple of members. And [name removed], and I even helped her draft a resolution. And [name of staff removed] gave some backgrounder"* (Participant 15). Another participant described the evidence that was provided to members, stating *"[sic when members] work through RNAO, they get a lot of research to support their arguments if they need it*" (Participant 20).

Efforts further aim to unite nurses for mass mobilization by creating infrastructure that allows members to act as a collective. For instance, RNAO prepares action alerts[16] and organizes lobbying events (e.g., Queen's Park Day[17]).

**Lending Support to and Leading Policy Change in Partnership with Others**

A fourth strategy taken by RNAO is lending support to or leading policy change in partnership with others. Participants suggested that participation in CEH inevitably requires RNAO to work with stakeholders from outside of nursing and health and with stakeholders from various jurisdictions and geographic locations. In order to work collaboratively, RNAO joins allies, engages in stakeholder analysis, and deliberately selects the roles they will play as either lending support to or leading components of CEH initiatives.

**Joining allies.**

Joining with allies was viewed as an essential step for engaging in CEH initiatives. Allies for CEH include players from various government departments, geographic regions, and levels of polity that included government officials, advocacy and environmental groups, coalitions and organizations, industry, and other professionals and their Associations. For instance, a participant stated:

> *RNAO will join the ranks of other efforts on policy issues like the environment. The same thing with the pesticide legislation that went though Ontario. RNAO was a stakeholder who collaborated with other stakeholders, I think including [name removed of provincial environmental advocacy organization].* (Participant 30)

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[16] Note: Action alerts are messages that are sent out to members and their supporters asking for a specific action to be taken on a current political issue.

[17] Note: Queens Park Day is an annual event where upward of two hundred nurses and political leaders meet to discuss policy issues of concern to nurses.

Participants indicated that relationships established from earlier policy initiatives are often sustained, with people continuing to work in consecutive CEH campaigns. For instance, one participant stated, "*a lot of the very same partners that we had on pesticides are working on toxics right now" (Participant 16).* The participant went on to explain, "*so when you are rolling over, you are sort of leveraging the material you developed in one campaign for other campaigns"* (Participant 16).

Participants suggested that working together has reciprocal benefits. As summarized by one participant, *"you lend your voice but also you get voice. You know what I mean. It's like power. You give and you get"* (Participant 15). Partnership approaches are used to share expertise and knowledge and to pool resources for more intense advocacy efforts. For instance, one participant described the various roles players assumed while campaigning for pesticide legislation:

> *And there was a large coalition of groups that were around there. So they were the ones who would usually initiate listservs and send around messages. They would keep track of meetings. They would take notes and the minutes and do follow-up, and so forth. And we would be there to participate in discussions and shape documents, review documents. And then each organization would sign onto a document and take whatever actions were necessary*. (Participant 16)

The participant further explained that combining various strengths and expertise creates a synergy that allows a greater push for policy initiatives:

> *It means that people with technical expertise in a particular area can combine with the people who are determined to push on a particular area. So you want to cover off all bases. And even with people who are, like say the [name removed of national environmental legal organization], they go through and dot every "i" and cross every "t". Sometimes we are able to push a little bit further on certain areas. But there is a really nice synergy that goes on because each organization brings its own expertise and its own strengths, and they play a certain role*. (Participant 16)

Participants believed collaborations account for successes in securing legislations. For instance, referring to the collaborative efforts undertaken for pesticides, a participant stated, *"they did a very targeted lobbying of politicians to get that legislation through"* (Participant 30). Advocacy efforts from the coalition contributed to the passing of Bill 64, which was provincial legislation banning the use and sale of pesticides for cosmetic purposes (RNAO Journal January/February 2011, RD54). Successful advocacy efforts were also apparent with the announcement of the closure of four coal-fired generating units (RNAO Journal

January/February 2011, RD54).

**Stakeholder analysis.**

Participants described how stakeholder analysis assists with decisions about the most appropriate partners that can help advance RNAO's CEH policy positions. Aligning with groups that held similar beliefs and used similar approaches is a strategic effort, as explained by one participant:

> *I think the credibility comes in what we state is based on evidence, isn't radical, lots of science behind it. And we will have other groups, health coalitions that agree with it as well. So other credible organizations partnered with us or we're partnered with them, however you see that.* (Participant 28)

The participant went on to note that RNAO does not join with players viewed to be more radical in their approaches:

> *And that we don't go on radical actions; that we don't try a radical strategy I think helps the credibility. If you try to outlie your strategy in some instances, you then become seen as an outlier.* (Participant 28)

Adjudicating whether RNAO would join or lead policy community environmental initiatives is an essential part of stakeholder analysis. As explained by a participant, RNAO needs to:

> *…decide which of those drill down areas will the organization lead versus which those areas the organization will join forces with others and let others lead, and which issues the organization will simply lend the name. Because that in itself could be helpful.* (Participant 15)

Participants reported that most often RNAO joins CEH initiatives led by other stakeholders. This included RNAO's participation in coalitions, government advisory groups, action committees, and commissions.

Although RNAO most often joins initiatives led by others, participants reported it is not uncommon for RNAO to assume a lead role for components of CEH initiatives. Some participants suggested that RNAO's choice for taking a lead role in policy initiatives is reserved for issues that are judged to have a direct impact on nursing practice, that are not already addressed by others, or that might otherwise be left unattended. As explained by a participant, "*if we don't drive them they will not happen"* (Participant 15). Another participant stated, without RNAO, groups may "*not be as successful. Why? Because not only do we lend the public trust that nurses have, but also we lend a lot of political acumen*

*because we have good relationships with the Premier"* (Participant 15). The participant went on to state:

> *So our key role, for example, and the fight for pesticides or toxics etcetera is not only to mobilize nurses behind the movement but to go with the movement, in that directly we have been able to open the doors at the Premier's Office to listen.* (Participant 15)

It is also not uncommon for RNAO to receive requests to take lead positions. One participant explained, *"a lot of the stuff is brought to us in part because we are known to be the go-to people for particular issues"* (Participant 16). The participant further stated, *"but it's because of that toughness and that commitment and the willingness to really push the envelope that the organizations seek you out"* (Participant 16). In some cases, RNAO is able to push where other organizations cannot. For instance, one participant stated, *"so we have to play a little bit tougher roles. The [name removed of Canadian health society] can't be as upfront or adversarial as we can. [name removed of Canadian government health agency] has to be even more removed from the action"* (Participant 16). Another participant stated that RNAO is approached to join groups as they bring credibility to positions taken. The participant explained, *"when the cosmetic pesticide legislation was first introduced as an idea, we were approached by [name removed of Canadian environmental advocacy organization]. And oddly enough, they said that if we were at the media conference with them, there would be more credibility"* (Participant 21). RNAO contributes their expertise to other environmental organizations and coalitions outside the profession of nursing. For instance, RNAO accepted an invitation *"by the [name removed of Canadian environmental advocacy group] and the Ontario [name removed of Canadian climate change advocacy organization] to talk about how important it was that the government not slow down its agenda"* (Participant 21).

**Exercising Political Acumen**

A fifth strategy used by RNAO is exercising political acumen, which entails the use of political skill to secure a nursing voice in CEH policy decisions. Exercising political acumen includes understanding the landscape and being opportunistic, understanding power dynamics, and framing and positioning key messages.

**Understanding the landscape and being opportunistic.**

Assessing the political**,** economic, socio-cultural, ecological and professional realities and determining the most appropriate targets, approaches, and forums for action is a political

skill employed by RNAO. There was widespread agreement among participants that RNAO has a high degree of political savvy. As a participant noted, "*RNAO continues to perfect but has been doing quite well for at least the last 10 to15 years. And that is understanding the political process"* (Participant 21).

Participants indicated that when political officials or the public are not receptive or when demands exceed organizational capacity, adjustments are made to the strategies used, the target for change (e.g., public or government), and to the timing and intensity of the efforts. As a participant noted, issues are not abandoned but rather, *"it varies both the where-how we engage, more than if we get engaged"* (Participant 15). One participant noted that lack of support by the government for CEH issues often signals RNAO to intensify efforts and redirect their target. "*At the federal level, we have a government that is completely unreceptive on environmental health issues. I mean we still advocate there, not with the expectation of changing their views but influencing the broader public debate"* (Participant 16). Another participant concurred, stating, "*I think if there are clearly political parties that get elected where there isn't a strong bent towards environmental health, we would be much heavier advocating for those organizations. And particularly if their direction is very negative towards environmental health*" (Participant 27).

Being opportunistic also means anticipating events and potential actions. For instance, one participant stated, "*there is legislation coming down in the fall concerning water. And so we are already aware of it and getting primed for it"* (Participant 21). Referring to RNAO's policy platform, another recalled, "*we started because we wanted it at least a year ahead of the elections. We had it out eighteen months ahead"* (Participant 15).

**Understanding power dynamics.**

Part of RNAO's political savvy included understanding power dynamics. RNAO weighed risks and benefits and negotiated policy positions with senior level government administrators. Participants frequently referred to the political clout RNAO has build with senior politicians, who are interested in engaging the Association on important matters related to health such as CEH. For instance, one participant described a meeting requested by a government official from the Green Party to discuss RNAO's political platform. Another participant spoke to the respect given to RNAO by senior government officials who routinely attends RNAO's AGMs:

> *And the fact that [name ED removed] often talks to the Premier, and the Premier comes to our AGMs. And actually, all of the political parties came to our AGM. One of the party leaders didn't come but he had [....] I could say it was a tough call for him because he had another function the same day. But in general, they tend to come and address the AGM. So I think that is pretty impressive.* (Participant 25)

Another participant explained that RNAO has established a political presence that politicians monitored. One participant stated:

> *In fact, it's almost humorous, I always run into someone [….] and he works in the Premier's office. And his job is to go to our media conferences and then get a copy of what we've said so that they know what we're saying.* (Participant 21)

While RNAO has a history of using confrontational approaches to move policy issues, the current sense from participants was that this is no longer necessary for CEH in light of the current effective working relationship that exists between senior government officials and RNAO. Recalling past events, a participant explained RNAO "*went for it, to take 600 nurses and seniors to the street [….] My god we got profile and it was fighting [name removed of politician]. Today [sic RNAO] couldn't take nurses to the street to fight [name removed of politician]"* (Participant 15).

**Framing and positioning key messages.**

Participants suggested that the way issues are framed and the types of evidence used have important implications for the degree of support an issue will receive. CEH issues are framed to underscore their relevance and enhance their visibility. The deliberate choice to separate environmental health from the rest of the social determinants of health is an example of this tactic. According to a participant, *"if you don't segment it out or single it out or whatever they can ignore it even more"* (Participant 15). Care is taken to ensure that the positions taken and the evidence presented are clear and user-friendly. For example, RNAO's 2010 policy platform was re-organized to encourage decision-makers to read it. The same criteria applied when preparing information and tools for members, as illustrated by the following participant's description about action alerts:

> *You've got a very simple message in your email, something that is easy to process and it's something that is easy for the person to get behind. So you want a message that an ultimate health professional can run with fairly easily. They can be very confident of this so you have to keep the issues pretty high level. And so what we found was that a more detailed message might get 100 messages. If we can get something that is a little bit easier to process, maybe 300.* (Participant 16)

RNAO adopted the economic parlance common to CEH policy that allows them to effectively engage in policy deliberations. Drawing attention to economic implications is particularly evident in RNAO's organizational documents, as exemplified in the excerpt taken from RNAO's policy platform:

> *Progressive, fair taxes ensure we have sufficient resources for all Ontarians to live equally in health and dignity with access to a decent income, affordable, good quality housing, clean air and water, and public health and education. Environmental taxes, such as carbon taxes, help both to achieve environmental objectives and strengthen public programs and services.* (RNAO Policy Platform 2010, RD12)

**Pushing Policy Positions**

A sixth strategy taken by RNAO is pushing policy positions that aim to get a CEH issue on the government's radar and agenda, or to change or strengthen existing policy. Tactics described for pushing policy positions include lobbying, holding government accountable, and investing long term to a CEH policy issue.

**Independent and collective lobbying.**

RNAO engages in direct lobbying by meeting or writing senior government officials or their staff, by testifying at political hearings, and by signing petitions. This was exemplified by a participant: *"For instance, what we will do throughout the year is make sure that we raise this issue with different MPPs who are handling the environmental portfolio. We'll write letters"* (Participant 20).

Lobbying also includes collective efforts. Participants suggested that RNAO's power multiplied when nurses are united, as noted by the following participant who stated, *"when politicians and decision-makers recognize that you can mobilize hundreds and thousands of people in 24 hours to respond to an issue that gives you credibility with those decision-makers"* (Participant 32). Collective efforts include mass e-mails (e.g., action alerts) to emphasize the seriousness of a CEH concern and to force discussion about a policy issue. In addition, collective lobbying includes participation in organized face-to-face events at the legislature. For instance, "*Queen's Park Day"* is an annual event that engages senior government official with hundred of nurses. As described by a participant, *"we take the two hundred nurses to Queen's Park in January they all go with briefing notes that they leave with the Minister and MPPs"* (Participant 15). Part of RNAO's recent Queen's Park Day events (January 2010) included a presentation of the Association's concerns and requests to

government related to CEH. Participants believed that RNAO is successful in its lobbying efforts. For instance, *"RNAO was singled out for its role in advocating for change"* (RD54) by a government official as part of the announcement of the closure of four coal-fired generating units by 2014.

On rare occasions RNAO engages in peaceful demonstrations. During these times RNAO takes time to speak to broad policy concerns, which the Association believed had implications for all their inter-related health and nursing concerns, including CEH. For instance, a participant reported action taken by RNAO during a recent political event. *"Yeah the G8 and G20 we did this small group because of the [sic police] brutality that was"* (Participant 15).

**Holding government accountable.**

Pushing policy positions includes establishing and articulating minimum expectations for government. RNAO closely monitored legislative activity related to CEH and held government officials accountable to their promises. As explained by a participant, during a press conference called by RNAO, the government was reminded of their promises made and action that still needed to be taken:

> *That was when we said you've promised to introduce this legislation. Not only should you keep your promise, but here is what we want you to do because this is what the legislation should look like. Because we wanted to make sure that it wasn't watered down and gave industry cart blanche to create chemicals that were going to be just as nasty as the stuff that they had already created. So we wanted to make sure that the law had teeth. And that is why that press conference took place.* (Participant 21)

**Invested for the long term.**

Pushing policy positions also requires long-term commitment to policy issues. While the degree of efforts varies over the years, CEH appears as an active area of action in RNAO's policy platforms. Referring to the policy platform, one participant stated, *"There was a huge chunk devoted to the environment"* (Participant 21) in RNAO's policy platforms. Participants emphasized that the withdrawal of RNAO efforts only occurs once a policy issue is resolved. For instance, a resolution related to banning the use of cosmetic pesticides was first endorsed in 2000. Since that time RNAO has consistently advocated for legislation at the municipal and provincial level. The importance of remaining committed to a policy issues was reflected by a participant who stated:

> *So I think that's tremendously important for nursing organizations to understand that it doesn't happen overnight [….] it grows if you stick with it. The issue is you also need to stick with it right. Like you need to be persistent and consistent and do it continuously. You cannot just say we will work today on pesticides and then do nothing on environmental health issues for the next five years. And that happens in organizations.* (Participant 15)

In some cases achieving a policy goal was not an end point for RNAO. For instance, once provincial pesticide legislation had been secured in 2008, RNAO raised the bar in terms of their expectation of government. This was noted in a letter addressed to government following the announcement of provincial pesticide legislation:

> *RNAO urges that Cabinet proceed with the regulations so that Bill 64 on cosmetic pesticides will come into full force and be implemented in the spring of 2009. The draft pesticide regulations take a very important step in the right direction, and we recommend below points to make the regulations even more effective at protecting the health of [sic population][….]requiring specific percentage reductions in toxic pesticide use on golf courses and specialty turf, with a deadline for stopping all pesticide use in those settings. (Letter to Government Official RD08)*

**RNAO's Overall Pattern of Engagement for CEH**

The attention given to CEH issues by the RNAO can be described as proactive and consistent. Formal involvement with CEH issues by RNAO was traced to a resolution concerning the use of cosmetic pesticides first proposed in 2000. The resolution directed RNAO to support local chapters in their efforts to secure municipal by-laws through the development of resource packages and to lobby for provincial legislation banning the use of pesticides. For the last decade, advocating for pesticide legislation has remained a priority area for RNAO. A sustained commitment to CEH issues is evident in the release of RNAO's 2007 provincial policy platform that articulates environment and human health as one of six policy pillars. Building sustainable green communities remains one of six main priority areas in RNAO's 2010 provincial policy platform, with ongoing attention given to clean green energy and climate change, toxics, cosmetic pesticide use, and clean water (Platform, 2010 RD13). Several background papers, position statements, technical papers, policy briefs, and resources continue to support both nurses and other stakeholders in their efforts to advocate for CEH issues.

## Case 3: Association of Newfoundland and Labrador

### Introducing the Association of Newfoundland and Labrador (ARNNL)

Founded in 1916, ARNNL is located in the capital city of St. Johns, Newfoundland and Labrador (collectively referred to as Newfoundland). Since 1953, ARNNL has served as the provincial regulatory body and professional Nursing Association for nurses and nurse practitioners in the province. ARNNL is a long time jurisdictional member of Canada's national body, the Canadian Nurses Association (CNA).

In the following case study I provide an overview of ARNNL's organizational attributes. I describe the Association's priority setting processes and policy advocacy related to CEH. The supports and challenges that influence the way ARNNL sets priorities and takes action for CEH are described within these sections.

### Organizational Attributes

#### Regulatory-Driven Mandate

ARNNL has the legal authority to exist and carry out its business under the provinces Registered Nurses Act (Queen's Printer, St. John's, Newfoundland and Labrador, 2010). Incorporation under this Act grants ARNNL the duty to self-regulate practicing nurses and nurse practitioners in the province. As a self-regulating body, ARNNL is required to develop regulations that define delegated specialized regulatory powers including the licensing, educational requirements and competencies, and practice. Final authority for these regulations rests with the Ministry. The Act further lays out the disciplinary procedures for the nursing profession in the province (Queen's Printer, 2008). The Act requires the Minister to define the composition, selection, and functions of Council Members, who are accountable for the ARNNL's activity. Final authority for implementing ARNNL's By-Laws rests with Council (Association of Newfoundland and Labrador, 2010).

Newfoundland's Registered Nurses Act supports a bifurcated mandate[18], which permits both a regulatory and public policy mandate to co-exist. This is possible with government support of objects that not only delineates the Association's regulatory responsibilities, but also allow for actions that promote the health and well-being of the public. The objects are:

> *…in the interest of the public of the province, (a) to advance and promote the ethical and professional standards of the nursing profession; (b) to promote proficiency and competency in the nursing profession; and (c) to encourage its members to participate*

[18] For additional explanation about bifurcated mandates refer to Bryce & Bayne (2010).

> *in activities promoting the health and well-being of the public.* (Registered Nurses Act 2008, AD02)

As a way to promote the health and well-being of the public, ARNNL's Council set an end to engage in healthy public policy. Aligning with their legislated mandate, ARNNL articulates their vision as, *"excellence in nursing. In pursuit of that vision, and in order, the Association identifies three priority areas: Public protection; Quality health care, and; Healthy public policy"* (ARNNL Mission Statement 2010, AD04).

There was agreement among participants that they are fortunate to have an object that specifically permits ARNNL to set an end to advocate for public policies in addition to their regulatory functions. As explained by a participant:

> *How fortunate we are in this province to be both... Because we do have the opportunity to not only work on the regulatory pieces to regulate the profession and to make sure that our practice is safe within this province but also to help influence public policy. Because we can advocate and we do advocate.* (Participant 35)

Another participant suggested ARNNL does not endure restrictions that perhaps other provincial regulatory bodied across Canada experience. This latitude means advocating for CEH issues is possible:

> *Yes, I do if they can stretch their mandate to include it. Which is what we've seen and have been able to do in NL [sic Newfoundland]. Now, I know in some provinces, they haven't. And I guess that is a government decision as to the types of legislation that they enact and what they put in their legislation to limit what a nursing organization is able to become involved in. Because some of them seem to be like solely regulation. And I guess then if that is all that is in their mandate, and that is all that they have enough funding to do, well, then they can't stretch themselves to be doing other things.* (Participant 40)

Some participants saw the roles of supporting standards and advocacy work as interdependent functions that should not be separated. Having these two roles under the authority of a single organization was perceived to have the advantage of uniting nursing power through unity. For example, when questioned about the advantage of a bifurcated mandate a participant responded:

> *Well, you know, divide and conquer type thing. You know, if you have three different groups representing various aspects of the profession, it just divides it up. And like the whole. Our standards inform our advocacy efforts, and vice versa. Our advocacy efforts inform our standards. I believe that advocacy is who we are as nurses. Like I believe that it is fundamental to us as nurses to advocate. So how do you separate it?* (Participant 36)

The public policy object is particularly important as ARNNL can choose to remain a participant in policy discussions of interest. A participant explained:

> *It's probably the smallest portion of our funds. But it still enables us to be out there speaking about some things and get some visibility for the organization, and developing partnerships. Because most of these things that we are interested in speaking our two cents worth about, somebody else is working on them, and we do it in concert with another group.* (Participant 40)

The public policy object means advocating for CEH is thus within the realm of possibilities for ARNNL. As explained by a participant there is great opportunity *"to be an advocate for any community health issues that may arise. It's just the way they are presented. And as long as we follow the governance suggestions, there's no reason why they can't be intertwined there"* (Participant 38).

Despite ARNNL's legal capacity to advocate for public policy, analysis of participant interviews and documents indicated that several barriers diminish the Association's public policy work. First, since regulation is the primary mandate of ARNNL, minimal resources are left to address public policy issues, including CEH. As a participant explained, "*10% of our resources goes towards promoting healthy public policy, towards that work. All the rest is going towards registration, professional conduct review, standards, approvals, schools of nursing standard setting for practice and education, position statement, directing practice"* (Participant 36). Another participant further explained:

> *Our public policy represents about 10% of our resources. And certainly our regulatory business is our primary mandate. Licensing, professional conduct review, those things take up the majority of our staff time. So in that way, it kind of determines what we work on because we are limited in our resources and availability to. So we have to be selective. We can't select 15 things*. (Participant 37)

Another participant agreed, stating:

> *You can get derailed a little bit if it's not your, it can become a little bit disproportionate, I guess. Because we know that healthy public policy is a certain percentage of the work that we do here. A certain percentage of the resources are dedicated to that. So if we become heavily involved in that, is it going to be at the expense of another piece of work that we do? So I think we have to be careful that we continue to maintain that balance and not lose sight of what it is that our mandate is.* (Participant 35)

Above all other work, ARNNL has to ensure it serves and protects the public through

licensing, establishing and informing standards of practice and education, and investigating complaints and disciplining. Participants claimed that ARNNL is diligent in ensuring resources are first invested in meeting government's expectations for self-regulation. As emphasized by a participant, *"first and foremost, that (sic regulation) is our responsibility"* (Participant 36). Advocating for public policy issues is only possible if opportunity permits:

> *So you kind of have to decide on what you are going to do within the resources you have and what our mandate is. And right now, our Association is our regulatory body as well. So they are very diligent in making sure that their staff kind of takes on exactly what they've got to. And if there's opportunities to promote other things of interest for public protection, we do.* (Participant 38)

Fear of losing the ability to self-regulate is a second barrier that limits ARNNL's policy work. Referring to ARNNL's role in regulation, a participant explained, *"if we don't do that well, that could be changed" (Participant 36).* The participant went on to describe how the privilege of self-regulation was lost in other countries, *"so my big worry here is if we stepped out of line, they could change our Act. You know, take powers away from us. And it's been known to happen in other countries"* (Participant 36).

How ARNNL's public policy mandate is understood in relation to public protection and interest poses a third barrier for CEH work. According to participants, even within the public policy mandate restrictions applied. ARNNL is only permitted to advocate for healthy public policies related to public protection and interest. A participant stated, "*well, our primary mandate is public protection. So everything that we do has to be put under the lens of advocating in the interest of the public"* (Participant 37). Participant interviews suggested participants are divided in their understanding of public protection and interest, with the concepts both narrowly and broadly conceived. A narrow interpretation of public protection and public interest focuses on practice, standards, licensure, and discipline. From this perspective, advocating for public policy focuses on the quality of nursing practice. As explained by a participant, *"the public protection piece of our mandate is really meant to be excellence in nursing. Like how can we affect excellence in nursing so that it can promote public protection"* (Participant 40). However, public protection and interest is also more broadly interpreted to include factors affecting the health of the public. A participant explained this distinction:

> *If you think your role is to decide on what are your standards, to measure people against the standards for practice, to set the rules around licensure and that's it, and to*

> *make sure that they follow the rules, then that is very different than working with the population and trying to make sure that people wear bicycle helmets and that clean water is available to drink.* (Participant 35)

Participants suggested the narrower understanding is influencing perceived policy roles for the Nursing Associations in their province and across the country. For instance, one participant stated, "*so if the legislation identifies the organization as purely regulatory or if they interpret the legislation to be purely regulatory then you are going to see that as your only role"* (Participant 35). The participant went on to explain:

> *But I know that in some provinces whose organization is purely regulatory, they see their role as very black and white. That it is regulatory. So it's licensing, it's disciplining, it's setting the parameters around nursing practice, and the standards for education, and that's that. So they wouldn't necessarily be out advocating for clean drinking water because it enhances safer living conditions for people and it's good for people.* (Participant 35)

This narrow understanding of public protection and interest means CEH is perceived by some to be outside the boundaries of ARNNL's mandate. For instance, one participant questioned why CEH should be an interest of ARNNL considering its mandate, noting:

> *I thought of all the things we could be involved in, why that one? Why are we spending time on that of anything else? Like there seemed to be bigger areas where we could be putting our effort into from a health perspective.* (Participant 41)

However, the participant went on to note that action by ARNNL for CEH could perhaps be appropriate if the issue is clearly tied to the regulatory and public protection mandate:

> *If it's a case of we need some action from a regulatory perspective on issues around the environment that is one thing that we could probably be educating government on. And then yes, there is a broader public through every issue around environment.* (Participant 41)

However, some participants questioned whether the restrictions were self-imposed, noting some associations are able to stretch interpretations of public protection and interest to include advocacy work for factors affecting health.

**Provincial Jurisdictional Mandate**

Participants indicated efforts to influence CEH should be directed at the provincial government. One participant stated, *"if you're going to be able to move an issue forward on a provincial level then it would be advantageous for us to do it at that level"* (Participant 35). The participant went on to note that the national nursing body serves as a vehicle through

which federal CEH policies can be addressed. *"A national organization can get the voice of a national government, whereas a provincial organization is going to get the voice of a provincial government*" (Participant 35). Another participant similarly noted that the national body provides the venue through which the voices of Newfoundland and Labrador nurses can be heard at the federal level. A participant stated, *"so I guess the Association with a national body like CNA gives that opportunity then to have a national voice and to have a national say"* (Participant 35).

The participants were clear that collaboration is required for the national body to speak about provincial issues. So although CNA can speak to issues that perhaps ARNNL cannot, a concern remains that the Provincial Association might experience negative repercussions if the National Association speaks out. The following participant explained:

> *You know, if the nationals are coming into the province, you need to work together on that. That has to be a collaborative thing because you don't want the national voice to jeopardize your provincial position with government. However, that may be the way to get around it. You can't say anything but the national can.* (Participant 36)

The participant went on to note that efforts with CNA still require consideration of ARNNL's primary function of regulation, *"I mean we have a regulatory role. As long as national is cognizant of that. We work together on it. There's no issue"* (Participant 36).

**Mandatory Registered Nurse Members**

ARNNL is comprised of registered nurses, with mandatory membership required to practice nursing in Newfoundland. At the time of the study, ARNNL represented approximately 6,000 registered nurses (RNs) and nurse practitioners (NPs)[19]. In addition to individual nurses, membership also includes fifteen groups that hold ARNNL Special Interest Group Status. Members are not part of priority setting for public policy.

**Functional Corporate Structure**

ARNNL represents a functional organization, structured to meet the geographic and domain specific interests of registered nurses (RN), as well as the interests of the public. Aligning with a functional model, ARNNL's governing Council is comprised of regional RN representatives, domain RN representatives (practice, advanced practice, education/research,

[19] CIHI (2010) reported an estimated 5,825 registered nurses in Newfoundland & Labrador's workforce in the year 2009

and administration), and public representatives. In accordance with legislation, the membership elected the Council's nursing representatives and the Minister of Health and Community Services appoints the Council's public representatives.

Participants believed the current governing body is able to represent public policy concerns from across the province as exemplified by the following participant's statement: *"It's (sic Council) representative. We have Council members from all parts of the province and different work environments and different practice areas"* (Participant 35). The participant went on to describe how Council members are actively involved in the decision-making of ARNNL, *"there are public representatives on Council who are very involved" and "they get into some really good discussions. So it's a really good dynamic Council. And it is very diverse, which is refreshing. They are not rubber stampers"* (Participant 35).

**Operational Structure**

ARNNL's policy work is operationalized through its home office, which includes 14 personnel. The Association does not have departments. Instead, AARNL personnel are responsible for various functions (i.e., corporate services, education and research, media inquiries). Ten percent of one staff position includes responsibility for the healthy public policy portfolio. This assignment includes efforts to address CEH. With the small number of staff, it is not uncommon for personnel to assist in each other's work.

**Summary of ARNNL's Organizational Attributes**

Overall, efforts for CEH are permitted under ARNNL's bifurcated mandate that supports the co-existence of regulatory functions and a healthy public policy end. However, since the mandate is primarily regulatory, minimal resources are left to address any public policy issue, including CEH. Fear of losing the ability to self-regulate or losing the ability to advocate for healthy public policy is a second barrier that constrains CEH work. Public protection and interest narrowly conceived as efforts related to practice, standards, licensure, and discipline (opposed to efforts that also include action on factors affecting the health of the public) diminishes efforts, as CEH is then perceived to extend outside ARNNL's mandate.

Although ARNNL's mandate endorses advocating for provincial healthy public policy, there was no evidence that the Association was leading CEH efforts at the time of the study. A voice in federal CEH issues is possible through ARNNL's membership in the National

Association. ARNNL's functional structure allows for representation of nurses' and the public's concerns about policy from across the province, which can include issues related to CEH. However, with few staff and resources, there is minimal capacity to engage in any public policy issues, including CEH.

## Priority Setting Related to CEH

Participant interviews and organizational documents indicated that priority setting by ARNNL for CEH is supported by core organizational values and beliefs. The decision as to whether CEH issues will get attention and what efforts will be invested follows from ARNNL's monitoring, screening, and adjudication process for public policy issues. The following section describes ARNNL's priority setting related to CEH.

### Guiding Organizational Values and Beliefs

Organizational values and beliefs endorsed by ARNNL supports policy work for CEH. Decisions as to whether CEH issues will be addressed are underpinned by a belief that the environment is a critical determinant of health. A participant explained, *"but I mean if you believe the definition of health and look at the social determinants of health, there's no way you could say environmental health is not a part of it"* (Participant 34).

Some participants suggested that because environmental conditions affect human health, CEH issues are an appropriate area for ARNNL involvement. For instance, one participant suggested that addressing poor environmental conditions is a way to protect the health of the public. "*Well, particularly from our point of view as an Association, we are public protection and advocacy in the interest of the public. Certainly environmental health plays a role in the public health forum. So I think it is an important issue"* (Participant 37). The participant went on to say, *"I think that nursing is a powerful voice. I certainly believe that there are valid environmental health concerns. And in that way, it could be positive for it to have nurses speak out on environmental issues"* (Participant 37). Another participant suggested that the Association has a responsibility to speak about CEH as they know affects health: *"I think we have a responsibility [….] We have to only speak about what we really know about, what we should be talking about, but that we do have a responsibility to speak on those things that we know about"* (Participant 35). Another participant similarly explained that nurses have the necessary knowledge to inform CEH issues, calling attention to nurses' educational preparation and historical roots in addressing such issues. "*But our preparation*

*is broad, and we have that piece about public health and health. And when you think about Florence [sic Nightingale], what was Florence all about"* (Participant 36)?

However, the link between CEH and a role for ARNNL was less clear for one participant. The participant stated, "*but I think it's a vaguer notion. At least for me it is, what the direct link is of how nursing could contribute as a profession to addressing issues [sic CEH]"* (Participant 41). The participant went on to describe issues other than CEH perceived to be more directly applicable to nursing and of higher priority to ARNNL:

> *And when I think of health promotion, I'm thinking of people eating well, keeping physically active, not smoking, those kinds of things. Maybe a little bit of injury prevention in terms of behaviours and that sort of thing. But beyond that, I'm not seeing that the direct link of nurses to intervening, we'll say, with some of the other factors in the environment. Like you mentioned, climate change and that sort of thing. To me, it's still vague.* (Participant 41)

**Monitoring and Organizing Information**

When asked how ARNNL identified CEH issues of concern, participants indicated that these issues come to the Association's attention during their routine formal and informal scanning and monitoring processes. According to participants, the opportunity to identify CEH issues was possible through *"a number of means"* (Participant 34). For instance, one participant stated:

> *We trend the media. So our communications director would play a role in that, in keeping aware of what is happening in the media. We have a subscription actually, the organization does, to Media Watch [….] and so we pay for updates, emails, things like that.* (Participant 34)

An important part of information gathering for ARNNL is a *"Link to Listen"* activity whereby Council members schedule tours around the province as a way to identify concerns. As explained by a participant, *"Council members would actually sit and have an open session and invite people to attend. Sometimes it's for members, sometimes it's for the general public [….] so that would give a forum for anybody to bring issues forward"* (Participant 35). Another participant described CEH concerns identified through this forum:

> *I mean like water quality issues certainly come forward from communities but not necessarily from municipalities as such sometimes. Sometimes it's from the members of a community. Pesticide use is one that we've heard a fair bit about in this province. I think water is the most common that we hear about – the effect that they think that is having on the health of the community.* (Participant 40)

However, one participant emphasized that CEH issues are not often raised during the linkage forums. The participant did recall one concern raised by a coalition during a linkage forum:

> *And we had someone from an environmental health coalition at that meeting in [name removed of city]. They did raise some good environmental concerns out in [name removed of city] with the pulp and paper mill. They had a lot of environmental concerns there. So that came out in that discussion.* (Participant 37)

Other participants suggested that lack of public participation in these forums may mean ARNNL might not be fully informed about the public's policy concerns: *"we try to do it with both but it's more difficult to link with the public"* (Participant 40). One participant indicated priorities are simply based on *"our own perspective and what the opportunities are"* (Participant 41), which means issues such as CEH may not get addressed.

Workplace representatives serve as another source for identifying policy issues. Through this forum a CEH issue had been raised in the past. As recalled by a participant, workplace reps *"actually suggested that we do some activities around healthy work environments. Like how do we reduce our footprint in the workplace"* (Participant 35)?

While the broad scanning practices lead to the identification of some CEH issues of concern to nurses and the public, there may be gaps for identifying CEH issues. For example, government websites reporting environmental activity are not part of the scanning process, as explained by a participant:

> *What Environment and Lands are doing is not something we are not trending their media releases and calls for consultation. And we are only trending the Department of Health. However, we'd read it in the Telegram, in our newspaper, or we'd read it somewhere else. But we are not actively trending those.* (Participant 34)

Overall, the participants indicated that CEH does not often emerge as an area of concern through their scanning and monitoring sources.

**Screening Policy Priorities**

ARNNL does not have a formal priority setting process or set of criteria to judge whether policy issues, including those within the realm of CEH, are of interest to the Association or to rank order those policy issues. However, data from both participant interviews and organizational documents indicated use of an implicit decision-making process that involves determining which issues are relevant and their order of importance. Although these implicit criteria are not formally articulated by ARNNL, they are understood to be the standards the decision-makers use to judge policy priorities.

Issue relevance to ARNNL's public protection mandate is an essential screening criterion. A participant stated, *"and of course it always had to be in public interest. In any conversation, it's got to be something that affects the public good"* (Participant 34). Judgments about the relevancy of policy issues are also based on whether policy issues have direct relevance to *"primary health care"* (Participant 34), which serves as ARNNL's founding philosophy for public policy work. An explicit link to health served as another criterion to judge the relevance of an issue. Some participants stressed that not only does there have to be a link to health, but also an explicit link to the relevance of the CEH issue for nursing. One participant explained, "*the big one for us is what do we think as nurses? Given all of that, what is it that nursing can help improve? What is that we have knowledge about that can help improve the health of the population"* (Participant 36)? Another criterion for screening the relevance of a policy issue is the state of evidence. A participant suggested that considering the growing evidence of the impact of CEH, ARNNL would "*be hard pressed to say no"* (Participant 34). Using these criteria, CEH issues are judged to be a relevant policy issue of interest to ARNNL.

Determining the order of importance of policy issues is also guided by an implicit set of criteria. A participant suggested, *"there's a number of lens we'll put on it"* (Participant 34). Organizational capacity in terms of time, resources, finances, and staff expertise serves as a critical criterion to determine if a public policy issue will get preferential attention. For instance, one participant stated:

> *I'm sure this is nothing that you haven't heard before, is our resources at our Association. I mean we do have limited resources. So you kind of have to decide on what you are going to do within the resources you have* (Participant 38).

Another clarified that, *"it could be either timing, people, money. Most public policies don't take money. It's more to do with timing and people"* (Participant 34). Considering the limited resources, a participant indicated that:

> *We have to pick and choose through some prioritization based on where we think we can have the most impact, what seems to be most topical at the time, and what seems to be having the most concern for nurses, the health profession more generally and then the public.* (Participant 41)

Higher priority is given to areas that were judged to affect a larger population:

> *How widespread is this, how big of an issue is it, how many people is it impacting, and how many people is it an issue for? So it's not always as simple as just having something come to the table that it's an issue.* (Participant 40)

Priority is also given to issues when opportunities arise. One participant stated, "*some of it is being aware of the opportunities that others are working on something that we can contribute to in this area"* (Participant 41). However, opportunity is not a sufficient condition for involvement. As explained by one participant, sometimes ARNNL does not want to "*upstage a smaller group presenting something"* (Participant 34). Nurse requests and population reach also guide priority setting: *"We won't necessarily react on an individual nurse [sic requests]. It's when we get a critical mass or it's significant enough that it sort of rises to the top that we'll kind of discuss it"* (Participant 34).

Overall, CEH issues receive higher priority that have a clear link to nursing regulation, that nurses have knowledge about, that receives less attention by other stakeholders, that potentially impacts a large population, and when resources and opportunities are available. However, participants suggested with no specific rationale or criteria to guide decisions, some issues might not get attention, including CEH. This was articulated by a participant, who stated:

> *So it's talked through, we'll say, more than anything else. There's no science to it but it certainly comes up from time to time that we have to pick and choose; or which policy issues. We probably wouldn't turn anything down that was within our mandate, but we might spend a hell of a lot more time on one thing versus another.* (Participant 41)

**Adjudicating Policy Priorities**

The process for adjudicating policy priorities is guided by a Carver Model of Policy Governance©, which defines "*the roles" (Participant 36)* in establishing the policy direction for the Association. As explained by a participant:

> *The Council sets the policy direction for the organization; like [….] what we are supposed to be looking at is what benefits can we produce for the world? Like 10 years from now, how can we say our organization has made a difference?* (Participant 36)

According to participants, their Policy Governance© clearly delineates the roles between the governing Council and home office staff. One participant stated, the governance model *"helps provide some clarity because we're not all over the place. You know, we understand the direction that Council has provided to staff. And so it's more clear about what we should and should not be working on"* (Participant 35).

Under this Policy Governance© model, Council holds ultimate responsibility for establishing and monitoring 'ends' policies, which are a "*statement of the goals or accomplishments to be achieved"* (AD04). In order to meet their vision of excellence in nursing, ends established by ARNNL's governing Council include: (a) public protection, (b) quality health care, and (c) healthy public policy (AD04).

With respect to the healthy public policy end, home office personnel are responsible to identify and prioritize public policy issues of interest to ARNNL. These decisions are considered operational and are made by the ED in consultation with home office personnel. For instance, home office personnel believed CEH issues are relevant to ARNNL's public policy mandate and are willing to engage in such initiatives. One participant explained home office's choice to address the use and sale of pesticide:

> *They [sic home office personnel] will discuss it. Like pesticides was one of the ones that was discussed at one point in time. And if they [sic home office personnel] feel that it is something that is a public protection and we should kind of more or less be a bit of an advocate for. They [sic home office personnel] don't force us [sic Council] to do anything. It's all voluntarily. But they [sic home office personnel] do put us [sic Council] in the know of why they feel that this is such a valuable project to become a part of or to submit your concerns because of the health and welfare of a lot of people involved.* (Participant 38)

To identify policy priorities, every year home office staff engages in strategic planning that includes a review of the public policy issues that will receive priority. Explaining the strategic planning process, a participant stated, *"we'll take that and sit in a staff meeting and say what is doable, what can we do within our resources. So that is internal only"* (Participant 34). CEH is not identified as a policy priority area for ARNNL.

'Executive limitation' policies establish what activities the Council finds unacceptable for ARNNL in pursuit of these ends. If uncertainty exists about action to be taken, consultation with the Council occurs at the discretion of the ED (ARNNL By-Laws 2010, AD05). This was explained by a participant:

> *So Council sets some parameters around what that means but then it's up to us as staff to identify now we are going to operationalize that. So for example, it might be that we [sic home office personnel] support healthy environment. It could be a broad statement like that. And then we would have to look at what do we think that means and how do we do that? So it could be about developing a policy or just participating in community discussions around environmental health.* (Participant 35)

### Summary of ARNNL's Priority Setting

Overall, priority setting for CEH is permitted under ARNNL's bifurcated mandate that endorses an object to encourage members to participate in activities that promote health and well-being. Under this object, Council authorizes a broad healthy public policy end and gives home office staff the latitude to decide the public policy issues that will be addressed. Since CEH issues are not systematically monitor, a possibility remains that CEH issues are not brought to the attention of ARNNL and thus do not get attention. In addition, regulatory issues must take precedence and clear links must be made between the CEH issue and ARNNL's public protection mandate.

## Policy Advocacy for CEH by ARNNL

Analysis of participant interviews and organizational documents indicated that ARNNL engages in strategies that primarily aim to build capacity and relationships that would then support efforts for CEH. The rationales provided for the types of efforts taken and the supports and challenges encountered point to important influences that shape actions taken by ARNNL. The following section describes ARNNL's policy advocacy for CEH. Table 5.2 provides a summary of advocacy strategies undertaken by ARNNL related to CEH.

### Building Organizational Capacity

For ARNNL, building organizational capacity includes efforts to maintain a legal right to advocate for healthy public policy issues such as CEH. Analysis of participant interviews indicated that efforts taken to build organizational capacity was not necessarily for the purpose of getting involved in any one-policy issue. Instead, efforts aim to establish infrastructure and ways of working that then serve as a prerequisite for involvement in various policy initiatives. Recognizing that other regulated professions in Newfoundland have already lost this privilege, and believing that advocacy for healthy public policy is a critical part of what nurses do, ARNNL pushed to secure an object in their most recent 2008 RN Act that would allow the Association to advocate for healthy public policy. A participant explained:

> *Not a lot of provincial regulatory organizations have that. And we fought to keep that. And we got support to keep it". It's really funny now because other groups, like when we look around, no one else is getting it [sic object to support advocacy work].* (Participant 36)

In order to maintain a legal right to advocate, ARNNL investigates, identifies, and articulates

how their policy choices are linked to the protection and interest of the public. As emphasized by a participant, public policy issues that are taken on are carefully positioned or *"stretched"* to illustrate the link to public protection:

> *We always try to route things back to our mandates. Now, when you're talking about healthy public policy, that is not very hard to do because public protection being the one of the mandates, it is not too hard to stretch something to make it sound so that it is for the protection of the public.* (Participant 40)

As part of building capacity for policy work, infrastructure is established that allows nurses and the public to bring forward public policy issues of concern and provides a means by which ARNNL can keep abreast of emerging issues. This is done through *"Link to Listen"* forums and workplace liaisons. As explained by a participant, the Link to Listen forums consists of regular meetings whereby *"our Council members would actually sit and have an open session and invite people to attend. Sometimes it's for members, sometimes it's for the general public"* (Participant 35). Another participant further explained that the forums are a way *"for them to talk to us [ARNNL decision-makers] about what they see nursing can do to make a difference"* (Participant 36). Workplace liaison representatives serve as a line of communication between the Association and nurses in various practice settings. A participant explained:

> *We have about 108 at any given time throughout the province who volunteer their time to become involved in their professional Association, and form a really good linkage between their co-workers in their particular work areas and the Professional Association.* (Participant 35)

Nurses can then be called upon to help with a particular policy issue, "*and then I guess if there's some suggestions in there about what nurses can do around a particular issue, then we call upon them to read that and take up that charge"* (Participant 35).

Building capacity also includes tapping into resources that will support efforts for CEH. Resources developed by other Canadian Nursing Associations are used or adapted to support ARNNL's efforts. As explained by a participant, "*we use all lot of CNA's material. I mean they've got a bigger department, bigger resources, do the research, put out beautiful papers with reference lists miles high. So we would certainly utilize their resources and materials"* (Participant 34). This participant continued, *"CNA just gave a whole package on something. That is why we did our blitz on the environmental health a while ago" (Participant 34).* Another participant concurred stating:

> *I find it really helpful to have a National Organization who prepares [....] They are usually ahead of the ball. Right? Like they got ahead of the environmental issue before we did. And it's because they did that we could do a little bit of stuff on it. So it's very helpful to have a National Organization who are ahead of the ball in the big picture kind of thing. To get money and resources to development resources that we can use, it's very helpful.* (Participant 36)

Another participant recalled that the resources shared from another Provincial Association permitted ARNNL to participate in a CEH initiative:

> *So the reason why we actually wrote that article was not because of the coalition and all their material, it was because of RNAO's material. We have a nursing group who has researched this, did this homework, got this position. I'm going to take all their summaries, all their materials because I haven't got time to do all that homework, and utilize it.* (Participant 34)

**Building Social Capital**

A second strategy related to ARNNL's CEH policy work is building social capital. Building social capital entails relational and communication efforts that aim to create opportunities for the Association to contribute to CEH initiatives. Primary tactics include fostering relationships and sustaining its reputation, which are described below.

**Fostering relationships.**

Participants indicated that efforts taken to foster relationships are not necessarily for the purpose of getting involved in any one-policy issue. Instead, efforts aim to sustain and enhance trusting and supportive relationships that then serve as a prerequisite for involvement in various policy initiatives, including CEH. Efforts are made to foster relationships with government officials and other stakeholders, and include being responsive to needs and managing conflict.

There was agreement among participants that ARNNL works diligently to establish and maintain amicable relationships with government officials. Changes in government parties and government officials leads to concerted efforts to build relationships:

> *They've changed players in the government, the bureaucrats in their own government. So they don't know us like the older ones did. The other ones knew us, and knew we were putting forward credible voices. And you would see our work in the policies that came out. You know what I mean? But we are in the process of re-educating now, like developing new relationships with this government.* (Participant 36)

In order to enhance opportunities for involvement in policy issues, another participant noted the importance of making connections with various community stakeholders, stating, *"I've*

*met all kinds of new people, different circles, different influences that I have never been involved in before. And so you don't know where that will open up opportunities down the road"* (Participant 34).

Managing conflict is a routine part of ARNNL's relational work. There was wide-spread agreement among participants that non-confrontational approaches are essential to maintain a working relationship with government officials in their province. As explained by a participant, *"we've never gotten in their way. We give them their due when they do good things. That kind of thing"* (Participant 36). This participant went on to explain that ARNNL chooses to use less assertive approaches to communicate their positions:

> *But we pick our battles. And we tend to be quietly doing it [….] Like we are not taking on government in a media way. We are more quietly doing the preparing briefs, going to the public sessions, meeting with people behind the scenes, that kind of a way.* (Participant 36)

Participants expressed that ARNNL might endure repercussions from some government officials if they were challenged or embarrassed. Participants expressed concern that changes might occur to their legislation that would diminish their ability to advocate for public policies. Exclusion from relevant nursing and health policy discussions was another concern. As explained by a participant:

> *The risk would be what could happen to our legislation. Or we'd be left out of consultations and stuff, not included in consultations - not listened to; turned a blind eye to. There are groups in this province [place] that they don't listen to. They [sic government officials] hear their names and they just go blank.* (Participant 36)

To avoid repercussions, sensitive topics that are perceived to be in opposition of government policy are avoided. This concern was exemplified in the following statement by a participant who stated:

> *If we did too many of these, I'll tell you, [sic government officials] would attack us and god knows what would happen to our legislation. They make sure that their public reps on Council are there to answer to them, not us.* (Participant 36)

Another participant's comments also exemplified how ARNNL is careful in the selection of policy issues to be addressed:

> *And we are not out there speaking about everything. So we do pick our issues. Because I mean it's a fine line that you are walking when you are involved with all of those things. So you have to be a little bit careful, I guess, as to what you are supporting and how you are supporting it. Because nobody wants anything to interfere*

*with the ability to self-regulate; which is a privilege.* (Participant 40)

**Protecting Reputation.**

Protecting their reputation as a knowledgeable and trustworthy source is a second key tactic for building social capital used by ARNNL. This tactic facilitates their engagement in CEH issues. Participants agreed that credibility for speaking to policy issues such as CEH is partly attributable to the reputation nurses hold as a trusted profession. This was exemplified by a participant who stated:

> *We are the most trusted profession. All the public surveys say 97, 98%. And our public surveys echo those, saying that people trust and believe in nurses, and believe they have confidence. So we have opportunity if we give voice to something.* (Participant 34)

While participants believed ARNNL and nursing are probably not seen as experts in CEH, positions taken by the Association would likely be taken seriously by the public. This perspective was explained by a participant, who stated:

> *Specifically to community environmental health, I'm not 100% sure. But I know that the Association is very much looked at in the public eye as there to support and to protect them. So if they became a network with community environmental health, I think the public and community perception would say I think this is something we need to listen and be attentive to, that this is a growing concern.* (Participant 38)

However, the participants agreed that this reputation can be threatened if ARNNL speaks to issues that are perceived to extend beyond *"what is nursing"* and nursing knowledge. One participant used an exemplar to explain nursing knowledge and the boundaries within which ARNNL should speak:

> *Like what do we know about pavement and about road construction? So from a nursing perspective, do we have anything to offer about that? Well, if we don't know anything about it then we shouldn't be commenting on it. So it has to be something that is within our knowledge [sic domain][….] I think that we do have public credibility about whatever we speak about because we are careful about what we speak about and limit that public address to issues that we would be knowledgeable about or should be involved in. And I think when you start delving then into those other things, that's when you start to lose credibility. Because then the engineers will say, 'What do nurses know about roads and highways and pavement'?* (Participant 35)

Participants further agreed that ARNNL has not yet established a knowledge base or expertise that warrants the Association to speak out about many CEH issues. This was exemplified by one participant, who stated, *"we just have not built a reputation of expertise in that area"* (Participant 34). Another participant stated:

> *That is my guess. If the government tomorrow said we're going to have to work on cleaning up the dump [….] I don't think they would be calling us to get involved, the city. Now that might be an extreme example. Or if there were issues with chemicals or something in the air, or climate change, I don't think they would be calling us.* (Participant 41)

Lack of perceived knowledge and expertise prevents ARNNL from speaking out for CEH issues. For instance, referring to an oil spill that had recently occurred, a participant explained why ARNNL would not speak out about the disaster:

> *That is why [sic ARNNL is] not getting into the oil spill. What do I, nursing, know about oil spills? [....] So yes, ultimately I can see it impacting health but we really don't know anything about it. So it would have to be something that comes from our knowledge base. Like what it is we are taught, what nursing is [….] And if it's something we know, if we can speak from there, then it is credible.* (Participant 36)

The participant further emphasized, *"so we don't jump on the bandwagon unless it's something we know and it's our role, and it's carefully thought out"* (Participant 36). Another participant agreed stating:

> *And we can't take on everything. Then you just become a mouthpiece instead of a group of professionals that people expect when you do bring something forward that it's worth listening to. Otherwise it's just like an open line call in radio show. You know, you have an opinion about everything and yet you're not really an expert.* (Participant 35)

Protecting reputation also included the use of current and relevant evidence. A participant explained:

> *And we speak from an evidence point of view. And I think that is what gives us credibility. If we don't know a topic, we will say so and we won't speak on it. But if it's something we can speak on, environmental health or what have you, we will speak on it but we'll use evidence to back us. And because of that, we are credible and we can't be attacked.* (Participant 36)

However, not all evidence warrants involvement by the ARNNL. Although evidence may indicate a link to poor human health, outcomes that may not appear for years seems an unrealistic area for nursing involvement by some. In addition, action taken to help individuals manage personal practices is seen as more relevant to nursing. This was exemplified by the following participant, who explained:

> *So there is not a real understanding, unless you're working with someone who has had an environmental impact or whatever, how you are going to be educating your patients about that. Health promotion, again I'm not sure that I'm really seeing the links*

> *between.. And when I think of health promotion, I'm thinking of people eating well, keeping physically active, not smoking, those kinds of things. Maybe a little bit of injury prevention in terms of behaviours and that sort of thing. But beyond that, I'm not seeing that the direct link of nurses to intervening, we'll say, with some of the other factors in the environment. Like you mentioned, climate change and that sort of thing.* (Participant 41)

Another participant suggested that nursing and their associations should maintain some understanding about CEH and monitor knowledge development about CEH issues. Then, as knowledge level about CEH issues change over time, roles for nursing and their associations may emerge.

> *And we may over time be able to comment on some things as we become more knowledgeable. Like pesticides, for example. We have to, I guess, have some level of understanding – what are pesticides, what is being used, what is the impact? So it may be that we've got to do some research and do some homework and be prepared to answer that question. But obviously if it is something that does impact health and well-being, if it impacts people's ability to breathe and whatever the concerns may be, then that is something that is nursing. So yes, we should have an opinion on that. But I think that our knowledge level can change over time. So what we may not see as relevant now may change.* (Participant 35)

**Inspiring a Mass of Support for CEH**

Although rare, a third strategy taken by ARNNL is inspiring a mass of support for CEH action. Tactics for inspiring supporters primarily includes raising awareness and creating opportunities for action among nurses and sometimes the public. The following section describes these tactics.

**Raising awareness.**

When asked about the roles taken on by ARNNL for CEH a participant replied, *"like we have roles with regard to developing capacity around advocating for healthy public policy, educating"* (Participant 36). To raise awareness, ARNNL developed posters in the past depicting green action as part of Nurses' Week, as explained by a participant:

> *They [sic work representatives] certainly came up with seven acts of green. And so each day of Nursing Week, there was an activity dedicated to reducing waste. One might have been take the stairs. Don't take the elevator [….] And turn off the lights in the room if you are not [sic using it] [....] Bring your lunch in a reusable container [….] get a ride to work with someone else. Some simple things like that. But that came from the workplace representatives. And we turned that into a poster, which became the Nursing Week activity.* (Participant 35)

ARNNL also occasionally engages in efforts to raise awareness among the public. For instance, a participant explained, "*we wrote an opinion piece for the editorial for the newspaper. Those sorts of public awareness kinds of campaigns"* (Participant 37).

**Creating opportunities for action.**

In order to inspire efforts for CEH, ARNNL creates opportunities for individual nurses to engage or take action. Resources related to CEH issues are provided to nurses as a way to inspire action. As described by a participant, "*so I think at this stage, our strongest area in environmental health is really encouraging our members to get involved, feeding them information, letting them know about opportunities to do more on it"* (Participant 34). Resources developed by other nursing associations were shared with nurses: "*So when CNA, in their big Centennial year, did all that work, they took a lot of that. Like we shared that information, got copies of the DVD and stuff like that"* (Participant 34). One participant described how ARNNL sponsored a Council member to attend a workshop organized by CNA. This allowed the Council member to join a pan-Canadian organization interested in mobilizing nursing action: *"We set one of our Board members off to, at the Centennial, she actually got on the environmental health committee"* (Participant 37).

Although enlisting supporters was viewed as an important step to influencing policy, participants identified several barriers that diminish efforts by ARNNL to inspire nurses or the public to take action. First, resources are a critical determinant deterring action. When speaking about CEH, a participant acknowledged the complexity of the issue and thus the resources required to be involved, stating*, "well, too many components or concepts within it, too many players, too much learning, too much research work to do on it"* (Participant 34). Another similarly stated, "*there's only so much we can do"* (Participant 36).

Participants believed that efforts to mobilize action are further thwarted by a lack of nurse, public, and government interest or motivation to address CEH issues in the province. For instance, a participant recalled the response taken when information was given about CEH to Council following a Director's attendance at a CEH workshop, noting:

> *And came back and did presentations to our Board. So they had the opportunity to hear it at an exciting, in-depth level. But there was no end created [….] Yes, we should spread the word. But we used the word, they didn't take a bite.* (Participant 34)

The participant noted disinterest in CEH issues is reflected in the broader population as well:

> *There's not a lot actually happening in our province. We are sort of slower on the*

> *environmental. I mean we've got a small population. I mean we don't have the smog or the pollution. Our issues are smaller. People believe our water supply is in abundance.* (Participant 34)

Another participant similarly noted, *"certainly since I've been here, I don't remember it coming up as a policy or as an activity in any of my early years, in the five long years that I've been here*" (Participant 37). Some participants suggested that people in the province may not be interested in addressing environmental concerns since such action may have implications for employment opportunities. This concern was explained by a participant:

> *And the thing with it too, if it's someone's livelihood. Like if the community relies on that as their livelihood, it's a real challenge. It may be folded up for two generations down but right now I've got to feed my family.* (Participant 34)

The participant went on to explain that deep water oil drilling is now providing employment to many families in the province and likely serves as a deterrent for action by ARNNL:

> *Like the deep water oil drilling, when it was happening and Obama put a stop to any further work, well, we were just launching. And there was no public outcry to pause or hold. There was certainly media coverage in terms of a reassurance that well, [name removed] did everything wrong, and we're doing everything right. So it got some attention, that people's questions were answered. But it never went much further than that kind of thing. And yet we are seeing reports of fishermen, which is what we primarily are [sic seeing the impact of oil drilling on] the birds, the sea. Like you could see the impact would be parallel to what impact we'd have but it's not going to happen in my backyard.* (Participant 34)

Participants also noted officials in the provincial health department were also not actively pursuing CEH concerns:

> *The Health Department here is very, very involved more in operational policy, I would hazard a guess, because of the type of resources and all the pressures on the system. So there's probably not the same amount of time and resources devoted to taking on bigger issues like we're talking – environmental health. I know for an example that environmental health was one element of the provincial wellness plan. Which was good to see it even get that far. That spoke to it. But how much was actually being done when you peel back the onion? It wasn't a lot.* (Participant 41)

**Lending Support to Policy Change**

Lending support to policy change entails contributing to collaborative efforts that address CEH issues. Participants from ARNNL suggested that their involvement in CEH issues is primarily possible because of opportunities to join others outside of nursing and health. In order to work collaboratively, ARNNL engages in stakeholder analysis and

identifies opportunities to join CEH initiatives.

**Stakeholder analysis.**

Participants agreed that stakeholders who tended to share similar views and values were essential partner qualities. Some deliberately avoided involvement with environmental "extremists" that could potentially taint the Associations' image and threaten their credibility. This was explained by a participant, who described ARNNL's involvement in coalition work for pesticides:

> *The coalition itself is made up a mixture of professional and public people, and some, I guess, organizations like the [name removed of provincial environmental advocacy network] and [name removed of Canadian public policy advocacy group]. Things like that. But there are also individuals there. And when you mix both groups, it doesn't necessarily work out for the lobby advocacy styles. You know, we are not going to tie ourselves onto a tree.* (Participant 34)

**Joining allies.**

Joining allies is viewed as an essential step that can lead to participation in CEH initiatives. Allies include community stakeholders that request ARNNL's involvement. As described by a participant, *"there are other groups that request our involvement, community groups like the pesticide coalition"* (Participant 37). The participant went on to say, *"so we look at the external environment, and if there are other people who ask us to join on, if it's something we can contribute to, we do"* (Participant 37). Participants emphasized that ARNNL will not assume a lead, but instead will lend their support to CEH initiatives. As a participant explained:

> *And some of it is being aware of the opportunities that others are working on something that we can contribute to in this area. We'd be a contributor. I don't think we would have the ownership of environmental health. Then we would seize that. So that is another external opportunity. It's that other organizations saying we are going to be working on this, we want you to partner with us.* (Participant 41)

ARNNL saw its main role as a contributor because addressing many CEH issues involved *"big"* issues that required expertise beyond nursing. While nurses have an obvious lead when caring for people who are ill or at risk, some participants believed that influencing a higher system level extends beyond the capacity of their Nursing Association. One participant explained:

> *It's too big. [….] We would feel that, well, does nursing have expertise in that area? Not necessarily. Right? And would we have nurses' involved working in those areas*

> *that would be looking for assistance? Probably not. If the nurse was in that community where the water was an issue, and everybody got beaver fever, for example, then that nurse would be utilizing her skills and working within her employer kind of thing. And then she should be doing some advocacy. Our standards of practice identify the role of advocacy for your community, for your leadership role. So that would be at her level or their level.* (Participant 34)

Another participant similarly emphasized that ARNNL's role is not to assume leads for such issues, but instead to offer support:

> *Because there's many issues within nursing, as you know. And I have to say, the Association's mandate is public protection. And I know a lot of those issues are public protection but I do think the Association, if they took the lead on one issue then they could get snowballed into taking the lead on many other issues. And I feel that we should be there as supporters and not necessarily as the ones there to take the lead on all those issues.* (Participant 38)

Thus, as explained by a participant, ARNNL would "*probably judiciously think about how much effort we'd want to put into something. You know, it might be go to meetings versus take on leading an action group or something or a subcommittee on something. Which is different"* (Participant 41).

Participants suggested that working in partnership has the benefit of strengthening arguments. As one participant stated, "*and if you've got the [name removed of Canadian advocacy organization], the Nursing Association on your group then that speaks volumes to supporting that. If you lose those health professions, it weakens your argument or presentation of your argument"* (Participant 34). Partnering provides a venue through which ARNNL can become involved in CEH concerns. For instance, a participant suggested that contributions to a pesticide ban initiative were possible through ARNNL's involvement in a committee. *"Those sorts of things help us. When they come to us to look for information or involvement, that would help determine what we work on, their issues, if we have someone sitting on a committee like that"* (Participant 37).

While partnerships are often the only venue through which ARNNL can become involved, participants indicated that opportunities to join other groups engaged in CEH issues do not often arise. For instance, recalling the need to address concerns about clean water, a participant explained that ARNNL was unable to address the problem in the absence of a lead by other groups:

> *And her [sic researcher] report [sic community assessment] came out indicating water was the number one concern, the quality of water - number one concern in a lot of the communities. And then we had the Walkerton incident… But still, we have boil water orders in our province. More often than not, it's on the radio - so especially in our real rural areas. Okay, so that is definitely proven provincial. It can make you real sick so it can affect health. What do we know about that? What could we do about that? What role would we take in that? It was like too big. You know? Now, if there was a sub-working group that had taken a piece of that and said we're going to work on such and such, and contacted us, we probably would have said okay.* (Participant 34)

**ARNNL's Overall Pattern of Engagement for CEH**

At the time of this study, CEH was not considered a public policy priority area. Attention to CEH by ARNNL issues was rare and sporadic. With the exception of one participant, most participants were unable to recall any action taken by ARNNL for CEH:

> *Well, right now I can't point to anything in particular or concrete that we are actually doing to work on that topic. Now, there may be some other things that others in the ARNNL has mentioned yes, we are actively working on this aspect of environmental health. I can't think of any.* (Participant 41)

The one CEH initiative taken on by ARNNL occurred over a year prior to the conduct of this research and was a one-time event initiated by ARNNL's workplace representatives. One participant argued that one-time investments do not equate to serious policy action:

> *Well, you see then kind of. Back to the earlier question about what do we work on and how much we work on it, it comes down to any number of issues and sticking with something for the long haul. So the posters one year, one week is one start. But if you are really going to be serious about this is an area that we really prioritize, you'd be doing some follow on stuff.* (Participant 41)

Policy work for CEH primarily includes efforts to maintain a right to advocate for public policy, to develop ways to identify and engage members in policy issues affecting the health of the public, and to disseminate information and resources developed by other nursing associations. ARNNL relies on joining other stakeholders as a way to contribute directly to policy change for CEH issues. As noted by a participant, ARNNL is perceived to be on the periphery of many CEH issues:

> *Nursing is like a step away from that. But you could be someone like to mobilize it a bit or to join a committee [….] You know, there are things we could be involved with that are not directly us but on the periphery of what we do. And even if we were helping groups learn how to advocate is doing good.* (Participant 36)

Although relying on collaborations, participants indicated there are few opportunities for

ARNNL to join or contribute to others work. Furthermore, participants indicated that in the absence of sustained efforts, actions taken by ARNNL do not amount to serious efforts on CEH issues. With numerous issues on the table, ARNNL believed investment in broader issues is a way that many problem areas, including CEH, may get addressed, at least to some degree:

> *Like in our small organization, we can only pick "x" number of things. Is it [sic CEH] the top one? I would say no. To me, the top one is primary healthcare reform. Like to me, if we got that then some of the others would fall into place. Right? But that would be a piece of it.* (Participant 36)

**Summary of the Three Nursing Associations' Engagement in CEH**

The preceding analysis described the nature of three Nursing Associations priority setting and policy advocacy for CEH. A review of the three cases underscores key organizational features that have implications for the choices and actions taken. These features include legislated mandates (i.e., sole healthy public policy or bifurcated mandate) jurisdictional responsibilities (i.e., federal and provincial), corporate structures (i.e., federated or functional), and operational structures (i.e., staff and departmental arrangements). Analysis of the three cases further indicates that their priority setting is anchored in a core set of organizational beliefs related to both the environment and health and roles for government and nursing in this domain. Setting policy priorities for CEH includes monitoring, screening, and adjudicating processes to decide whether a CEH is of interest to the Association and then its order of importance in relation to other organizational priorities. Once the Associations have decided that CEH is a policy priority, a number of strategies are taken to build capacity and influence policy decisions. These strategies include building organizational capacity, building social capital, inspiring a mass of support for CEH issues, lending support to or leading to policy change, exercising political acumen, and pushing policy positions.

Analysis of the three cases also indicates that the types of CEH issues addressed, the types of advocacy strategies employed, and the degree of engagement vary across the three Associations. CNA's engagement in CEH has been sporadic and ad hoc. The efforts for CEH by RNAO have been proactive and consistent. CEH was not considered a priority policy issue for ARNNL and efforts taken were sporadic and rare. The policy efforts by the Associations for CEH ranged from gaining political buy-in, establishing their self-interest, to

demonstrating political sophistication (Cohen et al., 1995). These variations suggest that the Associations are at different stages of political development in their efforts for CEH; that is the capacity of the Associations to organize for and engage in political action is uneven (Cohen et al., 1995; Wilson, 2002). Questions remain about why the Associations vary in their CEH efforts.

To understand variations in the way the Associations engage in CEH, their choices and action must be placed in context and further exploration given to how these factors influence their decisions. A cross-case comparison of the three Associations' would provide a way to examine these factors.

## INTRODUCTION TO CHAPTER 6: CROSS-CASE ANALYSIS

This chapter reports findings from Phase Two: Cross-Case Analysis. Descriptive patterns from the three individual case analyses were compared to identify factors and how they influence the Nursing Associations' priority setting and policy advocacy for CEH. A subset of participant quotes from the individual cases was used for the cross-case findings. The chapter will be prepared for submission to *"Journal of Comparative Policy Analysis"*.

# CHAPTER 6
# STRUCTURAL AND INSTITUTIONAL FACTORS INFLUENCING THREE NURSING ASSOCIATIONS' ENGAGEMENT WITH COMMUNITY ENVIRONMENTAL HEALTH: A CROSS-CASE COMPARISON

## Introduction

Even with the most aggressive efforts, aspects of the global environment are projected to deteriorate, with implications for intensification of human ill health (Chopra & Canji, 2011; McMichael & Butler, 2011; Stern, 2007). Nurses can expect to find themselves caring for families and communities experiencing acute and chronic illnesses, injuries, social disruption, and reduced quality of life resulting from the contamination of our natural resources, exposures to chemicals and hazardous wastes, and global warming (Boyd & Genuis, 2008; Stern). In addition to minimizing the consequences of disease, part of nursing practice has traditionally included mitigating sources of environmental problems (Butterfield, 2005; Sattler, 2005). Promoting health, preventing disease, and alleviating suffering from environmentally-associated community health problems requires system and policy change through political activism from the local to international level (Butterfield; Falk-Rafael, 2006).

Nursing organizations have historically served as vehicles for collective efforts to advocate for system and policy change (Cohen, 1995; Clarke, 2006; Lewenson, 2007). Knowledge and experience with policy and politics, their position of public respect and trust, political linkages, and strength of membership numbers are powerful features of nursing organizations that can be harnessed to influence policy decisions inside and outside of health care (Cohen & Reutter, 2007; Falk & Chong, 2008; Foley, 2007; Kany, 2007).

Some nurses are looking to their nursing organizations for guidance and leadership to assist them in their day-to-day community environmental health (CEH) work (Canadian Nurses Association [CNA], 2007a). Others in the profession suggest that nursing organizations should contribute to the development of government action plans and policies to mitigate environmental conditions that contribute to ill health (International Council of Nurses [ICN], 2008b). Yet, there is no agreement on what the role of nursing organizations should be. Little empirical evidence exists that describes nursing organizations' involvement in system and policy change (MacDonald, Edwards, Davies, Marck, & Read-Guernsey,

2012b), and their engagement in community environmental health (CEH) policy more specifically (MacDonald, Davies, Edwards, Marck, & Read-Guernsey, 2012a). Moreover, nursing organizations have diverse public policy and regulatory roles, jurisdictional responsibility, membership arrangements, and governance structures. A recent scoping review (MacDonald et al., 2012b) indicated that these factors could influence organizations' policy priorities and advocacy actions. In addition, organizational responses to events and conditions can vary and change over time (MacDonald, Edwards, et el.). Theory-driven research can assist in understanding factors and their mechanisms that support priority setting and policy advocacy by nursing organizations. This knowledge is fundamental to enhance decision-making (MacDonald et al., 2012a).

In an effort to fill this knowledge gap, I report findings from a qualitative comparative case study that explored how leaders from three Canadian Nursing Associations described their engagement in CEH within their provincial and federal contexts. The term CEH is defined as human-ecosystem health that is generated through human participation with natural, physical, chemical and biological systems and that can be supported through ecologically sound practices and policies across system scales and levels (Gunderson & Holling, 2002; Hansen, Marck, & Reutter, 2009; Laustsen; 2006; MacDonald, Edwards, et al.; Pruss-Ustun & Corvalan, 2006). The Nursing Associations in this study included those with a public policy and/or regulatory or support of regulation roles. Describing the nature and scope of the Nursing Associations' CEH policy work provides insight for those seeking to understand how the Nursing Associations set priorities for and take action on complex policy issues. The findings for individual case studies are reported elsewhere.

## Methodology and Methods

### Study Design

A qualitative comparative case study design (Yin, 2009) was chosen to answer the research questions: (a) how do the nature and scope of nursing organizations' engagement for CEH policies differ according to provincial and federal contexts? and (b) how do nursing organizational factors and external system factors influence the priority-setting and policy advocacy choices for CEH policy? A qualitative case study design supported an in-depth exploration, description, and interpretation of the Nursing Associations' engagement in CEH policy in their settings in which the jurisdiction, social, political, economic, and ecological

context were highly pertinent to understand their choices and actions. A comparative design permitted the identification of cross-cutting patterns, building a more powerful understanding of the ways in which the Nursing Associations set policy priorities and advocate for policy change.

**Theoretical Foundation**

Data collection and analysis were rooted in the epistemological rationale of interpretive description (Thorne, Kirkham, & MacDonald-Emes, 1997; Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004; Thorne, 2008). Interpretive description involves description and interpretation of a shared experience from the perspective of those who live it (Thorne, 1997) in order to generate practical knowledge that can lead to actionable outcomes (Hunt, 2009). In keeping with the conventions of naturalistic and interpretivist traditions, interpretive description requires a commitment to understanding the subjective and experiential knowledge of those experiencing the practice issue, explicit articulation of the design decisions (including choice of participants, data collection methods, and data analysis), and construction of a conceptual framework as a starting point for investigation.

The conceptual framework guiding this study (MacDonald, Davies, Edwards, Marck, & Read-Guernsey, 2012) is premised on whole-systems socio-ecological theory (Edwards et al., 2011; Gunderson & Holling, 1995, 2002). This theory explains the broad context and processes of change. Whole-systems change from this perspective refers to "uneven, nested cycles of adaptation that evolve within closely coupled, complex socio-ecological systems over time" (Edwards, Marck, Virani, Davies, & Rowan, 2007, p.2). This theoretical perspective guides examination of system interactions and dynamics characterized by overlapping phases of longer periods of growth and conservation, wherein physical and social capital are accumulated, and shorter periods of restructuring and reorganization, whereby opportunities for mobilization and lobbying are created (MacDonald, Edwards, Davies, Marck, & Guernsey, 2012). The conceptual framework was also informed by institutional theory that considers, more specifically, regulative, normative, and cognitive factors and their mechanisms that influence organizations' choices and actions (Hoffman, 1999; Scott, 1994; Szyliowicz & Galvin, 2010). Using this perspective, attention is specifically drawn to rules, beliefs, and expectations that determine what feasible,

acceptable, and legitimate policy priorities and advocacy options are for the Nursing Associations.

**Study Setting: The Canadian Context**

This study was undertaken in two provinces, where the participating Nursing Associations were located. Because Canada is a federated country, various legislative responsibilities, including those related to health and environment, primarily rest with provincial/territorial governments. Thus, legislation governing nursing associations varies across the provinces/territories as well as between the provincial/territorial and federal organizations. Geographic and economic contexts also differ among provinces.

**Case Selection**

The Nursing Associations were purposefully selected based on their jurisdictional authority (provincial versus national), their mandate (public policy and/or regulatory or support of regulation), and engagement in CEH. Website information that described nursing associations' legislative and jurisdictional authority was used to identify associations with varied mandates. Association resolutions, position statements, and resources (e.g., educational material) located on association websites were also used to assess the degree of engagement in CEH. The assessment was rudimentary, with associations with resolutions, policy documents, and resources considered to have a high degree of CEH involvement. Associations with resources or links to CEH information, but no evidence of resolutions or policy documents, were considered to have minimal CEH involvement. Four Nursing Associations meeting the eligibility criteria were invited to participate.

**Participant Sampling**

Participants were purposefully selected. Within each Association, personnel and members of the Board were eligible to take part in the study if they met the following criteria: a minimum of 1-year experience with priority-setting and policy advocacy during the past 5 years with their Association and/or had experience working in the area of CEH policy, and spoke English. Sixty-three participants meeting the eligibility criteria were invited to participate.

**Data Sources and Collection Processes**

Site visits occurred between June 2010 and December 2010. The researcher spent seven to nine days collecting data at each site. Face-to-face and telephone interviews lasting

30 to 75 minutes were conducted using an interview guide (Table 6.1). Variations in the length of interviews reflected differences in the detailed knowledge participants had about organizational structures and processes. The interviews were conducted at times convenient for participants and in their private offices or at alternate sites when requested. Field notes were written after completing interviews. Interviews were audio-taped and transcribed verbatim. Notes were taken and transcribed for two interviews that were not audio-taped.

Organizational documents were retrieved to corroborate and augment information gained from the interview data. These documents were purposively selected for review based on the following eligibility criteria: (a) one of five types of organizational documents (policy documents [e.g. Constitution and By-Laws, flow charts for decision-making], strategic plans, communications [media releases to nurses, the public, or politicians], minutes including Board of Director or Council and committee, and reporting documents [e.g. annual reports]); and (b) were produced from January 2005 until September 2010 or were published earlier but with direct relevance to CEH. Data extracted from documents included: (a) processes for policy priority-setting; (b) priority setting outcomes related to CEH; (c) actions undertaken for CEH; (d) outcomes from actions taken for CEH; and (e) references to factors that influence priority setting or policy advocacy choices and actions. All interview and document texts were imported into NVivo 8 qualitative data analysis software, which was used to assist with data management.

**Analysis**

Framework analysis as described by Ritchie and colleagues (1994, 2003) guided data analysis. This theoretically-informed, inductive, qualitative analytic process proceeded through two stages: (a) Phase One - Within-Case Analysis: Independent analysis of each case; and (b) Phase Two – Cross-Case Analysis: Findings from the three cases are compared and integrated. Phase one of analysis provided a way to examine the substantive content, compared participant and document findings, and built a foundation for cross-case comparisons. The within-case analysis led to the description of the nature and scope of each Nursing Association's priority setting and policy advocacy for CEH, as well as the supports and challenges they faced. Details for this phase are reported elsewhere (Chapter 4). This manuscript reports findings for Phase two of the study.

The second phase, cross-case analysis, compared descriptive patterns identified from

the within-case analysis for each case. Matrices were constructed that plotted the within-case descriptive patterns. Broadly these patterns described organizational attributes, priority setting processes, and policy advocacy actions. The matrices were comprised of columns that represented the Associations and rows that represented key features of a descriptive pattern. Row headings in the priority setting matrix, for example, included organizational values, Board decision-making tasks, and criteria for screening priorities. Summaries of key findings were plotted under the respective column and row headings. The column data were thoroughly compared to identify similarities and differences across the cases, which were then noted in a fourth column.

Interpretation about priority setting choices and policy advocacy actions and the factors that influence the Nursing Associations' priority setting and policy advocacy was achieved through systematically interrogation of similarities and differences across matrices, following up on hunches, referring to memo and journal notes, writing the findings, and re-visiting the case findings for clarifications and elaborations. The final findings were based on explicit factors described by participants as well as those inferred by me.

**Trustworthiness**

The trustworthiness - or truth-value - of this research was enhanced through attention to credibility, confirmability, and fittingness of the research. To ensure a credible match between the data and interpretation, members of the thesis committee reviewed a subset of transcripts, coding, and matrices. Feedback was also solicited from the Executive Directors of the Associations. Credibility of findings was further supported through triangulation of data by interviewing participants holding different positions with their Associations, by collecting data from three different Associations, and by using different sources of information (e.g., interviews and documents). To confirm the findings and conclusions an audit trail was kept, which includes the interview guide, raw data (i.e., interviews and documents), and thick description of all stages of the research. Members of the thesis committee provided feedback during all stages of the research, which further confirmed the findings. Details about the setting, cases, and participants are provided to allow readers to judge the fittingness of the findings to their own setting. The use of three cases in various federal and provincial contexts and with different jurisdictional and organizational mandates may enhance the use of findings in various settings.

## Ethics

Ethical approval was received from the University of Ottawa, Office of Research Ethics and Integrity. Organizational approvals were obtained from the three participating Associations from which study participants were recruited. Attention to ethical considerations included informed and voluntary consent and protection of confidentiality (e.g., participants names kept separate from data collected, encryption of electronic documents, information kept in secured area). The organizations were informed that the names of their Associations would not be kept anonymous in reports. Although efforts were taken to protect participants' identities (e.g., personal identifiers removed), participants were made aware that their anonymity could not be guaranteed.

# Results

## Cases

Three Associations agreed to participate. A fourth Association declined to participate. The first case, the Canadian Nurses Association (CNA), is a National Association with member-granted regulatory functions. CNA has been involved in CEH initiatives since 1990 and was judged to have a high degree of involvement. The second case, the Registered Nurses' Association of Ontario (RNAO), is a Provincial Nursing Association with no legal or member-granted regulatory functions. RNAO has been involved in CEH initiatives since 2000, also with a high degree of involvement. The third case, the Association of Registered Nurses of Newfoundland and Labrador (ARNNL), is a Provincial Nursing Association with legal responsibility to regulate nurses in the province. ARNNL was judged to have a low degree of involvement.

## Participants

Forty-one current and past personnel and Board Directors with senior management and decision-making positions agreed to be interviewed. They included Chief and Assistant Executive Officers, Executive Directors, Directors of policy departments, Board of Director members, and Chairs of committees. Approximately 34.1% (n=14) were from CNA, 46.3% (n=19) were from RNAO, and 19.5% (n=8) were from ARNNL, reflecting variations in the number of Associations' personnel and Board members. Of these, 85.4% (n=35) were female, 75.6% (n=31) were registered nurses, 85.4% (n=35) held a minimum of a Master's degree, 65.7% (n=27) practiced their profession for over 20 years, and 53.7% (n=22) had a

minimum of 10 years policy experience. Few participants had formal training (courses or certificates) related to CEH issues. Table 6.2 provides additional participant attributes.

Thirty-five percent (22/63) of participants who were invited did not participate. Ninety-one percent (20/22) of those who did not participate were Board or Council members and 9% (2/22) were current staff. Of the Board/Council members that did not participate, 40% (8/20) were current members and 60% (12/20) were past members. Seventy-percent (14/20) of Board/Council members who did not participate were from CNA, 10% (2/20) were from ARNNL, and 20% (4/20) were from RNAO. Individuals who did not participate did not respond to any of three invitations, thus the reason for not participating is unknown.

**Organizational Attributes**

Organizational attributes include the Incorporation Statutes and mandates, corporate structures, and operational structures that organized the way the Nursing Associations did their work. The following section highlights the similarities and differences among the three Associations under each attribute. Table 6.3 depicts various organizational attributes of the three participating Associations.

**Incorporation Statutes and mandates.**

Under their respective Incorporation Statutes, all three Associations had the legal authority to advocate for healthy public policy, which included CEH. In addition one Provincial Association, ARNNL, had regulatory functions and the National Association, CNA, engaged in activities that supported regulation. Both ARNNL and CNA reported greater challenges to engaging in CEH.

ARNNL is considered a regulatory-driven Association. Under Newfoundland and Labrador's Registered Nurses' Act (2008), the government grants ARNNL the authority to self-regulate practicing nurses. The Minister defines the governance and operations and holds the Association accountable for the regulation and discipline of its members. Newfoundland's Registered Nurses Act supports a bifurcated mandate[20], which permits both a regulatory and public policy mandate to co-exist. This is possible with government support of objects that not only delineates the Association's regulatory responsibilities, but also allow for actions that promote the health and well-being of the public. Under this object, ARNNL's Council endorses healthy public policy as an end. While this bifurcated mandate allows for

[20] For additional explanation about bifurcated mandates refer to Bryce & Bayne (2010).

CEH advocacy, ARNNL experienced several constraints. Regulatory functions legally took precedence over all other policy issues. Ten percent of ARNNL's resources were allotted for all public policy work undertaken by the Association, including CEH:

> *Our public policy represents about 10% of our resources. And certainly our regulatory business is our primary mandate. Licensing, professional conduct review, those things take up the majority of our staff time. So in that way, it kind of determines what we work on because we are limited in our resources and availability to. So we have to be selective.* (Participant 37)

Participants suggested that viewed through a regulatory lens, public policies to protect the public were limited. Participants suggested that some nursing leaders and government officials' perceived public policy to protect the public to include only those policies related to practice, standards, licensure, and discipline. This interpretation of protecting the public further diminishes efforts for CEH, as these issues are perceived to extend beyond a public protection mandate.

In addition to constrained resources, a fear of losing the right to self-regulate deterred ARNNL from engaging in many CEH issues. Newfoundland and Labrador's most recent Registered Nurses' Act (2008) saw increased state control in the regulation of its nurses including shifts in authority for professional conduct reviews; increased public representation on the governing body; and loss of membership rights to make, amend, or repeal bylaws (AD01). Noting that other professions within the province experienced even more severe self-regulatory losses, ARNNL deliberately avoided engagement in public policy issues that could be construed as self-serving or unrelated to their public protection mandate. In addition, action would not be taken for policies perceived to potentially anger government officials who might be in a position to accuse the Association of not acting in accordance with regulatory expectations. *"So my big worry here is if we stepped out of line, they could change our Act. You know, take powers away from us. And it's been known to happen in other countries"* (Participant 36).

Unlike the Registered Nurses' Act, Corporate Acts give Association members the authority to self-proclaim their objects, governance and operations. Thus, these Associations are considered to be member-driven and they are accountable to their members. Under their respective federal and provincial Corporation Acts (BillC-4: Statutes of Canada, 2009 C-4;

Ontario Canada, Ontario Ministry of Attorney General, n.d. 2009), both CNA and RNAO are member-driven organizations.

Members of RNAO endorsed action towards a range of sensitive CEH issues. Members of CNA also supported action for CEH issues. However, in addition, members granted CNA responsibilities related to the support of regulation. Support of regulation included developing and administering entry-level exams for Registered Nurses (RN), providing specialty certifications, and contributing to the development of credentialing standards. Although the support of regulation was not legislated, like ARNNL, these responsibilities contributed to constraints for CEH policy work. Their support of regulation activities was accompanied by a sense of responsibility to ensure they were perceived as not doing "silly" things. Thus, CNA was also guarded in the choices of CEH issues. One participant stated:

> *We are not a regulator, and we don't register directly obviously. But this is the home to which the colleges all pay their dues and is the seat of the national standards and the national exam [….] So CNA therefore is careful, I think, and has to be careful to not be seen to be doing silly things. I don't mean environment is silly. But CNA has to be more cautious than the union, let's put it that way, in its activities in public.* (Participant 6)

The Incorporation Statutes also legitimized the jurisdictional parameters within which the Nursing Associations undertook their work. However, this legislation did not prevent the Associations from acting outside at other jurisdictional levels as long as other laws did not prohibit action. For instance, CNA's primary focus was with federal level CEH policies. In addition, CNA was not legally restricted from advocating for provincial or international CEH policy change. Despite this jurisdictional flexibility, there was minimal cross-provincial or cross-jurisdictional work for CEH issues. Nursing leaders suggested they had less opportunity to form close relationships with government officials when advocating at other jurisdictional levels. For instance, leaders of provincial associations tend to know provincial government officials better than municipal government officials. Not knowing government officials was perceived as a factor that diminished inclusion in CEH discussions and initiatives.

In addition to challenges to know government officials across jurisdictions, there were unspoken rules to respect the jurisdictional boundaries of other nursing associations. Participants noted that a failure to respect those boundaries could create tensions among

nursing associations and could jeopardize policy efforts being sought by another nursing association. Thus, there were expectations that taking action in another province or jurisdiction required collaboration among the respective associations. One participant stated, *"if the nationals are coming into the province, you need to work together on that. That has to be a collaborative thing because you don't want the national voice to jeopardize your provincial position with government"* (Participant 36).

**Corporate structure.**

Nursing Associations operated from two different corporate structures orientations, which accounted for variations in their CEH work. CNA is a federation, comprised of autonomous nursing organizations with a primary affiliation to their own provincial/territorial organizations. Aligning with a federated orientation, the Board was primarily comprised of representatives from provincial/territorial jurisdictional nursing bodies. The federated orientation created opportunity for CNA to identify a range of CEH policy concerns from across the country and to bring together experienced nurses to discuss issues of concern. However, challenges were described. First, there were challenges to identifying a national focus from pooled provincial/territorial CEH issues raised at the decision-table. This challenge was partly attributed to short-term appointed Board Director positions that limited the time required to acquire skills necessary to work with a national perspective. Second, 10 of the 11 jurisdictional representatives were Presidents of regulatory driven nursing bodies. Thus, their concerns were primarily related to regulatory and health services issues and not public policy issues such as CEH. A participant stated, *"from a national perspective, I think it's more difficult because you're trying to deal with multiple different jurisdictions who are structured in very different ways, who may have very different policies"* (Participant 12).

In addition, some jurisdictional Directors were restricted from participating in decision-making for CEH issues because of their primary affiliation with a regulatory body. The matter of dealing with non-regulatory issues had grown so serious that one corporate membership organization[21] conducted an evaluation to determine the relevance of its relationship with CNA (CD48). Findings from the evaluation reported, "*legal and policy research and analysis leads to the conclusion that the CNA function of "lobbying*

[21] This association was a jurisdictional member of CNA, but not a case in this study.

*government" creates perceived, if not an actual, conflict for the College, given its public protection mandate under section 16 HPA" (CD48).* Divisiveness over the source of the restriction (i.e., law or interpretation of law) created tensions among Board Directors and hindered decision-making for policies not directly relevant to regulation, including CEH. A participant noted that while jurisdictional Presidents *"bring richness"* about provincial issues, "*it's also a downfall in some ways because they are focused on their jurisdiction"* (Participant 2). Another stated, "*right now in their interpretation of their regulatory rule, as a Board, they've given direction that they should only take votes on issues that are related to regulation"* (Participant 7).

The federated orientation was further complicated by corporate membership. While individual nurse membership was "*guaranteed*" (automatic) for those registered with one of the corporate members, CNA's direct access to these nurses was limited. This contributed to diminished efforts to engage nurses in CEH policy work. In addition, CNA believed that guaranteed membership failed to secure nurses interested in advocating for policy issues. Some participants of CNA reported a lack of interest and minimal demand from nurses for the Association to address CEH issues. One participant claimed, "*there's a certain inertia in a place that has a guaranteed membership"* (Participant 6).

Unlike CNA, both RNAO and ARNNL have functional orientations. A functional orientation means the Associations are autonomous organizations primarily comprised of nurses who represent geographic regions, nursing domains of practice (e.g., research, practice, education, research, administration, and socio-political affairs), and specialty areas (e.g., children's health). Both of these Provincial Associations reported that geographic and domain representation allowed CEH concerns to be identified from across the province and from diverse nurse settings and practices. While both RNAO and ARNNL had to similarly set priorities for diverse concerns emerging from various parts of the province, unlike CNA, they did not report challenges for reaching consensus for CEH policy priorities.

Unlike CNA, RNAO's functional orientation included nurses who volunteered to become members. These members contributed to decision-making and carried out the policy work of the Association. Voluntary membership in RNAO created an accountability mechanism that motivated the Association to ensure its relevance to members. CEH was endorsed by members and thus was a priority area for RNAO. However, meeting the diverse

expectations of members meant RNAO worked hard to balance organizational efforts on CEH with other issues. While voluntary membership in RNAO partly accounted for the support and willingness of members to conduct the policy work, there were substantial expectations placed on the Board Directors. Despite such demands, membership in RNAO continued to grow and members continued to contribute to the decision-making and advocacy work.

**Operational structure.**

The healthy policy mandate of the Associations was operationalized through their home offices. CNA was the largest Association, having 83 staff, one centre and six departments, including a small public policy department. Staff roles were highly specialized, with each employee having assigned policy portfolios. Despite its size, only one staff person was given some time to address CEH issues. In addition, highly specialized departments and staff assignments were not conducive for cross-departmental collaborations, which further limited capacity for CEH work. The unavailability of slack resources was particularly problematic for dealing with emerging issues. One participant commented, "s*o if CNA wanted to really impact the environment, you'd probably need a quarter of this organization working on that all the time. Not one person doing an hour a week"* (Participant 6).

RNAO was a smaller Association than CNA, having 59 staff. Unlike CNA, RNAO had one large policy department. While personnel within the policy department were assigned specialized policy portfolios (e.g., social determinants of health, environmental determinants of health), the one department structure permitted personnel to come together to collaborate and respond quickly during demanding and critical times. In addition, substantial resources were dedicated to CEH endeavours. For instance, RNAO had a full-time expert in CEH issues, in addition to another staff with CEH expertise, leaving the Association well equipped to respond to CEH issues. One participant stated, *"it is a well staffed department. A department that requires strong credentials, strong academia, strong understanding of policy, and certainly has some expertise particularly in one or two members on environmental policies"* (Participant 28).

ARNNL was substantively smaller than either CNA or RNAO, having 14 staff and no policy department. Ten percent of one staff position was dedicated to all public policy issues.

Few staff and resources meant there was minimal capacity to engage in any public policy issues, including CEH.

**Priority Setting for CEH**

Priority setting for CEH is described under the following headings: Values and beliefs, monitoring and organizing evidence, screening policy priorities, and adjudicating policy priorities. Similarities and differences in how the Nursing Associations set priorities are described under these respective headings.

**Values and beliefs.**

The Associations shared similar values related to CEH. All three Associations indicated that the environment was a critical determinant of health and that action could lead to improved human and ecological health. There was widespread agreement among participants that governments had a duty to protect citizens from conditions that compromised the natural environment and human health and to promote healthful environments, particularly for those most vulnerable. Participants further acknowledged that nurses and their Associations had an ethical responsibility and societal obligation to address CEH issues. Representative of other participants' comments, one participant stated:

> *…if you say why does an association or an organization exist, it exists to deal with issues that are relevant to health and nursing. And if some of those environmental issues are relevant to health and maybe not even to nursing but it's relevant to the health of the population, then we have an obligation to deal with it.* (Participant 11)

Nursing Associations were perceived to be well positioned to bring voice to issues that perhaps individual nurses could not do alone, or could not do as effectively. Collective action through the Associations was perceived as having the further advantage of inspiring motivation, increasing strength through numbers, enhancing access to less accessible targets, adding credibility, and improving chances to overcome potential roadblocks.

However, there were differences within and across Associations in terms of the perceived Association roles in addressing CEH. Both RNAO and CNA saw their roles as advocating for a range of CEH issues that included supporting nurses in their CEH practice and advocating for policy directly. ARNNL participants were divided and had different ideas about this role for their Association. Some participants thought ARNNL should not be advocating for environmental conditions that had less direct and more complex pathways to human health.

**Monitoring & organizing evidence.**

The way Nursing Associations monitored and organized evidence related to CEH had implications for their CEH work. Both CNA and RNAO engaged in broad formal and informal scanning and monitoring process that generated an extensive list of nursing and health issues of potential interest to their Associations. CEH was one of many policy issues. Government departments responsible for the environment and corporations and industries that affected environmental conditions were deliberately monitored, which kept CNA and RNAO attuned to emerging and current CEH issues. However, participants from CNA indicated that inconsistent information gathering from their jurisdictional members contributed to the failure for CEH issues to be considered as a priority area of concern. While ARNNL also engaged in broad formal and informal scanning processes, the Association did not specifically monitor sources that would keep them informed related to CEH. CEH did not often emerge as an area of concern through ARNNL's routine scanning sources and participants suggested that ARNNL might not be fully informed about the public's policy concerns related to CEH.

Findings further indicate that the synthesis and organization of evidence had implications for prioritizing CEH issues. RNAO collated evidence related to CEH under what was referred to as a "*policy pillar*". Building sustainable, green communities was one of six policy pillars. This format permitted easy contrast of CEH issues with other policy priorities, which were then given to the Board for consideration. Participants from CNA reported that the lack of a user friendly format to synthesize diverse policy issues contributed to a long list of disjointed and unfocused policy issues from which Directors were expected to establish priorities. One participant commented:

> *But then we've got a 20 page document full of issues with no mechanism to really bring it together in a way that synthesizes or really enables us to take something, an issue that we are working on, and build it from their evidence or their experiences and so on.* (Participant 9)

Participants from CNA further believed that CEH got lost amid the list of many issues of concern. Evidence related to CEH was not synthesized by ARNNL.

**Screening policy priorities.**

While none of the three Associations had a documented priority setting process, judgments about whether CEH was an issue of interest and the order of its importance were

based on an implicit set of criteria. Common criteria to judge whether a policy issue would be of interest to the Associations included mandate/mission statements and evidence of inequity and/or social justice dimensions. While all the Associations stressed that decisions were based on current and reliable empirical evidence, there were variations in the types of evidence required. For instance, RNAO included assessments of the promises made by political officials for CEH as well as a self-assessment of the progress made by the Association in their CEH efforts. CEH issues with definitive research identifying the human health risks are considered to be more deserving of attention by ARNNL and CNA. ARNNL also emphasized that evidence needed to demonstrate the relevance of the public policy issue to nursing. In addition, the topic had to be one which nurses were knowledgeable about. Giving an example, one participant stated:

> *That is why [sic ARNNL is] not getting into the oil spill. What do I, nursing, know about oil spills? [....] So yes, ultimately I can see it impacting health but we really don't know anything about it. So it would have to be something that comes from our knowledge base. Like what it is we are taught.* (Participant 36)

Other criteria used to judge the relevance of policy issues were unique to the Associations. For instance, membership directives or approval were key-screening criteria for RNAO. For ARNNL, relevance to its public protection mandate was an essential screening criterion. Guided by these screening criteria, CEH was judged to be a relevant policy area of interest to all the Associations. However, requirements by ARNNL to address only issues that were directly relevant to ARNNL's public protection mandate, that had definitive evidence identifying the human health risks and impacts, and that demonstrated direct relevance to nursing imposed narrower parameters in the types of CEH issues that would be addressed by ARNNL. For instance, tar sands, deep sea drilling, and climate change were issues that would be screened out as areas of interest for the Association and partly accounted for the choices made by ARNNL.

The order in which CEH got priority among the policy areas was also guided by implicit criteria, some of which were common among the Associations. For instance, all three Associations indicated that CEH issues would receive higher priority when there were opportunities (i.e., judged partly by public and government attention and receptivity), organizational capacity (i.e., manpower, finances, time, expertise), and potential for impact (i.e., judged partly by population reach). CNA and RNAO were also more likely to give

attention to CEH issues when there was a sense of urgency (e.g., judged partly through number of times the Association was contacted, references in media, or pending government Bills) or public and nurse demand. Given their minimal resources for public policy, ARNNL emphasized that the opportunity to join other stakeholder initiatives was critical to their choice for ordering CEH as a priority.

**Adjudicating policy priorities.**

The Carver Model of Policy Governance© (2006) guides decision-making for all three Associations. Under this model, the decision rules and responsibilities, what good the Association achieves, for whom, and at what cost are articulated. RNAO and ARNNL reported the model provided clear direction and delineation of roles and responsibilities related to policy work. 'Executive limitation' policies provide parameters for their work and consultation with their governing bodies was only required when uncertainty existed. CNA employed a modified Carver Model whereby the Board *"abandoned all the negative language and talk about what the CEO will do"* (Participant 3). Thus, instead of a list of behaviours to avoid, the Association created a list of appropriate actions that could be taken. Increased consultation and approval from the Board was required when issues did not appear on the "can do" list. This resulted in delays for decisions.

Decision responsibilities among the governing body and home office staff also varied and could be traced to the Associations 'ends' policies. 'Ends' policies articulate purpose of organization (why the world would be a better place because of the work) (Carver, 2006). RNAO and ARNNL's 'ends' policies related to public policy were broad. They essentially articulated the purpose of the Association and explained why the world would be a better place because of their work. For instance, building green communities was one of six broad policy directions or – *"pillars"* endorsed by RNAO's governing body. ARNNL's Council authorized an even broader policy direction, endorsing advocacy for health public policy as an overarching goal. The home office staff of RNAO and ARNNL then had authority to decide specific policy issues to address (e.g., pesticides, toxins) and how they would be addressed during their strategic planning. Less formal and flexible decision-making occurred between strategic planning sessions that permitted a reevaluation of priorities for specific issues based on order of importance criteria (e.g., opportunity or need). This was particularly

important for emerging issues, as decisions to take action could be made quickly and did not have to wait for annual reviews or approval from the governing bodies.

As part of their modified model of governance, CNA abandoned 'ends' policies. As noted by a participant, "*we do a modified Carver Model,- a very modified [sic version]. We try and abandon most of Carver's language [….] We don't use ends, we talk about goals"* (Participant 3). These goals were much more specific by comparison (e.g., address climate change or pesticides). Consequently, and unlike RNAO and ARNNL, decisions about whether and what CEH issues would be addressed were considered policy, not operational decisions. This included, for instance, decisions about whether CEH issues such as pesticides and climate change were filtered at the level of the Board. Reaching decisions for both planned and emerging CEH issues thus required a highly formalized and standardized set of decision procedures that included a series of iterative steps whereby home office staff would prepare policy documents that would then require feedback from the Board. Revisions and reviews would continue until the BOD gave final approval. The layers of consultation and approval contributed to inefficiencies in priority setting including long delays or even the absence of decisions. In addition there was minimal flexibility for home office staff to accommodate requests for new and emerging issues. Tensions were created between the Board and home office personnel who believed there was blurring of policy and operational roles and interference as noted by the following participant who stated, *"the problem in my opinion is the Board wants to be involved in everything"* (Participant 6). Another stated:

> *The Board is supposed to be a policy Board. So not operational. So they should just be giving us broad priorities, not saying you should do a survey kind of thing. But they often do do that. They often say you should do something specific.* (Participant 1)

**Advocating for Community Environmental Health**

The three Nursing Associations engaged in a range of strategies that either aimed to build capacity or to influence CEH policy decisions directly. The following section describes the policy advocacy strategies taken by one or more of the Associations for CEH under the headings: building organizational capacity, building social capital, inspiring mass support for CEH issues, lending support to and leading in policy change, exercising political acumen, and pushing policy positions.

**Building organizational capacity.**

Building organizational capacity entailed efforts to nurture the Associations' abilities to conduct their business and achieve their policy ends or goals. The focus of building organizational capacity for CNA was revamping their strategic plan that was blamed for inaction or insufficient actions for public policy including CEH. This was exemplified by a participant, who stated:

> *I think you can always tell in an organization when a strategic plan is out of date. So in the years, the two or three years leading to this strategic planning session, the Board on an annual basis scratched their head and said what are our priorities anyway?* (Participant 9)

Efforts were directed at improving ways of working among the Board, home office staff, and members. For instance, consideration was being given to adding nurse experts to the Board panel (e.g., expert in environmental determinants), to design ways for cross-departmental work within home office, and to identify opportunities for engaging individual nurse members in the policy work of the Association. Despite efforts, participants were skeptical that building organizational capacity would lead to enhanced commitment to environmental determinants because of lack of buy-in from members, competing priorities, strained resources, and pattern of not sustaining efforts for some policy issues in the past.

RNAO had a current and comprehensive strategic plan, with priorities established from a broader vision that incorporated interdependencies among their policy priorities. In addition, the Association had established a strong identity and commitment to "knowing who they were" and why they existed. This identity and their policy directions were consistently articulated and had become embedded in the organization: *"I mean people keep changing every two to four years [….] But I am actually completely confident today that it would remain because it is in the fabric of the organization at all levels"* (Participant 15). Thus, building organizational policy included efforts to continue to attract, engage, and support BOD, home office staff, and members. Moreover, efforts included strengthening of network and workplace structures, which provided a means to keep members informed; provided members access to expertise, mentoring, and training; permitted the coordination of activities across the Board, Home Office, and the membership; and enabled equitable distribution of the policy work.

While ARNNL had a meaningful and functional strategic plan like RNAO, building organizational capacity was focused on retaining their right to advocate for healthy public policy. Referring to their right to advocate, one participant explained, "*not a lot of provincial regulatory organizations have that. And we fought to keep that. And we got support to keep it. It's really funny now because other groups, like when we look around, no one else is getting it"* (Participant 36). In addition, ARNNL looked to draw on resources developed by other nursing associations in order to build resources for CEH. Overall, an examination of the Associations' efforts to build capacity suggest that having the authority to advocate, a comprehensive strategic plan, and supporting infrastructure were critical to their CEH work.

**Building social capital.**

Building social capital entails a series of relational and communication efforts that aim to establish the Associations as valued players in CEH policy dialogues and decision-making. Fostering relationships with decision makers and members is a key strategy employed by all three Associations. Both CNA and ARNNL reported that efforts were taken to establish or maintain formal and amiable relationships with government officials to maintain open communication. On the other hand, RNAO has not only well-established formal and amiable relationships with senior government officials, but has also established personal relationships. One participant explained, *"they [sic politicians] regard RNAO quite highly in that there's a lot of visibility at our AGMs. Our Premier attends our AGMs every year. And politicians from the other opposition parties also have attended in previous years as well"* (Participant 24). With well-established open communication, RNAO focuses on maintaining their position as a valued player (e.g., often consulted) in CEH policy discussions and initiatives.

Fostering relationships with members is also an important tactic related to CEH for both CNA and RNAO. CNA was concerned that members might not see the Association as relevant and able to meet their needs when dealing with issues such as CEH. Thus, the rationale is provided for their policy choices and extensive consultation is arranged as a way to ensure inclusivity and gain buy-in from members. The identification and inclusion of members' needs were embedded in priority setting processes by RNAO. RNAO's focus is thus turned to balancing their efforts across a wide variety of policy areas (e.g., best practice guidelines, CEH) in order to address diverse concerns for many nurses.

Managing conflict is also a routine part of relational work. Participants from both CNA and ARNNL reported the use of non-confrontational approaches and avoidance of some CEH topics. Both feared their potential exclusion from other health policy decisions by government. In addition, CNA honours requests from their jurisdictional members to avoid particular CEH issues. These members feared retaliation from their respective provincial governments if they were associated with an organization advocating for CEH issues (e.g., losses related to nurse practitioner legislation). One participant described this challenge, stating:

> *But they have said to CNA on the environmental health issues [....] please don't come out and say anything about the tar sands because as a member of CNA the moment you do that I am going to get a phone call from the Minister of Health and the next time I want something in terms of changes for regulation the answer is going to be no.* (Participant 3)

ARNNL's biggest fears were the loss of privileges related to self-regulation and the loss of their bifurcated mandate.

RNAO uses both non-confrontational and confrontational approaches to bring attention to issues ignored by government. RNAO participants felt insulated from government retaliation because the Association did not have a regulatory function and members of RNAO had respectful relationships with provincial leaders. However, one participant indicated that when opposition exists, confrontational approaches are an effective way advance policy positions:

> *The best time to put your organization in the forefront of healthy public policy is when you have an adversary [….] It is much easier to gain profile when you are fighting with someone than when half of the time you are in agreement with someone.* (Participant 15)

Establishing their relevance as a knowledgeable and key player for community health issues is a key strategy employed by both CNA and RNAO. Believing that a lack of understanding limited their involvement in CEH initiatives, efforts include communicating CEH risks, spotlighting nurses' scientific and experiential knowledge, and underscoring the roles the Nursing Associations could serve. In addition, the Associations articulated their non-serving motives for involvement, which was perceived as a way to enhance their relevance.

All three Nursing Associations employed efforts to protect their reputation as a trusted profession and a potential source to inform CEH policies. In order to protect their reputations the Associations only used credible sources of evidence. However, the different types and uses of evidence varied among the Associations. For instance, RNAO believed they had credibility to speak to CEH, partly because of their contributions to the municipal and provincial pesticide legislations. This Association conducted thorough policy analyses for CEH issues, even when the link to health was not well established (e.g., coal-fired plants).

CNA and ARNNL participants believed that credibility held by their Associations for CEH primarily derived from nursing's reputation as a trusted profession. Thus, CNA used and spoke to issues for which a strong evidence base already existed that linked poor environmental conditions to human health. However, there was disagreement about what value nursing was adding by speaking to existing evidence. This contributed to dissention about what tactics should be taken. For instance, some participants thought CNA should continue to use existing evidence to raise awareness among nurses and the public about CEH concerns and to make visible nursing's role in these issues. Others argued that neither nursing nor CNA had established what they brought to advance CEH policy discussions. These participants suggested that the Nursing Associations needed to rethink their involvement in CEH policy issues and the consequences for wading into issues some perceived to extend beyond nursing expertise. For instance, one participant stated:

> *What could CNA possibly say about the tar sands in a position statement [….] And then where is the nursing community going to stand when everybody who is employed in the tar sands start complaining that they are losing their jobs, and it's on the backs of nurses? At a certain point, you do the analysis and say so what is it that nursing can do about the tar sands? And is nursing ready to do that kind of thing?* (Participant 4)

These disparities contributed to challenges for taking action. Similarly, ARNNL would not speak to issues that were perceived to *"extend beyond nursing knowledge"* or for which a link to the role for nursing was not explicit. Thus, lack of perceived knowledge and expertise prevented ARNNL from speaking out for many CEH issues. One participant explained:

> *Well, if we don't know anything about it then we shouldn't be commenting on it. So it has to be something that is within our knowledge [….] we are careful about what we speak about and limit that public address to issues that we would be knowledgeable about or should be involved in. And I think when you start delving then into those other things, that's when you start to lose credibility.* (Participant 35)

Overall, an examination of the Associations' efforts to build social capital suggests that having respectful relationships with decision makers and members and established relevance facilitated opportunities to engage in CEH. Perceptions about credibility served to both enhance engagement and diminish involvement in a variety of ways.

**Inspiring a mass of support.**

Inspiring a mass of support entails efforts to enlist a foundation of supporters for CEH issues. Participants believed that changing political will and mass mobilization are key to shaping CEH policies. All the Associations aim to gain support for action on CEH issues by raising awareness among nurses about how they could take action as both nurses and citizens. Opportunities for individuals and collectives to take action for CEH are created by both CNA and RNAO through the development of tools and resources, supporting attendance at conferences, or creating infrastructure for collective actions (preparing action alerts[22] or organizing lobbying events such as Queen's Park Day[23]).

Although enlisting supporters is viewed as an important step to influence policy, participants of CNA and ARNNL identified several barriers that diminish efforts for inspiring nurses or the public to take action. Both Associations reported that efforts to mobilize action were thwarted by a lack of nurse, public, and government interest or motivation to address CEH issues. Some of this apathy was attributed to the implications for employment opportunities, including the potential loss of employment opportunities if industries accused of compromising environmental conditions were to close. One participant explained:

> *And the thing with it too, if it's someone livelihood. Like if the community relies on that as their livelihood, it's a real challenge. It may be folded up for two generations down but right now I've got to feed my family. So it is interesting. Like the deep water oil drilling, when it was happening and Obama put a stop to any further work, well, we were just launching. And there was no public outcry to pause or hold.* (Participant 34)

Overall, examination of Associations' efforts to inspire mass mobilization indicates that lack of buy in and apathy among nurses, the public, and government diminished opportunities and efforts for CEH.

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[22] Note: Action alerts are messages that are sent out to members and their supporters asking for a specific action to be taken on a current political issue.

[23] Note: Queens Park Day is an annual event where upward of two hundred nurses and political leaders meet to discuss policy issues of concern to nurses.

**Lending Support to and Leading Policy Change in Partnership with Others.**

Lending support to and leading policy change in partnership with others entailed efforts to work collectively with those outside of nursing and health in order to address CEH issues. Participants suggested that shaping CEH policies required working with multiple partners and crossing jurisdictional and sectoral boundaries in order to create a synergy of expertise and knowledge, increase resources, provide a way to navigate geographical and jurisdictional barriers, and increase the power and legitimacy of the Associations in the eyes of the government.

All three Associations engaged in a stakeholder analysis, assessing and identifying appropriate CEH allies. They tended to join stakeholders who shared similar views and values, avoiding -*"extremists"* - in order to protect their reputation. One participant claimed:

> *The coalition itself is made up a mixture of professional and public people, and some, I guess, organizations like the [name removed of provincial environmental advocacy network] and [name removed of Canadian public policy advocacy group]. Things like that. But there are also individuals there. And when you mix both groups, it doesn't necessarily work out for the lobby advocacy styles. You know, we are not going to tie ourselves onto a tree.* (Participant 34)

However, some participants' suggested uncritical dismissal of potential partners likely led to missed opportunities for action. For instance, one participant argued:

> *So some of that is what we need to modernize and change the kind of people we partner with…. I think we just need to partner differently. And I think we also need to really look hard at who is the enemy, the traditional enemy.* (Participant 6)

While all three Associations join community environmental initiatives orchestrated by others, the roles they assume differed. For instance, both CNA and ARNNL primarily contribute to CEH initiatives by offering insights from a nursing perspective, lending their name (e.g., signing petitions), and serving as a knowledge broker with nurses and the public. For ARNNL, joining initiatives led by others is the only way they can become actively involved. The Association reported they could not be seen as being distracted from their primary regulatory mandate and CEH was seen as an issue on the periphery of nursing. However, opportunities to join groups in their province were rare. CNA looked for opportunities to approach potential partners to let them know the role the Association could play (e.g., developing clean air index). In order to access government officials in the Ministry of Environment, CNA would sometimes work through the Minister of Health.

While RNAO also joins CEH initiatives initiated by others, the Association often assumes lead positions in the initiatives. For instance, they are often approached to develop a policy analysis paper or to provide access to senior government officials. Because of the reputation they have for successfully advocating for policy change, it is not uncommon for the Association to be invited to carry over their partnerships to other CEH initiatives. One participant exclaimed, *"we are known to be the go-to people for particular issues"* (Participant 16). Another elaborated stating:

> *I think RNAO, certainly say in the pesticide ban, gained a lot of credibility as an organization that would go to bat for something that was in a way targeting big business where people said there is absolutely no way there would be any change made here.* (Participant 33)

Overall, examination of the Associations' collaboration for CEH suggested cross-sectoral efforts provide opportunities to inform policy work and influence change across geographic and jurisdictional boundaries. However, fear of tarnishing reputation and lack of opportunities to join initiatives diminishes efforts for CEH.

**Exercising political acumen.**

Exercising political acumen entails efforts to secure a nursing voice in CEH policy decisions. Both CNA and RNAO exercise political acumen for CEH. There were no reports that ARNNL reached this level of policy advocacy specific to CEH. Assessing political, economic, socio-cultural, ecological and professional realities and determining the most appropriate targets, approaches, and forums for action are political skills employed by both CNA and RNAO. When political officials or the public are not receptive or when demands exceed organizational capacity, adjustments are made to the strategies used, the target for change (e.g., public or government), and to the timing and intensity of the efforts for CEH.

RNAO did not just respond to shifting contexts, but was also proactive in planning action in anticipation of events. For instance, RNAO developed and released policy platforms well in advance of provincial political elections as noted by a participant who stated, "*so we are usually out a year and a half ahead of the next election because our goal is actually to shape the platform, not to respond to the platform of each party"* (Participant 32).

Both CNA and RNAO examine power dynamics and weigh risks and benefits. When faced with risks,  and their responses differed. For instance, when government is unreceptive,

actions were not often taken by CNA, as efforts were thought to be futile and resources thought to be better invested in other areas. Deliberate choices were made to avoid topics to prevent potential loses in other areas (e.g., gains in other policy areas). However, unreceptive governments were often a signal for RNAO to enhance efforts. Participants explained that the Association could not deviate from what it stood for: "*so I think the success of organizations is in large part built on knowing who you are as an organization and what do you stand for [….] Otherwise your identity changes every other day. And no one knows who you are"* (Participant 15). Another went on to say, "*I know just by who RNAO is and what it stands for that we wouldn't change our message if somebody didn't agree"* (Participant 21). Thus, RNAO did not abandon issues, but made deliberate choices to approach topics in ways that would maintain respectful working relationships with government officials.

Framing is an essential tactic to underscore the relevance and enhance the visibility of CEH issues. For instance, participants from CNA emphasized the human health impacts, believing this position would bring more attention to CEH problems. Sometimes CEH issues are attached to the prevailing public agenda in order to bring attention to specific concerns (e.g., water issues attached to maternal-child issues). However, some participants suggested that the messages by CNA are conservative and their vocabulary needs to expand in order to seriously speak to government. Framing employed by RNAO was different from CNA. First, RNAO deliberately speaks of environmental health as a separate issue from other social determinants to bring emphasis to it. Second, RNAO conducts economic analysis and adopts the economic parlance common to CEH policy that allows them to effectively engage in policy deliberations. Overall, examining the Associations' exercise of political acumen underscored the importance of reading and responding to shifting contexts in order to ensure the right strategy, intensity, target and timing of efforts. Associations were less likely to be derailed from their efforts when they took a strong stance on what they stood for as an organization, anticipated events and were proactive, and immersed in the language and dialogue of the CEH field.

**Pushing policy positions.**

Pushing policy positions includes a direct effort to get a CEH issue on the government's radar and agenda, or to change or strengthen existing policy. While both CNA and RNAO push policy position, some actions differ. Both CNA and RNAO engaged in

direct advocacy efforts. There were no reports that ARNNL reached this level of policy advocacy specific to CEH.

Leaders of CNA meet directly with members of federal parliament, and on occasion international government officials, to communicate their CEH concerns, to go on record about issues on behalf of the Association, and to share their analysis of alternatives and recommendations for action. Collective advocacy efforts are rare for CNA, but occasionally include mass writing campaigns. Some participants from CNA believed the Association had not achieved a visible presence in terms of CEH and there is risk involved when claims for involvement are not supported by substantive efforts:

> *There is always a risk of claiming to be present on an issue when your only presence is a press release or a one-night stand media statement or event or whatever. Because basically people who are involved in the policy workings of government will be dismissive. "Oh, yeah. That's CNA. They are just mouthing off again. They won't follow up. Don't worry about it.* (Participant 4)

On the other hand, RNAO consistently engages in an active advocacy campaign for CEH issues. Direct advocacy by RNAO includes meeting or writing senior government officials or their staff, testifying at political hearings, and signing petitions. Believing RNAO's power multiplied when nurses were united, direct advocacy also includes collective efforts such as mass e-mails (e.g., action alerts) or participation in organized face-to-face events at the legislature in order to emphasize the seriousness of a CEH concern and force discussion about a policy issue. Overall, the Associations used individual, as well as collective advocacy efforts to gain the attention of the government and the public. However, lack of sustained efforts sometimes compromised the effectiveness these actions and the Associations' reputations as valued players in CEH.

## Discussion

A whole-systems socio-ecological approach for health system change informed the research design and is the analytic lens used to discuss the findings. Through this lens, processes and structures and their interplay across spatial, jurisdictional, and temporal scales and levels of the system were revealed and help explain the way the Nursing Associations set priorities and took action for CEH.

### Priority Setting Processes

The study findings indicate three key priority setting processes establish whether a

CEH issue is of interest to the Association, as well as the order of its importance. These processes include: (a) knowledge development; (b) assessing perceived value added and risks; and (c) screening and adjudicating. First, knowledge development, including the scanning and monitoring, organizing and synthesizing, and presentation of evidence to organizational decision makers, is an essential component of successful policy priority setting. Other research has identified information management as a key element of priority setting (Peacock, Mitton, Bate, McCoy, & Donaldson, 2009; Sibbald, Singer, Upsur, & Martin, 2009). From a whole-systems socio-ecological perspective, having substantive knowledge and knowing how to respond to environmental change is a form of cultural capital. This capital is considered a prerequisite for "the management and sustainable use of resources" (Gunderson & Holling, 2002, p. 123). During periods of growth and conservation, nursing organizations accumulate various types of knowledge that can then be used during periods of reorganization (e.g., response to crises). Moreover, information that is organized, synthesized, and presented to Association decision-makers in a user-friendly format (Lavis, 2006) renders CEH more visible amid other policy priorities and facilitates screening and adjudication processes.

Assessing the perceived value added or the risks involved because of their participation is a second dimension of nursing associations' priority setting processes. A sense of added value was a necessary element for involvement. Motives supporting involvement in CEH initiatives, for instance, included a belief that their engagement would improve CEH policy decisions by bringing practice knowledge and policy analyses to CEH policy decisions, by enhancing group credibility, by serving as knowledge brokers, or by providing access to government officials. On the other hand, the Nursing Associations did not get involved when they perceived they did not have the expertise or skill required to enhance policy decisions. While substantial literature indicates that lack of role clarity and misunderstanding about stakeholders roles can inhibit participation in policy collaborations (Martin-Misener & Valaitis, 2008; Xyrichis & Lowton, 2008), less is known about the collaborative capacity an organization "should be equipped with and how those capacities are developed" (Lai, 2012, p.15). Collaborative capacity includes the ability to "resolve difficult policy problems across agency, jurisdictional, and public problem domains" (Rogers & Weber, 2010, p. 547). Lack of collaborative capacity at the organizational level is a factor deterring organizations from

entering into, developing, and sustaining collaborative relationships (Lai; Page Hocevar, Jansen, & Fann, 2011). For instance, in their case study research investigating watershed partnerships, Leach, Pelkey, and Sabatier (2002) noted that organizations got involved in environmental projects for various reasons including a perceived ability that they had something to offer to the solution. Thus, part of the capacity to engage in CEH requires a belief and acknowledgment by the Nursing Associations that they do have contributions to bring to CEH policy decisions, including those that are outside the health sector.

A third dimension of priority setting for CEH includes screening and adjudicating. Findings from the three cases indicate that while an explicit set of criteria may be helpful to identify policy priorities of interest to the Associations, a precise list of criteria are seemingly less helpful in ordering those priorities. Broad screening criteria such as mandates and values (e.g., social justice issue) served as checkpoints to ensure that the priorities set aligned with the purpose, and thus were relevant to the Association. However, criteria to establish order of priority were not fixed, but fluctuated in the dynamic and day-to-day decision-making of the Associations' policy environments. For instance, membership preferences and sense of urgency used to judge preferential treatment shifted in response to external disturbances (e.g., crisis or introduction of a new Bill). This shifted the order of priorities over time as the Associations strove to be responsive to changes in the policy context. In addition, a list of criteria did not necessarily assist members of the governing Boards to reach consensus about the order of priorities. It was particularly difficult to get Board consensus on what policy issues were most urgent. This finding aligns with other priority setting research that indicates criteria or principles used to guide decisions are often controversial (Daniels & Sabin, 1997; Lindstrom & Waldau, 2008). In pluralist societies, reasonable disagreement about principles that guide priority setting is likely. Thus, processes for adjudicating priorities become critical (Daniels & Sabin). From a whole-systems socio-ecological perspective, organizations need to be able to use contextual professional, legal, social, economic, political, and ecological knowledge to decide whether the most appropriate response is to innovate or perhaps accumulate resources.

**Policy Advocacy for Community Environmental Health**

Nursing Associations engage in a range of advocacy strategies that aim to build physical and social capital and to mobilize and advance policy positions. Other research

similarly notes the importance of accumulating resources that can then be accessed during opportune times (Gunderson & Holling, 2002). In their case study research of ecosystems, Gunderson and Holling reported that building social capital was particularly essential in order to "capitalize on the energy and movement of others" (p. 354). Social capital is described as "the aggregate of actual or potential resources that can be mobilized through social relationships and membership in social networks" (p. 231). Stakeholders enter into collaborations "on the basis of their belief that they share representations, interpretations, and systems of meaning" (Gunderson & Holling, 2002, p. 232). Making links among like-minded stakeholders has the benefit of profiling issues for those who are unaware that a problem exists or have not considered what role they might play. Profiling also gives a collective name to a problem, and exerts influence at levels of aggregation that could not be done by stakeholders working in isolation of one another (Gunderson & Holling). In addition, open-ended or loosely-coupled relations that grant flexibility and adaptability enhance organizations' collaborative capacity, permitting them to adapt to environmental contingencies and coordinate the exchange of resources (Lai, 2012).

Participants further identified that the formation of relationships with those with seemingly different views than those of the Nursing Association may be an important tactic for change. Gunderson and Holling (2002) agree, suggesting change may become "particularly restricted when either patterns of collaboration or patterns of conflict become so established and routine that they become rigid and ritualistic" (p.230). Forming partners with those who may appear as *"strange bedfellows"* or the *"enemy"* fosters interactions among stakeholders with differing power and interests and can generate change or an ability to deal with barriers to change.

**Structures Organizing Nursing Associations' Engaged CEH**

**Incorporation Statutes.**

At the federal and provincial level, Incorporation Statutes that allow the Associations to set ends for public policy issues are essential for the Nursing Associations to engage in CEH. In the case of ARNNL, the legislation permits a bifurcated mandate, which allows the Association to hold both a public interest and professional interest mandate. With these dual roles permissible, the leadership of the Association then has the latitude to set an end for healthy public policy that supports action for CEH. In the case of CNA and RNAO, the

legislation permits the members to determine both their mandates and organizational ends. In consultation with members, leadership sets ends or goals for public policy issues that support CEH. The absence of a public policy end may inhibit action for public policy (Bryce & Bayne, 2010), including CEH.

**Regulatory functions and support of regulation.**

With the authority for the regulation of professions resting with Canada's provincial/territorial governments, recent regulatory legislation reforms have resulted in diverse regulatory and policy mandates for Nursing Associations across the country. In some cases regulatory functions and public policy mandates co-exist. For instance, a review of legislation governing Alberta's Nursing Association determined it acceptable for the organization to hold a bifurcated mandate, recognizing that separation would impose excessive costs and might polarize the profession (Bryce & Bayne, 2010). Newfoundland and Labrador's most recent reform of its Registered Nurses Act (2008) similarly retained a bifurcated mandate. Other reviews (Health Professions Council, 2001) have led to opposite conclusions, suggesting that without separation "the public protection function of the college would become blurred with the membership promotion function of the professional association" (section Barriers to Interdisciplinary Practice). Another review of Canadian case law (Bryce & Bayne) similarly emphasized that legislation must expressly allow organizations to act for both public and professional interests if an association is to engage in public policy efforts. However, even when legislation endorses a public policy function, the public interest mandate related to the profession's core function - in this case, the core responsibility to oversee and regulate the practice of individual registered nurses - must be kept paramount. Thus, legislative reforms that require the delineation of regulatory privileges from other professional interests, including public policy advocacy, diminish or remove the ability for nursing associations to engage in CEH.

In addition, disagreement among Canadian nursing associations about the restrictions imposed by these diverse legislations contributes to tensions among the nursing associations and diminishes opportunities for collaborative endeavours for CEH among nursing organizations. A greater understanding of the implications of regulatory legislation reforms can lead to clarification of the parameters under which nursing associations must abide and to opportunities to support cooperative and synergistic efforts. For instance, an opportunity

may exist for regulatory bodies to incorporate environmental health competencies into education curricula, which aligns with a regulatory mandate.

**Federated corporate structure.**

My findings underscore the challenges faced by the federated Association to reach consensus or take action for CEH. Tensions in the way national and regional entities interface are shown to be a major stumbling block in the ability of national organizations to enact strategic priorities (Ferkins & Shilbury, 2010). Scholars investigating the problems faced by federated organizations provide suggestions for overcoming such barriers. For instance, Fafard and colleagues suggest that addressing federal and provincial/territorial tensions requires members "to place less emphasis on social and political cohesion and much more on establishing "a relationship of mutual trust between the various entities in the political federal space" (p. 21). The experiences of other non-governmental organizations (NGO) suggest that frank discussions can bring greater awareness of the interdependencies between the national and provincial/territorial bodies and clarification of power dynamics and issues of ownership (Mollenhauer, 2006). Other factors critical to the success of NGO federations include a clearly articulated and agreed upon mission and values, the delineation of roles and responsibilities, a willingness and capacity for the Board to provide good governance (e.g., mix skills and expertise and focus on interests of the federation), a well understood and agreed process for decision making and conflict resolution, shared leadership, and consistent adherence to policies (Mollenhauer).

**Governance.**

Governance is the building block upon which association ends/goals are developed and the capacity to carry out the work is established (Carver, 2006). The findings in this study underscore that the design of 'ends' and 'executive limitation' policies have a critical influence on the Associations' flexibility and capacity to respond to CEH in a dynamic policy environment. High-level ends that "represent what the organization is, not about what is does" (Carver, 2006, p.48) and that allow home office to attend to operational issues support timely responses to the policy context and to emerging issues. Other scholars similarly note that those involved at the operating level, including executive directors, often have a better understanding of operational issues since they are more directly involved in the policy work and political environment (Stone & Ostrower, 2007). Thus, home offices of the

Nursing Associations are in a better position to choose the most appropriate specific policy goals and ways to address them.

'Executive limitation' policies that define what is considered unacceptable behaviour as a way to establish boundaries for prudent and ethical organizational behaviour "leaves open all other possible methods" (Carver, 2006, p.122) and saves the governing Board from making countless separate decisions (Carver). On the other hand, Boards that retain approval power over specific policy goals or how to achieve them (i.e., operational matters) can stifle responses and paralyze policy work. Moreover, tensions arise when there is disagreement between the Board and home office staff regarding policy versus operational roles. Other scholars have noted that perspectives and expectations among Board members and home office concerning their roles and responsibilities can vary greatly (Carver; Stone & Ostrower, 2007). In order to reduce tensions, careful attention should be given to the definition of roles, distinct responsibilities, and mutual relationships expected for the governing and operating bodies. Operating bodies can help Boards retain their appropriate Policy Governance© role by not taking executive decisions to the Board table and by avoiding making recommendations. Instead, policy options and their various implications should be presented to the Board for consideration (Carver). In turn, governing bodies must establish policies that empower the ED to work to full potential. Returns are most promising when the ED has the freedom to make decisions that are bounded by clear limitations as to what is not acceptable.

**Policy capacity.**

Policy capacity was shown as an essential factor shaping whether and how the Nursing Associations' engaged in CEH. Incomplete and inadequate synthesis of evidence, lack of cross-departmental collaboration, absence of CEH networks or opportunities to join initiatives, and lack of access to stakeholders to carry out the work (e.g., members) diminished or delayed decision-making, prevented the Nursing Associations from engaging in CEH initiatives, and contributed to tensions when significant demands or expectations were placed on staff and Board Directors. My findings support other research that identified similar factors impacting policy capacity (Carver, 2009; Gleeson, Legge, & O'Neill, 2009; Gleeson, Legge, O'Neill & Pfeffer, 2011; Greenwood, Raynard, Kodeih, Micelotta, & Loundsbury, 2011; Lavis, 2006). For instance, knowledge translation literature suggests that establishing processes and formats to systematically gather, synthesize, and present

information in user-friendly formats is important to facilitate decision-making (Lavis). Deliberately hiring and recruiting personnel with knowledge and values that align with the organization, and making use of external expert consultants are means to cultivate an appropriate mix and supply of expertise required (Carver, 2006; Gleeson et al., 2009; Gleeson et al., 2011). Improving communication and ways of working among departments or among different policy portfolios are other important tactics for enhancing policy capacity (Gleeson et al., 2009; Greenwood et al., 2011). Investments in building and maintaining relationships and communicating with stakeholders on major policy areas are also critical (Gleeson et al., 2009; Gleeson et al., 2011).

**CEH Policy Field and Cross-Scale and Cross-Level Interactions and Dynamics**

This study further underscores the need to consider the governing and operating environment, and the broader authorizing environment that establishes the parameters for the Nursing Associations' CEH work. According to Hoffman (1999), actions taken by organizations are "not seen as a choice among an unlimited array of possibilities determined purely by internal arrangements" (p.351). Rather "a choice is made among a narrowly defined set of legitimate options" (Hoffman, p.351) determined by the group of stakeholders composing the organization's policy field. Thus, policy fields are centres of debates wherein field constituents with both similar and opposing perspectives, both collaborate and compete to shape policy change (Cash et al., 2006; Hoffman, 1999). It is here that possibilities for choices are shaped.

Nursing Associations' engagement in CEH is embedded in a policy field comprised of community of stakeholders brought together through their interest and objects related to CEH issues of concern. This field is characterized by channels of dialogue and disputes whereby the type of evidence and issues that are important, the legitimate geographic and jurisdictional levels to target, the appropriate strategies to take, and the relevant stakeholders who should be involved are communicated.

Examining the Nursing Associations within this policy field underscores cross-scale and cross-level interactions and thus opportunities for enhancing relationships and actions for CEH. Scales refer to "spatial, temporal, quantitative or analytical dimensions" (Gibson, Ostrom & Ahn, 2000, p. 119) that can be to used to study and measure structures and processes. Examples of scales relevant to the Nursing Associations' CEH work that emerged

include spatial scales (e.g., geographic spaces such as provinces or countries), jurisdictional scales (e.g., bounded political units such as municipal and provincial governments), and temporal scales (e.g., units of time such as rates, frequencies, or durations). Levels refer to the locations or units of analysis that are located at different positions on a scale (Cash et al., 2006). For instance, Newfoundland, Nova Scotia, and Ontario can be viewed as level units on a spatial scale.

The different ways that the Nursing Associations were affected by system changes (e.g. events and conditions) are suggestive of cross-scale and cross-level interactions and dynamics. For instance, restrictions to addressing a CEH issue (e.g. tar sands) by a Nursing Association in one part of the country imposed limitations for a Nursing Association to take action for the same CEH issue in another province and jurisdiction. Cross-scale and cross-level interactions were evident in the findings that identified how changes result in diverse effects among the Nursing Associations. For instance, changes to regulatory legislations seemingly impose different degrees of constraints for public policy work among jurisdictional members of the National Association. In addition, the Associations interpreted the extent of these constraints differently. In turn, these diverse constraints and interpretations had implications for the way the National Association could conduct its policy work for CEH.

The findings further underscore the need for attention to cross-scale and cross-level interactions when planning policy change. For instance, there were few examples when CEH efforts were coordinated across provinces, across jurisdictions, or across times. An exception to this finding was action taken to influence pesticide legislation at both the municipal and provincial or territorial level. Evidence suggests that "systems that more consciously address scale issues and the dynamic linkages across levels are more successful at assessing problems and finding solutions that are more politically and ecologically sustainable" (Cash et al., 2006, conclusion).

From a whole-systems socio-ecological lens (Gunderson & Holling, 2002), managing within dynamic systems requires consideration of the nature of change. From this perspective change is episodic, characterized by slow accumulation of capital and sudden releases and reorganization of a system. Change is also non-linear and discontinuous, with unpredictable and uncertain change occurring at various points in the system, with uneven intensity of

influence experienced at these points, and with varying rates (i.e., slow and fast moving), frequencies, and durations (i.e., degree of persistence). Thus, management has to be flexible, adaptive, and experimental across scales and levels (Cash et al.; Gunderson & Holling). The goal is not to command and control (Gunderson & Holling), but to set overall conditions that allow adaptation. In other words, in order to manage their policy work within dynamic environments, the goals for the Nursing Associations is to conserve the ability to adapt to change and "be able to respond in a flexible way to uncertainty and surprises" (Gunderson & Holling, p. 32).

Strategies are offered in the literature for guiding how to recognize and exploit cross-scale and cross-level interaction, which can support priority setting and policy advocacy for CEH by the Nursing Associations. First, there is a need to overcome what Cash et al. (2006) refers to as *"ignorance"* (Challenges section) about cross-scale and cross-level interactions and dynamics. The failure to recognize scale and level interactions is considered a problem of ignorance and can lead to management problems. For instance, the implications of regulatory legislation reforms showed its face in the boardrooms of the Nursing Associations attempting to set policy priorities for CEH. Lack of agreement about whether it was legislation or the interpretation of that legislation that prevented the Nursing Associations from participating in public policy discussions created substantial tensions among the Nursing Associations and hindered decision-making for policy priorities and action. Attention to cross-scale institutional dynamics in which legislation at higher levels of a scale impose barriers at lower levels of scale (e.g., hierarchy of legislative rules) draws emphasis to the source of constraints (Cash et al). Shifting the focus from examining whether legislation or interpretation hinders engagement, to identifying solutions to work within imposed constraints can facilitate opportunities for enhanced decision-making and engagement in CEH.

Second, there is a need to address *"mismatched"* (Cash et al., 2006, Challenges section) cross-scale and cross-level dynamics. The failure to coordinate across scales and levels is a problem of mismatch and can lead to unexploited chances to redesign or restructure efforts for more desirable outcomes (Cash et al.; Young, 2006). For instance, a mismatch occurs at the temporal level when the timing of policy efforts within and across the Associations is not considered. Associations that engage in one-off initiatives or fail to

coordinate efforts across provinces or across jurisdictional levels can lead to missed opportunities for mutual gains, synergistic effects, or sustainable impacts. Other health services research has found that combining and sequencing efforts within and across spatial, jurisdictional, and temporal scales and levels can lead to synergistic effects (Edwards et al, 2007; Riley et al., 2008).

Third, addressing the problem of cross-scale and cross-level *"plurality"* (Cash et al., 2006, Challenges section) is essential. A problem of plurality includes the failure to recognize the heterogeneity in the way factors affect organizations differently or the assumption that there is a best solution that applies to all organizations. Problems of plurality lead to ineffective decisions and an inequity in outcomes among the organizations (Cash et al., 2006). For instance, advocacy strategies that are safely and effectively employed in one province or jurisdiction can lead to unfair burdens if employed in other provinces or jurisdictions (e.g., government retaliation). Preferences of one scale or level-bound group of stakeholders may not align with gains hoped for by others. Thus, procedures for scale choice, explanation, and resolution need to be negotiated and devised "in ways that allow for the appropriate representation of scale-related interests" (Cash et al., p. 8). This approach is similar to what Young (2006) describes as negotiated agreement where there are recognized roles for stakeholders at more than one level. This is in contrast to imposing regimes that may be successful in one context on another level, assuming the same result will be possible. Thus, when planning CEH policy efforts, the Nursing Associations need to consider that approaches to policy change may look different across geographic and jurisdictional spaces (e.g., threats of government retaliation may require different approaches to lobby government).

A further plurality barrier for engaged CEH advocacy concerns the diverse ways that knowledge and roles can be perceived among different stakeholders in the system. Perceptions of participants about the credible and legitimate knowledge and contributions the Nursing Associations could bring to CEH discussions was an essential factor guiding their appraisal of issues to address, as well as roles they would take on. Believing that the public and government officials did not understand the value added by the Nursing Associations' participation, substantial efforts were directed toward fostering relationships, establishing their relevance, and protecting their reputations in order to gain visibility and support for

their involvement as valued players in CEH policy dialogues and decision-making. In a similar vein, the Nursing Associations' policy endeavours were further shaped by a concern that their involvement in public policy change for issues such as CEH would be perceived to extend beyond the boundaries of public protection and in some cases be judged as self-serving. In addition, the concepts of public protection and interest are both narrowly and broadly conceived. Public protection and interest conceived narrowly focuses on practice, standards, licensure, and discipline. From this perspective, advocacy for public policy focuses on the quality of nursing practice. Public protection and interest conceived broadly include factors affecting the health of the public. Cash et al. (2006) suggest that knowledge can be held, stored, and perceived differently across scales and levels, resulting from differences "about what is perceived as salient, credible, and legitimate knowledge, or what is perceived as the important scale or level of the problem" (section on boundary and bridging organizations). To address this challenge, players that serve an intermediary role can help to manage barriers and facilitate the co-production of knowledge about problems and their solutions (Cash et al.). My findings suggest that an intermediary roles was already taken on by one Association. This Association opened doors to government and engaged in activities to mobilize support and change the political will of the public for enhanced CEH.

The findings call into question conceptualizations of leadership when addressing CEH. Solving complex policy issues through cross-scale and cross-level efforts requires stakeholders to lead diverse and essential roles. The combined contribution of efforts lend to successful advocacy (Crosby & Bryson, 2005; Sharma & Kearins, 2011). Yet, leadership within collaborations is not well understood (Connolly, 2007). Leadership is commonly portrayed as a leader-follower interface. However, more recent political and organizational leadership literature draws attention to processes rather than hierarchical relationships. For instance, Barrett and colleagues (2007) conceptualize leadership as a multi-dimensional process involving multiple stakeholders across levels of the policy field. Friedrich and colleagues (2009) similarly suggested that many team members might serve as leaders in both formal and informal capacities, with shifting leadership responsibilities rooted in "which individual's expertise is most relevant to the given problem" (p. 933). These conceptualizations are a better fit with the leadership expected of the Nursing Associations in their engagement with complex policy issues that require collaborative approaches, such as

CEH. Leadership, as a multi-dimensional process, not only provides a way for nursing to name what they do, but also to bring recognition and value to the contributions made. For example, providing the lead for access to government would reflect political leadership. Successes such as these could serve as models from which other associations might learn. An expanded conceptualization of political leadership also points to areas for potential growth and opportunity for nursing associations. Enhancing skills in joint decision-making, revisiting how nurses select acceptable team players, reconsidering acceptable levels of risk, gaining skills as good followers, and refining how to adapt in dynamic and conflict-laden collaboratives may be areas for development (Barrett, Plotnikoff, & Raine, 2007; Friedrich,Vessey, Schuelke, Ruark, & Mumford, 2009).

**Institutional Pressures**

Lastly, this study also highlights regulatory, normative, and cognitive institutional pressures that operate to define what is possible, acceptable, and legitimate engagement for CEH among the Nursing Associations. These institutional pressures contributed to diminished policy capacity, restricted the types of issues addressed and the strategies used, and deterred cross-scale and cross-level efforts. For instance, potential losses (e.g., loss of membership support), retributions (e.g., exclusion from inclusion in other healthy public policies), or unintended consequences (e.g., create repercussion for other nursing associations if action taken within another associations' primary provincial/territorial and jurisdictional territory) served as coercive pressures limiting the choices and actions taken. Normative prescriptions about professional and reasonable behaviour influenced the selection of partners and deterred action for issues perceived to be on the *"periphery"* of nursing or outside normative expectations of what nurses do. Beliefs that the environment is a static entity that can be separated from human health deter action for issues in the absence of definitive evidence identifying the human health risk and impacts and the direct relevance to nursing. Other research indicates that regulative, normative, and cognitive institutional pressures influence the range of organizations options when involved in CEH (Hoffman, 1999). Hoffman proposes that institutional pressures are social processes determined by the group of stakeholders comprising the policy field that shape what can and cannot be acted upon.

## Conclusion

The Nursing Associations' priority setting and policy advocacy for CEH is shaped by federal, provincial, and organizational structures and institutional pressures, including rules, expectations, and beliefs that both create opportunities and limit the choices and actions taken. Institutional theory is specifically facilitative in identifying social processes and their mechanisms through which choices and actions are taken and for revealing the limited options that are imposed.

A whole-systems socio-ecological approach to examining the Nursing Associations' priority setting and policy advocacy brings understanding to the discontinuous and non-linear nature of change and to the supports and constraints experienced by the Nursing Associations operating in various provinces, jurisdictions, and at different times. Understanding cross-scale and cross-level dynamics is essential to plan policy priorities and to taken action. Moreover, overcoming ignorance, dealing with issues of cross-scale and cross-level mismatch, and addressing problems of cross-scale and cross-level mismatch can lead to enhanced ability to navigate within the dynamic policy field and to manage the inherent collaborative relationships that characterize policy advocacy for CEH.

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**Table 6.1 Interview Guide**

| Questions to guide participant interviews |
|---|
| 1. How does your organization become aware of a policy issue? |
| 2. How does your organization decide which policy issues it will become involved with? |
| 3. How do your nursing members inform the policy choices and actions of your organization? |
| 4. What role do you think nursing organizations should play in environmental health?<br>• Probe: What distinction do you see between the role for individual nurses and those for nursing organizations for community environmental health? |
| 5. What public credibility does your organization have with respect to its role in community environmental health?<br>• Probe: Does anyone ever question "what nursing has to do with environmental health"? |
| 6. What political credibility does your organization have with respect to its role in community environmental health? |
| 7. How does your organization's governance structure influence your policy choices and action for community environmental health?<br>• Probe: composition of BOD; how members become part of the BOD; processes used |
| 8. There are 13 nursing organizations in Canada: 12 provincial and 1 national. How does the [provincial/national] jurisdictional mandate of your organization influence its policy choices and actions for community environmental health?<br>• Probe: ask about opposite level |
| 9. How does regulatory and/or policy mandate of your organization influence its policy choices and actions for community environmental health? |
| 10. What are major external influences on your organization's policy priorities and actions for community environmental health? |
| 11. How do system shocks such as catastrophes, crisis, or government changes influence your organization's policy priorities and actions for community environmental health? |

- Would you describe an example of when your organization decided to address a community environmental health issue and/or when they decided NOT to address a community environmental health issue?
- Probes: What triggered your organization's decision to consider addressing the community environmental health issue? What were the main factors that influenced the choices made?

12. Describe the benefits for nursing organizations to be involved in community environmental health?

13. Describe the risks for nursing organizations to be involved in community environmental health?

**Table 6.2 Demographics by Associations and Participant Sex, Education, Professional Occupation, and Organization and Policy Experience**

| | Cases (N = 41) | | | |
|---|---|---|---|---|
| | CNA n =14 | RNAO n =19 | ARNNL n = 8 | Totals[1] |
| Particulars | n (%) | n (%) | n (%) | n (%) |
| Sex | | | | |
| Female | 13 (92.9) | 14 (73.7) | 8 (100.0) | 35 (85.4) |
| Male | 1 (7.1) | 5 (26.3) | 0 | 6 (14.6) |
| Professional Education | | | | |
| Nursing | 13 (92.9) | 12 (63.2) | 6 (75.0) | 31 (75.6) |
| Non-nursing | 1 (7.1) | 7 (36.8) | 2 (25.0) | 10 (24.4) |
| Highest Education Completed | | | | |
| Diploma/Degree | 1 (7.1) | 3 (15.8) | 2 (25.0) | 6 (14.6) |
| Masters | 10 (71.4) | 14 (73.7) | 6 (75.0) | 30 (73.2) |
| PhD | 3 (21.4) | 2 (10.5) | 0 | 5 (12.2) |
| Years of Professional Experience[2] | | | | |
| 3- 9 | 0 | 2 (10.5) | 1 (12.5) | 3 (7.3) |
| 10-19 | 2 (14.2) | 4 (21.1) | 1 (12.5) | 7 (17.1) |
| 20-40+ | 12 (85.7) | 12 (63.2) | 6 (75.0) | 30 (73.2) |
| Training in Community Environment Health | | | | |
| None | 9 (64.3) | 8 (42.1) | 4 (50.0) | 21 (51.2) |
| Self-Taught | 2 (14.2) | 7 (36.8) | 3 (37.5) | 12 (29.3) |
| Formal Training | 3 (21.4) | 4 (21.1) | 1 (12.5) | 8 (19.5[3]) |
| Position in Association | | | | |
| Current Staff Member | 8 (57.1) | 15 (78.9) | 5 (62.5) | 28 (68.3) |
| Current Board Member | 4 (28.6) | 4 (21.1) | 3 (37.5) | 11 (26.8) |
| Past Staff Member | 2 (14.2) | 0 | 0 | 2 (4.9) |
| Role in Association | | | | |
| Senior Management/ Decision-Makers | 12 (85.7) | 14 (73.7) | 6 (75.0) | 32 (78.0) |
| Consultants/Research Analysts | 2 (14.2) | 5 (26.3) | 2 (25.0) | 9 (22.0) |
| Years with Association | | | | |
| Less than 2 | 4 (28.6) | 4 (21.1) | 1 (12.5) | 9 (22.0) |
| 2-9 | 8 (57.1) | 10 (52.6) | 5 (62.5) | 23 (56.0) |
| 10-30+ | 2 (14.2) | 5 (26.3) | 2 (25.0) | 9 (22.0) |
| Years of Policy Experience | | | | |
| Less than 2 | 0 | 5 (26.3) | 0 | 5 (12.2) |
| 2-9 | 3 (21.4) | 9 (64.3) | 2 (25.0) | 14 (34.1) |
| 10-30+ | 11 (78.6) | 5 (26.3) | 6 (75.0) | 22 (53.7) |

[1] Column totals do not always equal 100 percent because of rounding
[2] One value missing
[3]One held a diploma related to community environment health; one held a certificate in occupational health; the remaining had taken course

**Table 6.3 Comparison of Organizational Attributes Among the Three Canadian Nursing Associations Included as Cases**

| | CNA[24] | RNAO[25] | ARNNL[26] |
|---|---|---|---|
| Location of head office | Ottawa, Ontario | Toronto, Ontario | St. John's Newfoundland |
| Jurisdiction | National | Provincial | Provincial |
| Mandates | | | |
| Delegated by legislation | Ministerial approval for self-proclaimed objects under the Canadian Not-For-Profit Corporations Act; Bill c-4: Statutes of Canada, 2009 c-4 | Ministerial approval for self-proclaimed objects under Ontario's Corporation Act R.S.O. 1990, Chapter c-38 | Self-regulatory college under Newfoundland and Labrador's Registered Nurses Act of, SNL2008 Chapter R-9, R.S.N. 1990; Amended: 2009 c-30 s14 |
| Delegated by governing body | Public policy and support of regulation | Public policy mandate and ends | Public policy end[27] |

Note: [24] CNA=Canadian Nurses Association.
[25] RNAO=Registered Nurses of Ontario.
[26] ARNNL=Association of Registered Nurses of Newfoundland.
[27] A bifurcated mandate whereby legislation permits professional interests to co-exist with a regulatory mandate (Bryce & Bayne, 2010).

| | CNA[24] | RNAO[25] | ARNNL[26] |
|---|---|---|---|
| Membership | | | |
| Criteria for membership | Voluntary (jurisdictional registrants[28]) | Voluntary | Mandatory (required to practice in the province) |
| Types and numbers of members | Includes both RN and non-RN[29] and individual and group/corporate/ members<br><br>Represented approximately 143,843 RNs (about 54.0% of Canada's registered nursing workforce[30])<br>Members included:<br>a) 11 jurisdictional corporate nursing bodies<br>b) Student members<br>c) Associate member (groups constituted in Canada that have a majority of regulated nursing members)<br>d) Affiliated members (other national organization or corporate | Includes both RN and non-RN and individual and group/corporate/ members<br><br>Represented approximately 30,000 RNs (about 31.8% of Ontario's registered nursing workforce[31])<br>Members included:<br>a) Individual RNs<br>b) 30 independent interest or affiliated groups<br>c) Independent interest groups<br>d) Out-of-province associates (registered nurses in other Canadian jurisdictions or any person who wishes to support the work of RNAO)<br>e) Friends of RNAO (any person | Comprised of solely registered nurses with the exception of honourary members<br><br>Represented approximately 6,000 registered nurses and nurse practitioners [32] |

[28] Quebec is the only province without jurisdictional membership in the national Association, however nurses in the province can become members by registering with RNAO, the Nurses' Association of New Brunswick (NANB), or Yukon Registered Nurses' Association (YRNA

[29] RN=registered nurse

[30] CIHI (2010) reported an estimated 348,500 registered nurses in the Canada workforce in 2009

[31] CIHI (2010) reported an estimated 94,296 registered nurses in the Ontario workforce in the year 2009.

[32] CIHI (2010) reported an estimated 5,825 registered nurses in Newfoundland & Labrador's workforce in the year 2009

| | CNA[24] | RNAO[25] | ARNNL[26] |
|---|---|---|---|
| | bodies constituted in Canada) Guaranteed members were individual registered nurses of a jurisdictional member | who wishes to support the work of RNAO who does not meet the requirement as a member or associate) | |
| Governance | | | |
| Model & Director Roles | Modified Carver model of Policy Governance©; Board of Directors charged with three main roles: policy development, advocacy, and visioning | Carver model of Policy Governance©; Board of Directors charged with setting the strategic direction for the Association | Carver model of Policy Governance©; Council charged with establishing and monitoring Ends |
| Board or Council Directors (unless otherwise stated all positions elected by voting delegates) | 19-member Board of Directors<br>a) President<br>b) President-Elect<br>c) Chief Executive Officer (non-elected & non-voting)<br>d) 2 Associate group representatives (appointed by Associate group members)<br>e) 2 public representatives (appointed by Directors)<br>f) 1 student (President of the Canadian Nursing Association)<br>g) 11 jurisdictional Presidents (selected through their respective jurisdictions) | 21-member Board of Directors<br>a) President<br>b) President-Elect or immediate-past president<br>c) Executive Director (non-elected and non-voting member)<br>d) 12 Chapters/ Regions without Chapters Presidents<br>e) 5 members at large (representing nursing domains of practice, education, research, administration, and socio-political affairs)<br>f) 1Interest Group representative | 15-member Council<br>a) President<br>b) President elect<br>c) Executive director (non-elected and non-voting)<br>d) 4 regional RN representatives elected by voting delegates<br>e) 4 nursing domain RN representatives elected by voting delegates<br>f) 4 government appointed non-nurse public representatives |
| Other | N/A | Assembly (elected leaders who carried out the work of the | N/A |

| | CNA[24] | RNAO[25] | ARNNL[26] |
|---|---|---|---|
| | | Association throughout the year)<br>a) President<br>b) President elect or immediate past president<br>c) Executive Director (non-elected and non-voting)<br>d) regional representatives<br>e) designates from each Chapter/Region without Chapters[33]<br>f) group representatives (Board, Provincial, and Associate Interest Groups)<br>g) members-at-large representatives | |
| Mission/Vision | "The national professional voice of Registered Nurses, supporting them in their practice and advocating for healthy public policy and a quality, publicly funded, not-for-profit health system" | "Speaking out for health and speaking out for nursing; to pursue healthy public policy and to promote the full participation of registered nurses in shaping and delivering health services now and in the future". | "Excellence in nursing. In pursuit of this vision, ARNNL exists so that there will be in order of priority: public protection, quality health care, and healthy public policy". |

[33] RNAO is divided into 12 Regions. Nine regions are comprised of 3 to 5 local Chapters. Three regions do not have local chapters and identify as Regions without Chapters. Chapters and Regions without Chapters act as the voice for the nursing profession across Ontario, provide a network of professional resources and support, and maintain the unity of the association while serving the interests of RNAO members (RNAO, 2009c).

# CHAPTER 7

# INTEGRATED DISCUSSION AND CONCLUSIONS

This final chapter presents an integrated discussion about key insights gained from this research. A final conceptual framework is presented that represents findings from this study situated within the broader empirical and theoretical literature. The strengths, limitations, and contributions of this dissertation are also discussed.

# CHAPTER 7: INTEGRATED DISCUSSION AND CONCLUSIONS

## Introduction

The purpose of this last chapter is to provide an overview of insights gained from this research. I present a final integrated conceptual framework and its key elements, which represent key research findings. I then discuss the empirical evidence for the framework and situate the elements of the framework in the broader theoretical and empirical evidence. A description follows that highlights the conceptual links between the guiding conceptual framework (presented in Chapter 2) and the final conceptual framework depicted in Figure 7.1. The strengths and limitations of the research are discussed, as is the contribution to knowledge. The chapter ends with a summary of the implications for practice, policy and research.

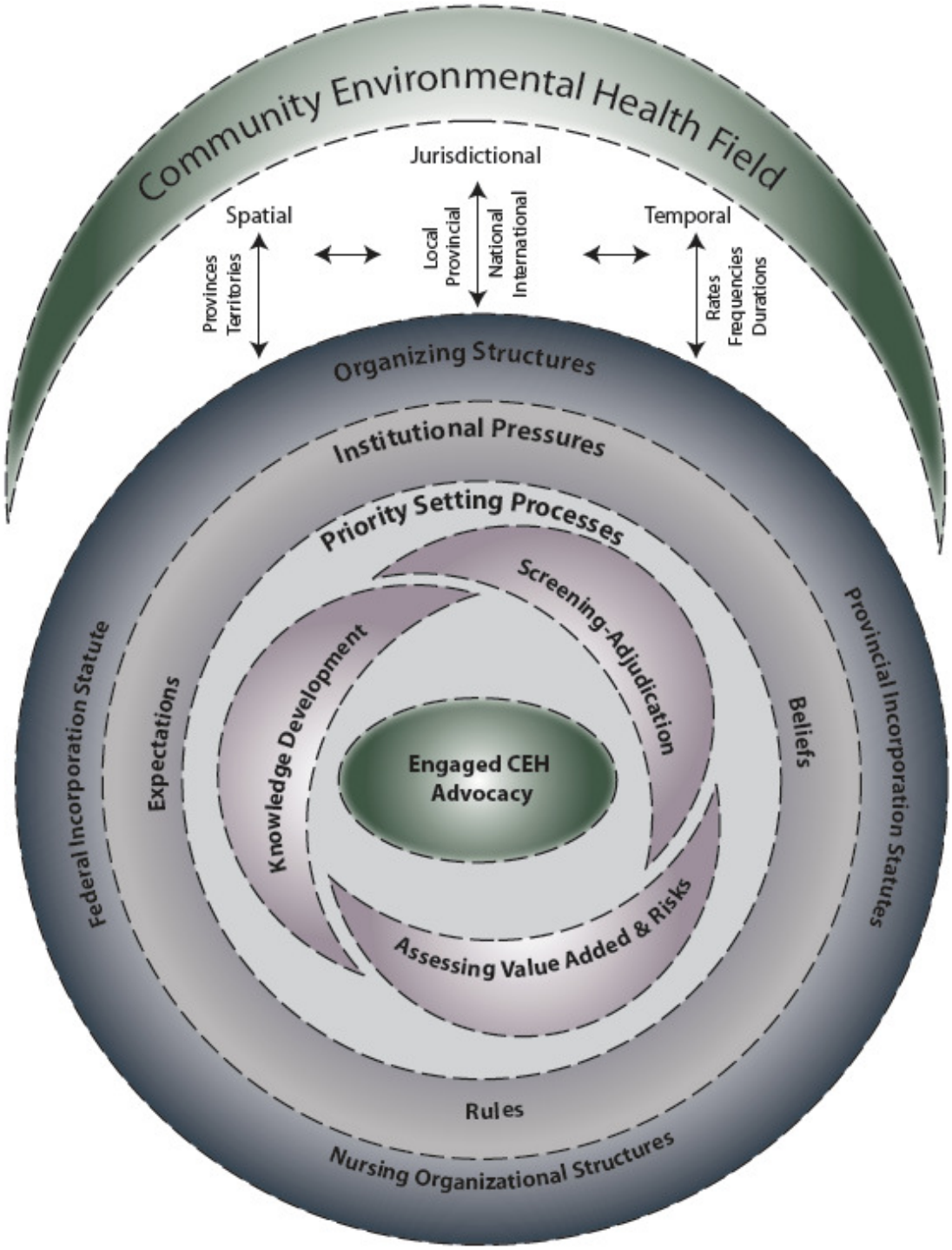
## Conceptual Framework: Whole-Systems Socio-Ecological Perspective on Nursing Associations' Engaged CEH Advocacy

### Description of the Final Integrated Conceptual Framework

The conceptual framework depicted in Figure 7.1 describes how inter-related factors influence the nursing associations' priority setting and engaged CEH policy advocacy. The framework suggests that nursing associations' priority setting and policy advocacy for CEH occur within a CEH policy field that determines possibilities for engagement. Federal, provincial, and organizational structures and institutional pressures create opportunities or narrow nursing associations' options. The framework represents a dynamic process wherein structures organize how decisions and actions are taken. In addition, rules, expectations, and beliefs (institutional pressures) operate through these structures to influence nursing associations' priority setting and, in turn, their policy advocacy for CEH.

Major components of the framework appear as five layers and include: (a) nursing associations' engaged CEH advocacy (represented centrally by an oval); (b) priority setting processes (represented by half-moon crescents); (c) institutional pressures including rules, expectations, and beliefs (represented by the inner ring); (d) organizing structures including federal, provincial, and organizational structures (represented by the outer ring); and (e) CEH field (represented by an overarching arch) and spatial, jurisdictional, and temporal scale and level interactions and dynamics that cross the layers (represented by arrows under the arch). The structures, processes, and relationships in the framework are interdependent (represented

**Figure 7.1 Whole-Systems Socio-Ecological Perspective on Nursing Associations' Engaged Community Environmental Health (CEH) Advocacy**



by broken lines). A more detailed explanation for the framework components follows.

## Framework components and their inter-relationships

### Engaged CEH advocacy.

At the core is nursing associations' engaged CEH advocacy, which refers to the ways in which nursing associations attempt to influence CEH policies that promote or improve reciprocal human-ecological health. Common categories of CEH policies that nursing associations attempt to influence include those that affect the healthfulness of settings (e.g., such as homes, workplaces, schools, or communities); those that influence the quality of ecological systems (e.g., such water, air, or land); and those that target local, sub-national, national, or international governments responsible for human and ecological health (e.g., municipal by-laws or provincial/territorial legislation). Nursing associations attempt to influence these policies through engaged CEH practices, which include: (a) employing a range of strategies; (b) exploiting cross-scale and cross-level interactions; and (c) planning and sustaining efforts.

***Employing a range of strategies.*** Engaged CEH advocacy involves building organizational capacity, which entails efforts to nurture nursing associations' ability to conduct their business and to achieve their policy goals. Tactics for building organizational capacity include comprehensive strategic planning, attracting the right people to nursing associations, advocating to retain a healthy public policy end, and strengthening infrastructure and ways of working.

A second strategy is building social capital, which entails a series relational and communication efforts that aim to establish, sustain, or enhance associations as valued players in CEH policy dialogues and decision-making. Key tactics for building social capital include fostering relationships, establishing organizational relevance, and protecting organizational reputation.

Inspiring a mass of support for community environmental policy advocacy by individuals and groups is a third strategy, which aims to change political will and enlist a foundation of supporters. Tactics for inspiring a mass of support include raising awareness, finding champions, and creating opportunities for individual and collective action.

A fourth strategy is lending support to and leading change in partnership with other stakeholders, which acknowledges the need to work with stakeholders from outside of

nursing and health and from various geographic and jurisdiction boundaries. Tactics for lending and leading change include stakeholder analysis and joining allies.

Exercising political acumen is a fifth strategy and entails the use of political skill to secure a nursing voice in CEH policy decisions. Tactics for exercising political acumen include understanding the landscape and being opportunistic (i.e., adjusting tactics, targets, timing, and intensity in response to opportunities), understanding power dynamics, and framing and positioning key messages (e.g., framing issues within dominant economic discourse).

A final strategy involves pushing policy positions in order to get a CEH issue on the government's radar and agenda, or to change or strengthen existing policy. Tactics for pushing policy positions include individual and collective lobbying, establishing and articulating minimal expectations of government, and remaining committed and persistent to the CEH policy issue.

***Exploiting cross-scale and cross-level interactions and dynamics.*** Engaged CEH advocacy includes recognizing and exploiting cross-scale and cross-level interactions and dynamics. Scales refer to spatial, temporal, quantitative or analytical dimensions used to study and measure structures and processes (Gibson, Ostom, & Ahn, 2000). Scales relevant to understanding nursing associations' engaged CEH include spatial scales (e.g., geographic space such as a provinces), jurisdictional scales (e.g., organized political units), and temporal scales (e.g., time spans). Levels refer to the locations or units of analysis that are located at different positions on a scale. For instance, municipal, provincial/territorial, and national are levels of a jurisdictional scale (Cash et al., 2006). Interactions occur between scales and levels. For instance, cross-scale refers to interactions across scales such as between provinces and jurisdictions. Cross-level refers to interactions among levels, such as between provincial/territorial and national levels of polity. The interactions among scales and levels change in strength and direction over time, which is referred to as "the dynamics of cross-scale and cross-level linkages" (Cash et al., cross-scale and cross-level section).

Exploiting cross-scale and cross-level interactions includes acknowledging and considering the non-linear and discontinuous dynamics of change. This includes first recognizing non-linear change in which change in one part of a system can result in diverse and unpredictable change to other parts (e.g., changes in regulatory statutes can affect

associations' policy capacity differently and therefore their responses may be different). It further means recognizing that change is discontinuous, having different times of onset (e.g., sudden and unexpected versus chronic long-term problems) and occurring at different rates (slow and fast moving changes). Thus, planning requires strategies that are context specific and look different across scales and levels (i.e., different provinces or jurisdictions). By way of example, one association may be able to lobby for CEH policy change, while an association in another province or jurisdiction may be better positioned to change nursing standards of practice to support CEH work.

Exploiting cross-scale and cross-level interactions also requires the coordination of scale and level interactions. For instance, policy efforts are planned across municipal, provincial/territorial, and national levels and across different provinces/territories. Efforts are also coordinated across targets. For instance, efforts include not only enhancing knowledge and inspiring political will at the individual level, but also pushing for policy change among decision makers at different levels of polity. Multiple strategies are also implemented such as creating tools and resources, building social capital, and exercising political acumen, for example.

***Planning and sustaining efforts.*** Engaged CEH advocacy includes planning and sustaining efforts. Planned efforts are intentionally organized to include cross-scale and cross-level efforts. Sustained efforts include those that combine periods of learning (e.g., inventing, testing, or experimenting) with periods of continuity (stabilizing and conserving). In other words, time is required for associations to build their capacity and relationships. There will also be times when associations will need to respond to and exploit opportunities for policy change.

**Priority setting processes.**

Priority setting processes lead to engaged CEH advocacy. Priority setting processes include; (a) Knowledge development; (b) Assessing the value added and risks; and (c) Screening and adjudication.

***Knowledge development.*** Knowledge development includes processes for obtaining evidence to inform priority setting. It includes scanning and monitoring, organizing, synthesizing, and presenting to the governing body information related to CEH. Nursing associations monitor a broad range of sources including government departments responsible

for the environment and corporations and industries that affect environmental conditions, which keep attuned to emerging and current CEH issues. Information that is organized, synthesized, and presented to the governing body in a user-friendly format renders CEH more visible amid other policy priorities and facilitates screening and adjudication processes.

***Assessing value added and risks.*** Priority setting further includes an assessment of the perceived value added and risks involved because of participation in a CEH initiative. Nursing associations that believe their engagement will improve CEH policy decisions are motivated to get involved. For instance, supporting motives includes a belief that the nursing association brings practice knowledge and policy analyses to CEH policy decisions, enhances group credibility, can serve as a knowledge broker, or provide access for other stakeholders to government officials. Determining whether to engage in a CEH issue also includes an assessment of the risks and benefits for participating in CEH and the role an association will play. Perceived risks that will deter engagement include: potential losses (e.g., loss of membership support), retributions (e.g., exclusion from inclusion in other healthy public policies), or unintended consequences (e.g., create repercussion for other nursing associations if action taken within another associations' primary provincial and jurisdictional territory).

***Screening and adjudicating.*** Priority setting includes screening and adjudicating among a list of issues of interest to nursing associations. An explicit set of criteria help to ensure that priorities align with the purpose and values of the organization. In addition, nursing associations use contextual professional, legal, social, economic, political, and ecological knowledge to decide which are the most appropriate issues and responses. Nimble responses are more likely when criteria provide some parameters but allow for responsiveness to context (e.g., changing resources and opportunities). Moreover, the identification of relevant priorities and timely consensual negotiation of those priorities is facilitated when there is inclusivity of stakeholders (e.g., BOD, home office staff, and members), and complementary decision tasks for the BOD (e.g., set broad strategic directions) and home staff (e.g., rank order priorities).

**Rules, beliefs, and expectations: Institutional pressures.**

Three institutional pressures frame and validate the way the nursing associations work and interact with others in their CEH efforts and include rules, expectations, and beliefs.

These pressures define what feasible, acceptable, and legitimate priority setting and policy advocacy options for CEH work are. More than one institutional pressure can be at play in shaping priority setting and engaged CEH advocacy.

***Rules.*** Rules represent regulative pressures that exert their influence through formal and informal forms of coercion or threats. Formal coercion includes legislation that restricts the allocation of resources for public policy. Informal coercion includes fear of potential losses, government retribution, or creation of unintended problems for other nursing associations. Both formal and informal coercion limit the types of CEH issues addressed. Coercion also diminishes cross-level efforts across different scales. For instance, there may be a lack of coordination across levels of the spatial geographic scale (i.e., lack of coordination of efforts across different provinces) or across levels of the jurisdictional scale (i.e., lack of coordinated efforts at municipal, provincial/territorial, national levels of polity).

***Expectations.*** Expectations represent normative pressures that exert their influence through expectations about appropriate forms of behaviours for associations and appropriate relationships. Normative prescriptions about professional and reasonable behaviour influence the selection of partners with whom the nursing associations' ally, which potentially reduces opportunities for participating in CEH initiatives (e.g., avoid associating with stakeholders that support extreme behaviours such as tieing themselves to trees to prevent tree clear-cutting). Issues perceived by associations to be on the *"periphery"* of nursing or outside normative expectations of what they believe the public expect of nurses are avoided to protect associations' credibility and to preserve the trust awarded to them by the public. In addition, unwritten expectations to respect spatial (e.g., Nursing Association in Ontario should not take action in Newfoundland) and jurisdictional (e.g., provincial association should not take action at national level) boundaries create tensions among the nursing associations (e.g., divisiveness about action for CEH) and limit the coordination of cross-scale and cross-level efforts.

***Beliefs.*** Beliefs represent cognitive pressures that exert their influence through taken for granted assumptions and conformity to the status quo. Beliefs about CEH and public protection are particularly influential in shaping nursing associations' priority setting and policy advocacy for CEH.

Organizational beliefs about CEH guide the selection of and weight given to evidence

when making choices, which can broaden or limit the CEH issues addressed. Associations can support one of two different views about CEH. First, there is a view that the environment is a static separate entity that can be separated from human health. In the absence of explicit evidence of the human health impacts, this view may limit the types of CEH issues addressed. Compelling evidence that clearly identifies the human health risks and impacts and thus the direct relevance to nursing (e.g., will take action because evidence maps the impacts of pesticides to human health) is required before action is taken. Second, there is a view that the environment and human health are inseparable and inter-dependent entities. Associations that support this view endorse evidence about environment degradation even in the absence of definitive health links (e.g., will take action on coal-fired plants even if the evidence of the impacts to human health are not yet conclusive or are controversial).

Organizational beliefs about public protection and interest determine the type of public policy issues nursing associations address. When public protection and interest is interpreted as ensuring clients suffer no harm as a result of care provided from a registered nurse, public policy work focuses on practice, standards, licensure, and discipline. In contrast, when public protection and interest is interpreted as ensuring that the factors creating or sustaining poor health and inequities are changed, public policy work ensues on a broad set of healthy public policy issues.

**Organizing structures.**

Organizing structures provide the means or systematize the way nursing associations make decisions and take actions. Organizing structures exist at the federal and provincial level in the Incorporation Statutes that articulate the legal existence of associations. Organizing structures exist at the organizational level in the form of regulatory functions and support of regulation, corporate structures, governance 'ends' and 'executive limitations', and policy capacity.

***Federal and provincial Incorporation Statutes.*** A public policy mandate or public policy end is a prerequisite for engagement in community environment health. In the case of regulatory-driven organizations, regulatory Acts (i.e., Registered Nurses' Act) may include a bifurcated mandate that permits both public interests and professional interests to co-exist. With these dual roles permissible, the leadership of an association then has the latitude to set an end to engage in healthy public policy that supports engagement in CEH. In the case of

member-driven organizations, Corporate Statutes permit membership to self-proclaim a public policy mandate. In consultation with members, leadership can set ends or goals for public policy issues such as CEH. The absence of a public policy end may inhibit action for CEH.

***Organizational structures.*** Regulatory functions or support of regulation limit nursing associations' CEH policy work in two ways. First, legislation governing regulatory-driven associations imposes restrictions on the allocation of resources that can be used for public policy work (e.g., regulatory mandate legally takes precedence). Second, fear of repercussions from government (e.g., exclude from other healthy public policy dialogues) or members (e.g., loss of support) also deter action for CEH by both regulatory-driven and member-driven associations.

Corporate structure is a second organizational dimension influencing nursing associations engaged CEH. Reaching consensus for political goals such as CEH is more challenging within a federated corporate structure compared to a functional corporate structure. A federated model is comprised of autonomous nursing associations that have a primary affiliation to their own provincial/territorial organization. A functional model is an autonomous nursing organization. Members of federated organizations may experience apathy and lack of interest in the parent organization's choice of political goals, conflict or competition between provincial/territorial and federal bodies, and divisiveness about whose needs and interests should be served (i.e., does the national association exist to meet provincial/territorial needs or should provincial associations be responsible to conduct work at the provincial/territorial level on behalf of the National Association). Failure to reach consensus may diminish efforts for CEH.

A third organizational structure is governance 'ends' and 'executive limitation' policies. The design of governance 'ends' and 'executive limitation' policies influence associations' flexibility and capacity to respond to CEH in a dynamic policy environment. High-level ends that provide direction to the organization and allow home office operations to decide the means to achieve those ends (e.g., operations including what specific CEH issues will be addressed and how) support possibilities for home offices to respond in a timely manner to emerging CEH issues. Boards involved in operational level decisions, on the other hand, can lead to organizational stress, bottlenecks and inability for home offices to

do their work. Decisions for CEH are therefore delayed or not made.

Associations that endorse 'executive limitation' policies that articulate what an association will not tolerate (instead of what it can do) in the pursuit of their 'ends' save Boards from making countless separate decisions and empower home offices to respond to emerging CEH issues. Boards retaining approval power over operational matters can stifle responses and interfere with timely and innovative responses, thus reducing effectiveness. Essentially home office operations can become paralyzed until the Board has time and sees fit to give approval for CEH issues. Disagreement about policy versus operational roles also contributes to tensions between the Board and home offices, which interferes with and can render operations ineffective and unable to address CEH issues.

A fourth organizational structure is policy capacity. Lack of policy capacity including incomplete and inadequate synthesis of evidence, lack of cross-departmental collaboration, absence of CEH networks or opportunities to join initiatives, and lack of access to stakeholders (e.g., members) to carry out the work diminishes or delays decision-making. Without adequate policy capacity, planned and sustained efforts may be diminished and nursing associations may be prevented from engaging in CEH initiatives. In addition, lack of policy capacity contributes to tensions when significant demands or expectations are placed on Board Directors and staff.

**CEH field & Cross-Scale & Cross-Level Dynamics.**

The CEH field represents the community of stakeholders brought together through their interest and objects related to CEH issues of concern (Hoffman, 1999). It includes the channels of dialogue and debate whereby the type of evidence and issues that are important, the legitimate geographic and jurisdictional levels to target, the appropriate strategies to take, and the relevant stakeholders to be involved are communicated. The field is not static. New issues, evidence, stakeholders, or events reconfigure dialogues and relationships. Thus, the CEH field represents the cross-scale and level interactions and dynamics within which nursing associations policy work transpires (Cash et al., 2006; Gunderson & Holling, 2002).

## Integrated Discussion of Conceptual Framework

### Empirical Evidence for the Framework

The following section discusses the empirical evidence for the conceptual framework. This evidence includes findings from the individual case analysis (Chapter 5) and the cross-case analysis (Chapter 6), as well as relevant broader theoretical and empirical evidence.

#### Priority Setting and Engaged CEH Advocacy.

Findings from individual and cross-case analyses indicate that nursing associations advocate for a range of policy issues. For instance, efforts were taken to address community concerns such as toxic wastes, to address ecological system concerns such as clean water, and to address concerns across multiple levels of policy such as municipal and provincial pesticide by-laws. This finding aligns with descriptions about the types of environmental health issues addressed by nursing associations (Sattler, 2005) that are primarily documented in non-research descriptive case reports and discussion papers (Chapter 3).

The findings indicate that cross-scale and cross-level interactions and dynamics have important implications for the choices and actions taken by nursing associations. For instance, changes in provincial legislative regulatory mandates have an effect on CEH priority setting in nursing association boardrooms. Restrictions placed on nursing associations for addressing specific policy issues in one province have far reaching effects, deterring the efforts taken by nursing associations in other provinces or in other jurisdictions. Literature from the field of ecology provides important insights to understanding these cross-scale and cross-level interactions and dynamics (Gibson et al., 2000; Gunderson & Holling, 2002).

Understanding system change as non-linear and discontinuous (Gibson et al., 2000; Gunderson & Holling, 2002) helps explain why some associations are affected by system changes and others are not; why the intensity of responses to shifts in the system (e.g., changes in government) may vary among nursing associations situated at different points in the system; and why associations sometimes concentrate efforts at building capacity and relationships, while at other times focus on creating opportunities for innovation and change. More specifically, the way associations behave and adapt can be explained by a phenomenon coined as panarchy by Gunderson, Holling, and Light (1995). Panarchy describes

unpredictable and uneven dynamic interactions among scales and levels and between shorter and longer adaptive cycles of change.

Findings from the cross-case analysis (Chapter 6) further underscored the importance of planning, coordinating, and investing long-term in order to affect policy change. This finding aligns with case study research by Gunderson et al. (1995) investigating successful and failed attempts to repair damaged ecosystems and a case review exploring blockages and leverage points influencing the integration of nurse practitioners into the Canadian health care system (Edwards, Rowan, Marck, & Grinspun, 2011). Affecting CEH policy includes long-term investment that allows for a panarchy of slower and faster moving adaptive cycles that transect scales and levels (Gunderson & Holling, 2002; Edwards et al.).

Gunderson and Holling further explain that at the heart of understanding and designing system change is recognizing ecosystem resilience, described as the "magnitude of disturbance that can be absorbed before the system changes its structure by changing the variables and processes that control behavior" (Gunderson & Holling, p.28). This has important implications for managing systems change. Emphasis is shifted from a "command and control" approach that attempts to maintain or return to an ideal perceived state, to emphasis on sustaining an existence of function and setting the conditions that allow for adaptation (Gunderson & Holling). Appling this notion to nursing associations', engagement in CEH policy not only means that consideration should be given to association-specific responses (e.g., one association lobbies government, while an association in a different province is better positioned to change nursing standards of practice to support CEH work), it also means that goals, roles, and strategies will evolve over time.

**Organizing Structures and Institutional Pressures.**

Findings from the individual case and cross-case analyses provide evidence about how organizational as well as provincial and federal structures organized the way nursing associations set policy priorities and take action for CEH. While having legislation that supports public policy was essential to support policy work, having concurrent regulatory functions diminished the capacity to carry out that work. Regulatory functions such as licensing and disciplining members are privileges granted by governments to associations through legislation (i.e., Registered Nurses' Acts). Member-driven organizations can also provide support to regulation, such as the administration of examinations. Unlike regulatory-

driven organizations, associations with member-granted regulatory functions do not have any legal accountability to government vis-a-vis the regulation of nurses. However, regardless of whether associations were primarily regulatory through legislation or supported regulation through member directives, the regulatory responsibilities impose restrictions for CEH work.

The constraints imposed on public policy work by regulatory bodies have been described in the literature. Legislated obligations to ensure safeguards are in place to protect the public restrict other public policy work by regulatory bodies (Bryce & Bayne, 2010; Chiarello, 2011). The failure of self-regulating bodies to fulfill regulatory duties can result in government investigation and action against an association (Bryce & Bayne; Chiarello). Even where legislation allows a regulatory body "to encourage members to participate in activities promoting the health and well-being of the public" (Association of Registered Nurses of Newfoundland, 2010, under objects), the public protection mandate must be kept paramount (Bryce & Bayne). Compliance with legislated regulatory mandates leaves minimal opportunity or resources to engage in CEH initiatives.

However, compliance with legislated regulatory mandates only partially explains how regulatory functions deter action for CEH. Fear is also a powerful coercive pressure accounting for the choices made by organizations with regulatory functions (Delvin & Chen, 2010). Engaging in activities that extend the public protection mandate, including direct advocacy at any government level for changes to legislation, policies, or funding, may be viewed as a compromise to a regulatory body's statutory obligations. Regulatory bodies may find themselves unable to justify to government the reason for engaging in such actions or unable to account for their choice to divert resources away from regulatory duties (Bryce & Bayne, 2010). Moreover, regulatory bodies may need to demonstrate the independence of their regulatory roles from any other professional interests. For instance, a recent review of relevant Canadian case law (Bryce & Bayne) noted that courts are shifting their support of roles for regulatory bodies from protecting the members to protecting the public. Other research has similarly concluded that regulatory bodies must sustain public trust through demonstrable impartiality and cannot be seen to be promoting or protecting professional interests (Freckelton, 2008; Waring, Dixon-Woods, Yeung, 2010). Thus, fear of the potential loss of self-regulatory functions prevent nursing associations from engaging in CEH

initiatives that may be perceived as depleting resources from regulatory roles or compromising their image of impartiality.

Even when regulatory functions were not legislated but granted by members, fear serves as a formidable motivator for deterring action for CEH. Member-driven associations lack any legal authority to take action against individual nurses who are not in compliance with regulation and they are not subject to legal sanctions if they do not adhere to regulatory functions (Bryce & Bayne, 2010). Thus, in this situation, fear includes the loss of perceived legitimacy and support from members. Organizational legitimacy refers to the congruence between the social values associated with or implied by the organization's activities and the norms of acceptable behaviour in the larger system of which organizations are part. When a disparity exists between these two value systems a threat can exist in the form of social sanctions including reputational damage or termination of beneficial relationships (Wendel, 2001). Nursing associations take action (or not) in order to achieve or preserve legitimacy.

Findings from the individual case and cross-case analyses further indicated that reaching consensus for CEH was seemingly more challenging within the federated Nursing Association compared to the Associations with functional orientations. These challenges are supported by other scholars who note that federations face issues such as a "lack of transparent and timely flow of information, confusion about roles and responsibilities, and challenges of compliance" (Mollenhauer, 2006, p.3).

Research also points to reasons federated organizations might experience difficulties uniting for common public policy issues (Boatright, 2011; Bryce & Bayne, 2010; Fafard, Rocher, & Cote, 2010; Ferkins & Shilbury, 2010). First, while federations can be advantageous to members interested in attaining tangible material goals such as the development of resources (e.g., Codes, standards, or exams), members may not necessarily agree or wish to be associated with their parent organization's choice of political goals (e.g., CEH) (Boatright; Mollenhauer, 2006) and apathy is a common problem (Balassiano & Chandler, 2010). Second, tensions quite often exist between federal and provincial/territorial interests for federated organizations (Fafard et al.; Ferguson, Langlois, & Roberts, 2009; Ferkins & Shilbury). Jurisdictional members may believe that national interests do not align or are in conflict with provincial/territorial interests and attempt to preserve their autonomy. Tensions between the national and regional entities can be a major stumbling block for

national organizations to enact strategic priorities (Ferkins & Shilbury, 2010). A third issue contributing to challenges faced by national boards is related to disparate views related to ownership. Ownership refers to whose interests are served by organizational action. National boards may consider provincial/territorial bodies to be responsible to deliver on national priorities and programs, and in the case of this research, work to address nursing concerns, which may include CEH. Provincial/territorial entities, on the other hand, may believe the national body exists to coordinate their wishes as owners. In this case regional entities believe that as owners they should not risk being disadvantaged by collective decisions that may not address their provincial/territorial concerns (Ferkins & Shilbury).

Individual and cross-case analyses also indicated that governance had important implications for the Associations' CEH policy work. Governance is the building block upon which 'ends' policies are developed and the capacity to carry out the work is established (Carver, 2006). The research findings suggest that the design of governance 'ends' policies and 'executive limitation' policies more specifically had a critical influence on the Associations' flexibility and capacity to respond to goals in a dynamic policy environment. 'Ends' policies identify the reason for an organizations' existence in terms of "intended effects on the population or world (Carver, 2006). High-level 'ends' policies (sometime referred to as goals) provide direction to the organization. 'Executive limitation' policies establish the boundaries for executive decision-making and organizational behaviour that is both prudent and ethical by establishing what is considered unacceptable behaviour (Carver, 2006).

The Nursing Associations' that set high-level ends allow home office staff the freedom to quickly respond to emerging issues. Other scholars have reported similar findings (Carver, 2006; Ferkins & Shilbury, 2010; Stone & Ostrower, 2007). Scholars argue that policy goals set by governing boards should represent "what the organization is for, not about what it does" (Carver p.48). Those involved at the operational level, including executive directors, often have a better understanding of operational issues since they more directly involved in the policy work and political environment (Stone & Ostrower, 2007). Thus, how policy ends will be achieved and how an association will behave in order to achieve those ends are considered operational decisions that are more effectively managed by the organizations' management and staff (Caver). On the other hand, boards that tell home offices how to do

their jobs rather than focusing on the results they expect can have unintended negative consequences including organizational stress and pathology (Carver). Bottlenecks can develop because the "part-time board cannot keep up with staff activities fast enough to prescribe them" (Carver, p. 49). In addition, the executive directors "cannot empower staff by decentralizing decision making because the board has withheld the power to make decisions" (Carver, p.49). Decisions about CEH are thus delayed or never made.

How the governing bodies exercise control over the operations can affect the extent to which members influence their public policy goals for CEH (Carver, 2006; Ferkins & Shilbury, 2010). 'Executive limitation' policies provide the boundaries for organizational behaviour that is both prudent and ethical by establishing what is considered unacceptable behaviour. Scholars suggest that focusing on actions that are "not approvable, rather than those that are simplifies the board's work and makes it less onerous for management as well" (Carver, p.121). According to Carver, "telling a subordinate how to do a task automatically eliminates all other methods. Telling a subordinate how not to do it leaves open all other possible methods" (Carver, p.122). Thus, boards are saved from making countless separate decisions when policies describe what will not be tolerated in the pursuit of goals. Boards retaining approval power over operational matters can stifle responses and interfere with innovativeness and effectiveness (Carver). Essentially home office can become frozen in place until a board has time and sees fit to give approval.

Governance policies also have implications for board and home staff relationships. Disagreements about policy versus operational roles contribute to tensions. Other scholars have noted that perspectives and expectations among board members and home office concerning their roles and responsibilities can vary greatly (Carver, 2006; Stone & Ostrower, 2007). Scholars indicate that a disparity between a board and operating body interferes with and can render operations ineffective (Carver).

Individual and cross-case analyses further indicated that lack of policy capacity, including insufficient evidence, allies, opportunities for collaborations, and human resources, diminished planned and sustained CEH efforts. Policy capacity is a multi-dimensional phenomenon (Gleeson, Legge, O'Neill & Pfeffer, 2011). It refers to "the ability to marshal the necessary resources to make intelligent collective choices about and set strategic directions for the allocation of scarce resources to public ends" (Painter & Pierre, 2005, p. 2).

In addition to this rational dimension, policy capacity concerns system-wide political, cultural, and institutional structure and relationship resources (Gleeson et al.). The findings in this study support other research that has noted organizational structures, processes, and cultures that either enable or constrain effective policy work (Gleeson, Legge, & O'Neill, 2009; Gleeson et al.). For instance, Gleeson's et al. (2011) case study research investigating organizational factors influencing policy capacity reported that information and evidence; personnel management and workforce development; relationships with stakeholders; intergovernmental and cross-portfolio coordination; monitoring, evaluation and review; and leadership and organizational culture affect organizations' ability to conduct policy work. Of particular interest were Gleeson's et al. findings that constraints to policy capacity were greater when dealing with more politically sensitive issues (e.g., in this case, CEH). In addition, policy capacity varied across time.

**CEH Policy Field.**

Individual and cross-case analyses indicated that the Nursing Associations' engagement in CEH was embedded in a policy field comprised of stakeholders brought together through their interests and objects related to a CEH issue of concern. Thus, this study conceptualized the policy field formed around CEH issues.

This view of a policy field draws on Hoffman's (1999) research. Hoffman's notion of a field diverges from the idea of fields comprised of a community of organizations that share meanings and engage in frequent exchanges. Instead, a policy field forms around issues and includes the channels of dialogue and debate that "brings together various field constituents with disparate purposes" (Hoffman, p.352). The organizational field is analytically detected by: "(1) an increase in the extent to which certain organizations interact; (2) an increase in the information load they share; and (3) the development of mutual awareness that they are involved in a common debate" (Hoffman, p. 352).

The field represents cross-scale and cross-level dynamics conceptualized from a whole-systems socio-ecological perspective (Gunderson & Holling, 2002). The dynamics of change from this lens is episodic, characterized by slow accumulation of capital and sudden releases and reorganization. Change is also non-linear and discontinuous, with unpredictable and uncertain change occurring at various points in the system, with uneven intensity of influence experienced at these points, and with varying rates (i.e., slow and fast moving),

frequencies, and durations (i.e., degree of persistence).

**Conceptual Links Between the Guiding and Final Conceptual Frameworks**

The conceptual framework that guided this research (Chapter 3 - MacDonald, Davies, Edwards, Marck, & Read Guernsey, 2012) depicts nursing associations' decision-making for engagement in CEH embedded in a policy decision context in which factors internal and external to the organization influence the choices and actions taken. Internal factors include governance, jurisdictional mandate, membership, and professional mandate. External factors include legislated authority, credibility, and system disruptions. The framework is premised on whole-systems socio-ecological thinking that draws attention to broad context and processes for change across all system levels and on regulative, normative, and cognitive institutional pressures that operate to shape organizational choices and actions. Given these premises and using the internal and external factors as a starting point, this research investigated how nursing associations set priorities and take action for CEH and the factors that influence those choices.

Given that the concepts from the original framework guided the exploration of nursing associations' priority setting and policy advocacy for CEH, components of the guiding framework are inherently integrated as part of the final framework. However, the final conceptual framework represents a more comprehensive depiction of how these factors and their interactions and dynamics shape the policy work of nursing associations. The final conceptual framework retains the theoretical premises of whole-systems socio-ecological thinking and institutional influences. The following section describes how concepts in the guiding framework informed the development of the final conceptual framework.

Both legislative authority and governance from the guiding framework are retained in the final framework. However, legislative authority is relabeled as Incorporation Statutes, which reflects a more accurate representation of the legislation that provides the legal existence and operation of the nursing associations. Both Incorporation Statutes and governance are identified as structures that organize the way nursing associations conduct their policy work in the final framework.

'Membership' in the guiding framework included nurse registrants and other supporters as well as their contributions to policy efforts. While the guiding framework suggests that membership composition plays a role, this research did not find enough

evidence to support this claim. Membership in the Associations varied in terms of individual and corporate membership and in terms of voluntary, guaranteed, and mandatory registration. When participants from the study spoke about membership they did not often refer to the effects of membership composition. However, the participants did describe the influence of relationship interfaces within and between the Nursing Associations for policy work. In the final framework, relationship interfaces are represented as part of governance (e.g., how organizational members work together) and as part of strategies for engaged CEH advocacy (e.g., building social capital). The study findings underscore the importance of federated and functional corporate structures. Thus, corporate structure appears as an organizational factor in the final framework.

Jurisdictional mandate in the guiding framework represents associations' political territorial responsibility (e.g., provincial or federal). It is not simply the jurisdictional territory within which nursing associations' operate that influences their policy work, but rather cross-scale and cross-level work and interactions that shape the nature of their policy work. For instance, the positions taken by a province have implications for positions taken (or not taken) by other provinces or at other jurisdictional levels. Thus, in the final framework jurisdictional mandate is represented as part of the cross-scale and cross-level interactions and dynamics occurring within the CEH policy field.

Professional mandate in the guiding framework represents the beliefs members of nursing associations hold about their social obligation for CEH. The study findings extend this conceptualization, underscoring other beliefs and expectations that are important motivators for the way nursing associations' engaged in CEH work. More specifically, the final framework depicts institutional pressures including beliefs, expectations, and rules as important influencing factors. For instance, understandings about CEH influence the type of evidence required to support action. Expectations about appropriate behaviour and appropriate relationships are also important drivers shaping the choices and action taken. In examining beliefs and expectations, clarity is also gained about the concept of credibility as conceptualized in the guiding framework. In the latter framework, credibility is depicted as an external factor and refers to the perceptions or assumptions held by those outside the profession about the expertise or contributions nursing associations can appropriately make to CEH. However, the findings in this study indicate that nursing associations not only

respond to a self-assessment about the value they can bring to policy tables, but they also respond to expectations they perceive others have about them (e.g., they are trusted, they have knowledge to offer). Thus, in the final framework, credibility is incorporated as part of the institutional pressures. In addition, the research findings underscore coercive pressures in the form of rules and fear that shape nursing associations' policy work. Thus, rules are included as part of the institutional pressures influencing nursing associations' CEH policy work.

In the guiding framework, system disruptions represent environmental shifts or events that occurred outside a nursing association and its control. These create opportunities that essentially alter the course of action taken by associations. The findings indicate that shifts in context in which nursing associations make decisions do influence the way nursing associations plan and respond to CEH issues. However, shifts in professional, legal, social, economic, political, and ecological systems influence nursing associations' policy choices and action are not easily mapped or understood. The final model depicts nursing associations' priority setting and policy advocacy embedded in a dynamic CEH field whereby cross-scale and cross-level interactions shape the choices made. There is recognition that the choices made are not only affected by shifts in the field, but also by an associations' ecological resilience. Moreover, options for engagement change over time. This conceptualization in the final framework aligns with underlying assumptions of the guiding framework that underscored nursing associations' "capacity for effective policy work is critically shaped by their ability to adequately target variable resources during overlapping phases of longer periods of growth and conservation, whereby capital such as relationships and networks are accumulated, and shorter periods of restructuring and reorganization, whereby opportunities for innovation are created" (MacDonald, Edwards, Davies, Marck & Read Guernsey, 2012, p. 9).

Two concepts not appearing in the guiding framework are included in the final framework: regulatory functions or support of regulation and policy capacity. The findings indicate that having regulatory functions or the support of regulation has important implications for the Nursing Associations' CEH work. The guiding framework acknowledges the potential significance of legislated regulatory mandates. However, the findings more clearly delineate that is it not just legislated regulatory function, but also

member-directed support of regulation that emerges as a related, but stand alone factor. Thus regulatory functions and support for regulation that do not appear in the guiding framework appear as a stand-alone term in the final framework.

The findings further indicate that incomplete and inadequate synthesis of evidence, lack of cross-departmental collaboration, absence of CEH networks or opportunities to join initiatives, and lack of access to stakeholders to carry out the work (e.g., members) decreases the ability for engaged nursing associations' CEH policy work. Thus, policy capacity, not represented in the original framework, appears an organizational structure in the final framework.

The guiding framework depicts priority setting and policy advocacy at the core, recognizing their interdependence. While this assumption is retained in the final framework, priority setting and policy advocacy processes are more clearly delineated. Priority setting processes in the final framework include decisions first, about whether or not a CEH issue will be addressed, and second about its rank order. Priority setting includes knowledge development, assessing the value added and risks for participating, and screening and adjudicating among policy priorities. Policy advocacy is depicted as the center and renamed as engaged CEH advocacy. This more in-depth conceptualization not only considers the strategies that are taken, but the nature of the interactions and dynamics of a socio-ecological approach to policy change.

## Strengths and Limitations

### Strengths

This research provides an in-depth description of the structures, processes, and institutions that shaped the way nursing associations set policy priorities and took action for CEH. Descriptions of the setting and participants permit judgment about the applicability of the finding in other areas with similar characteristics. The findings may be useful for other nursing associations that are making decisions in similar contexts.

Steps taken to ensure the trustworthiness strengthened this study. Rich qualitative data gathered from participant interviews and document review permitted corroboration and strengthened the credibility of findings. Data were gathered from participants holding various positions within the Associations in order to get a more complete view. Where possible, the words of the participants were used to convey the findings. While formal

observations were not included as part of the data, my time spent in each Association allowed me to gain a sense of the day-to-day workings of these busy policy organizations. I had an opportunity to get to know some of the staff and Board Directors and gain access to organizational documents that helped to build a more comprehensive interpretation of data. In addition, the site visits provided an opportunity to reflect upon my personal views that could bias the research. Theoretical and methodological decisions were made in consultation with members of my research committee.

Details were provided to expose my methodological and analytical processes so that readers could judge the methods and conclusions made. Adherence to methodological principles of interpretive description and to analytical processes of framework analysis enhanced the methodological rigour.

**Limitations**

There are many methodological and theoretical limitations to this study. Thirty-five percent of participants invited to participate declined. This poses a methodological limitation. Since the majority (91%) of these participants were Board Directors, there may not be representativeness of Board members' views. Their reasons for not participating are unknown. In addition, data collection took place shortly after the announcement of the potential disaffiliation of a jurisdictional member from the National Association, which created tensions among some nursing associations. Individuals who believed their views were not aligned with the majority and were concerned that their confidentiality could not be protected may have chosen not to participate. The impact on the study findings cannot be known.

The study context posed some challenges for data collection. Some interviews required two to three meetings to complete because of disruptions in these busy policy organizations. It is possible that the richness of some data was diminished for participants who were under time constraints and interrupted during the interviews. One organization was undergoing substantial restructuring and had significant personnel changes. To address these challenges, interviews were sought from personnel prior to their departure and past employees were interviewed. In addition, organizational documents were used to corroborate evidence and identify areas requiring further investigation.

My role as researcher in the study underscored potential for bias in the analysis and

interpretation of the data. I have minimized the potential for bias during data collection and analysis processes by making and reviewing memo and journal notes and through familiarization processes. Interpretations were based on participant quotes and excerpts from organizational documents. The thesis committee reviewed a subset of the findings. The Executive Directors of the participating Nursing Associations reviewed the findings.

The findings from this study are limited to the context in which the research took place. However, sufficient details are provided about the study setting and participant to allow readers to judge the applicability to their own contexts. The inclusion of three cases enhances analytic generalizability – that is the ability "to generalize a particular set of results to some broader theory" (Yin, 2009, p. 43).

A final methodological limitation to this study was the loss of data (stolen computer). While most data was recovered some information for one Association was not. Two interviews were lost. One of the lost interviews was repeated, but was significantly shorter than the original interview. In addition some examples were not included or details about specific CEH examples were removed to protect identities and the Associations.

While theory development prior to data collection is an essential step to case study research (Yin, 2009), it does impose parameters around the research and presents a theoretical limitation. The study was based on several key pre-determined internal and external factors derived from the literature that were shown to influence priority setting and policy advocacy. While they were not intended to represent the only factors accounting for the choices and actions taken by the Nursing Associations' policy for CEH, the interviews focused on understanding how those factors influenced the choices made. Other factors important to nursing associations' priority setting and policy advocacy may not have been uncovered through the line of questioning used in this research.

## Contributions to Knowledge

A scoping review was published, which provided knowledge of priority setting and policy advocacy by non-profit and non-governmental organizations, and of innovative policy work undertaken by nursing organizations that has not been the focus of empirical inquiry. This peer-reviewed publication drew on a diverse and strong evidence base that bridged research, narrative accounts, and theoretical nursing and non-nursing literature. Essential dimensions and processes of priority setting and policy advocacy are identified.

Organizational and systemic factors that influence organizations' policy choices and actions are revealed.

Knowledge is provided about the application and value of using of a whole-systems socio-ecological lens to guide research. This lens was valuable because the broad context and processes for change across system scales and levels was described. A whole-systems socio-ecological lens yielded cross-scale and cross-level interactions and dynamics that played out in relation to CEH. To my knowledge, this is the first study to use a whole-systems socio-ecological approach to better understand nursing associations' priority setting and policy advocacy actions.

In addition, knowledge is provided about the complementary roles of whole-systems socio-ecological theory and institutional theory to understand the nature of nursing associations' priority setting and policy advocacy and the factors that influence their engaged CEH. Using both these theories was essential, as whole-systems socio-ecological theory guided a description of processes of system change, while institutional theory guided a description regulative, normative, and cognitive pressures and their mechanisms that shape nursing associations' priority setting and policy advocacy. Thus, attention is not only drawn to tangible structures and resources (e.g., legislations and governance) that shape nursing associations' choices and actions, but also to the less visible rules, expectations, and beliefs that either enable or diminish options for engaged CEH policy work.

A final integrated conceptual framework is offered that depicts factors influencing nursing associations' priority setting and engaged CEH advocacy. The concepts and their relationships are theoretically and empirically informed. In addition, members of my thesis committee, who have theoretical, practical, and research experience related to whole-systems socio-ecological theory, professional nursing associations, environmental health, nursing and community health and epidemiology, critiqued the framework. Thus, the framework offers a robust and interprofessional lens that depicts of how nursing associations make choices among competing policy priorities and the supports and challenges they face when attempting to engage in CEH.

This is a first study to use a cross-case comparison and to provide a detailed description of the nature of nursing associations' policy work for CEH and factors that influence their choices and actions. This study illustrates the application of framework

analysis to systematically describe and compare multiple cases. This study contributes empirical evidence to an understudied area of nursing. The empiric evidence gained through this study adds to the existing narratives that describe the work undertaken by nursing associations' CEH policy work. Evidence is added about the priority setting and policy advocacy practices by nursing associations for CEH. Evidence is also added to the structures and institutional pressures and their interactions that shape the options available to the nursing associations engaging in CEH work.

## Implications for Nursing and their Associations, and for Policy Decision-Makers

In view of my study findings, the following implications for nursing and their associations and for policy decision-makers are proposed.

### *For Nursing and their Associations*

1. **Address organizational structures that diminish effective priority setting and nimble advocacy responses.** In order to more efficiently use resources, alleviate the development of bottlenecks, and allow more timely responses to the demands characteristic of dynamic policy environments, associations should: (a) develop comprehensive strategic plans with priorities that are grounded in a broader vision, core values, and recognition of the interdependencies among issues; (b) develop 'ends' policies that identify what good the association aims to achieve and that allow home office staff to respond to changing context and emerging issues; (c) design 'executive limitation' policies that define what an association must avoid in the pursuit of 'ends' (opposed to developing a list delineating what the association can do); and (d) organize departments in ways that permit communication, flexibility, and pooling of resources across departments and/or policy portfolios (Carver, 2006; Gleeson, Legge, & O'Neill, 2009; Greenwood, Raynard, Kodeih, Micelotta, & Loundsbury, 2011).

2. **Collect, synthesize, and organize evidence in a format that permits easy identification of CEH and the links to other association objects.** Evidence that is organized, synthesized, and presented to the governing body in a user-friendly format

that will render CEH more visible amid other policy priorities and facilitate screening and adjudication processes. Learning can be drawn from recent knowledge translation research that articulates strategies for communicating research evidence and other data clearly to users such as other staff and board members. Employing staff with CEH expertise or having access to knowledgeable consultants with such expertise can facilitate ready access to, knowledge about, and engagement in CEH. (Graham et al., 2006; Lavis, 2006).

3. **Strengthen views of nursing and their associations as a political force.** This includes: (a) articulating the role of nursing and their associations in CEH; (b) legitimizing the role for nursing and their associations by emphasizing similarities between past roles and new roles (e.g. like Nightingale in the past, nurses continue to address environmental issues that impact health, such as climate change); applying old meanings to a new identity (e.g., nurses traditionally work collaboratively with others to support health, which can now include addressing CEH); presenting new roles as normal responses in society (e.g., like others, nurses have a broadened understanding of environmental determinants effecting health that must be addressed); identifying with referent groups about their knowledge and skills (e.g., nurses have a scientific background and thus can understand and use research results for improved health ); and highlighting implicit and explicit authority (e.g., reporting past successes from nursing involvement in CEH) (Goodrick & Reay, 2010; Grinspun, 2010; National Expert Commission, 2012).

4. **Shift hierarchical views of leadership to the support of collaborative/shared leadership.** While traditional views of leadership would direct nursing associations to become the initiators or innovators of health policy, leadership for complex policy issues requires shared responsibilities and accountabilities. Shared or collaborative leadership would be characterized by shifting responsibilities, determined by stakeholder's expertise and who is most able to address tasks at hand. Enhancing skills in joint decision-making, revisiting how nurses select acceptable team players, reconsidering acceptable levels of risk, gaining skills as good followers, and refining how to adapt in dynamic and conflict-laden collaborations may be areas for development that would enhance capacity for

collaborative leadership approaches (Barret, Plotnikoff, & Raine, 2007; Cohen et al., Friedrich, Vessey, Schuelke, Ruark, & Mumford, 2009).

5. **Clarify the purpose and ownership of the National Association.** Addressing the issue of ownership and whose interests the National body serves is a critical part of building organizational capacity to conduct policy work. Distinguishing roles can become a source of tension when expectations among members are not aligned. National associations may expect provinces and territories to deliver programs in which they are not prepared to deliver. Provinces and territories may expect a national association to coordinate their needs. Thus, ongoing dialogue and debate is required to answer: does the National Association exist to coordinate the needs of jurisdictional members or do jurisdictional members join to assist in the work of the National Association? (Ferkins & Shilbury, 2010).

6. **Clarify interpretations of public protection and interest through transparent discussions.** Given the tensions arising from varying interpretations of public protection and interest, dialogue and debate are needed among those in the profession. Understanding must be gained about advocacy gaps that exist in light of narrowing interpretations of public protection and interest so that discussions can begin about how various nursing organization might continue to fulfill ethical and theoretical commitments to CEH.

7. **Challenge persistent views of environment as a static entity separate from human health.** The study suggests that views guiding the choices for CEH remain tied to notions of the environment as a static entity and separate from human health. Thus, in the absence of evidence clearly mapping pathways from poor environmental conditions to poor health, opportunities are lost for nursing associations to speak out. Nurses and their associations should support recent understandings of CEH as human-ecological health generated through human participation with natural, physical, chemical and biological systems and supported through ecologically sound practices and policies across system scales and levels. (Hansen-Ketchum, Marck, & Reutter, 2009; Lausten, 2006;

MacDonald, Davies, Edwards, Marck, Read Guernsey, 2012).

8. **Consider the redesign of professional health education for enhanced collaborative practice.** Working collaboratively to address CEH underscores the importance of professional health education approaches that are responsive to changing health needs and professional roles and that are capable of preparing a cadre of workers educated and competent to address shared public policy concerns. Preparation should be underpinned by whole-systems socio-ecological thinking that underscores cross-scale and cross-level approaches. The application of policy competence skills through structured mentoring opportunities is one way to develop leaders in health policy. Experiential learning, including mentoring by seasoned nurse policy advocates and immersion in policy practicums can provide exposure to strategies for building social capital and policy advocacy work (Frenk et al., 2010; Hofler, 2006; Martin-Misener & Valaitis, 2008).

9. **Reconsider choice of appropriate stakeholders for advancing CEH.** Nursing associations tend to join with stakeholders who share similar views vis-à-vis CEH. However, broadening interactions with other stakeholders can generate change or an ability to deal with barriers that create resistance to change. Nursing associations also tend to partner with other advocacy groups, organizations, and government partners. Although participants were not specifically questioned, partnerships with researchers were not raised. Developing more formal links with the environmental health professional community who provide leadership on scientific evidence in CEH (e.g., International Society of Exposure Science, Society of Toxicology, or Canadian Institute of Public Health Inspectors) may be important (Gunderson & Holling, 2002).

***For Policy Makers***

10. **Continued encouragements for whole-of-government approaches and whole-systems socio-ecological thinking.** Solving and sustaining health gains is more likely with whole-of-government approaches incorporating Health in all Policies (HiAP) (World Health Organizations [WHO], 2010). Thus, policy decision makers could consider ways to embrace whole-systems socio-ecological approaches to address complex problems and achieve policy coherence. Policy makers could consider ways to

enhance capacity to support collaborations. This would include providing supports and tools to support cross-sector and cross-level work.

## Implications for Research

This cross-case study permitted an in-depth exploration and description of nursing associations' engagement in CEH policy in their natural setting in which the organizational, federal, and provincial context was highly pertinent to understanding the choices and actions. Further cross-case comparisons would be useful for identifying cross-cutting patterns that support or hinder nursing associations socio-ecologically engaged policy work. Comparing different provinces, jurisdictions, and sectors, for instance, could lead to greater understanding of the similarities and differences that account for choices made. This research examined nursing associations' CEH at a point in time. As noted by other scholars (Cash et al., 2006), longitudinal studies are required to understand the cross-scale and cross-level interactions and dynamics of change over time. In addition, constraints to policy evolve with time (Gleeson et al., 2011), lending support for studies that can map slower and faster cycles of adaptation. A longitudinal study could provide insight into how these institutional pressures change over time and influence the policy choices and actions taken.

An in-depth understanding about nursing associations' priority setting and policy advocacy primarily was gained from the perspectives of nursing organizational leaders. Future research could consider the perspectives of others, at all system levels and from both within and outside of health (e.g., front line nurses, stakeholders, government decision-makers, public), about factors that influence nursing associations' engagement in CEH. This approach may further understanding about how organizational and provincial/federal structures and institutional pressures shape the professions' and nursing associations' engagement in CEH policy work. A question that might be addressed is whether nursing associations' perceptions about the degree of legitimacy in this policy arena are supported by those outside the profession. In addition, further inquiry could explore the supports and barriers that prevent members from engaging in both their nursing organizations and their policy work.

While key factors were identified that shaped nursing associations' choices and actions, further research is necessary to confirm or refute the influence of the structures, institutional pressures, and relationships identified through this study. This research primary

focused on a limited set of factors at the organizational and system level. Future research could consider additional factors and include other system levels (e.g. individual attributes or global influences). For instance, although individual and leadership attributes were not examined in this study, this would be an important area of inquiry to give a broader understanding of nursing associations' policy work.

Exploring other nursing associations with varying mandates, governance structure, and contexts would be required to understand the influence of these diverse arrangements have for the associations' policy work. In addition, the findings point to cross-scale and cross-level interactions that shaped nursing associations' CEH policy work. However, further research is needed to understand these interactions in order to better plan and engage in policy change efforts for CEH.

This study used CEH as a policy issue exemplar to explore factors that influence nursing associations' choices and actions. Constraints for policy work are greater when dealing with more politically sensitive issues (Gleeson et al., 2011). Advocacy tactics, including building social capital, can be more challenging when dealing with environmental health issues because there is often disagreement about core values (e.g., environmental quality versus economic freedom). In addition, the presence of diverse stakeholders (e.g., advocacy groups and technical experts) contributes to a lack of common language and epistemology (Leach, Pelkey, & Sabatier, 2002). Exploring other policy areas that require multiple sector and jurisdictional collaborations such as poverty and homelessness could lend support to factors found in this study or lead to the identification of different influences on the decisions taken by nursing associations.

This study found that regulatory legislation had significant implications for nursing associations' policy work. While not a focus of this study, the study underscored the significant fractures that existed among nursing associations in light of their changing regulatory and public policy roles. For instance, demands for enhanced transparency and accountability for the conduct of members, recommendations for increased consumer input and for flexible registration processes (to accommodate changing work environments and the migration of professionals) have contributed to increased government involvement in professional regulation, including nursing associations in Canada (Bryant, 2005; Canadian Institute for Health Information [CIHI], 2007; Crown Copyright, 2007). Following changes

to its regulation and a review to evaluate its Canadian Nurses Association, the College of Registered Nurses of British Columbia [CRNCB] confirmed intentions to formally withdraw its jurisdictional membership from the National Association just prior to the collection of data for this research. The National Associations' function of directly advocating government presented a perceived if not actual conflict with the regulatory body' mandate to protect the public (Bryce & Bayne, 2010) was the reason given for the decision to disaffiliate. Understanding the implications of the changing roles of nursing associations and the implications for nursing associations' policy work would be an important area of research.

## Conclusion

Little empirical evidence exists that describes nursing associations' engagement in healthy public policy and CEH more specifically. This study addressed this gap through a comparative case study with three Canadian nursing associations that examined priority setting choices and policy advocacy actions for CEH within different provincial and jurisdictional contexts. The findings lead to the development of a conceptual framework that depicts the choices and actions taken by nursing associations for CEH embedded in a dynamic policy field that determines possibilities for engagement. Federal, provincial, and organizational structures and institutional pressures either create opportunities or narrow associations' options.

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## Appendix A

## Papers Included in the Scoping Review

| Author/Year | Purpose & relevant findings for review |
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| Afzal, B. (2007). | This narrative paper described how the Maryland Nurses Association actively lobbied for implementation of a four pollutant 2006 Healthy Air Act. Strategies taken to influence the policy were described. The paper identified external factors that provided the impetus for action taken by the association. The association's credibility was an influential factor determining the association's participation. |
| Andrews, K. & Edwards, B. (2004). | This literature review examined the scholarship related to the role and influence of advocacy organizations in the U.S. political process. Evidence of the influence of organizational structures, membership, resources, and networks on advocacy efforts was synthesized. Most evidence derived from organizations operating at the national level. The authors suggested that although current evidence is limited, organizations operating at the national, state, and local levels differ in important ways. |
| Baillie, L., & Gallagher, A. (2009). | This qualitative evaluation study described how the Royal College of Nursing initiated a high-profile campaign for an initiative entitled Dignity: At the heart of everything we do. External factors that provided the impetus for action by the organization were described. Strategies included engagement with stakeholders, a survey of members, and the development and dissemination of educational and practice development materials. The article underscored the relevance of membership relationships for advocacy efforts. |
| Ballou, K. (2000). | This narrative paper reported findings from an extensive analysis conducted to search for evidence of nursing's socio-political obligation. Professional documents and scholarly literature suggest the profession has obligations related to social reform and political activism. However, several reasons were identified that contribute to the silencing of nursing including oppressive and bureaucratic healthcare environments, nursing heterogeneity, and lack of understanding about what nurses know. |
| Baltussen, R., & Niessen, L. (2006). | This theoretical paper presented the main principles of multicriteria decision analysis (MCDA). The authors argued for MCDA as a way to establish policy priorities. MCDA establishes preferences between options by reference to an explicit set of objectives identified by a decision making body, and for which there is |

| Author/Year | Purpose & relevant findings for review |
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| | established measurable criteria to evaluate the achievement of objectives. MCDA offers a number of ways of aggregating the data on individual criteria to provide indicators of the overall performance of options. |
| Barr, V., Pedersen, S., Pennock, M., & Rootman, I. (2008). | This synthesis report provided an analysis and synthesis of key learning from 18 case studies that explored intersectoral action for health and health equity. While addressing many determinants and complex policy problems required partners to act in collaboration (e.g., various government sectors and society), many factors influenced collaborative efforts. Trust, understanding of mandates and partner contributions, views about problems, crisis and disruptive events, flexibility of roles, and presence of champions were all shown to influence the choices and approaches taken. |
| Beyers, M. (2000). | This narrative paper argued the role of the association in policy development is derived from its vision and mission. The development of a policy agenda and platform by American Organization of Nurse Executive's (AONEs) was described. Key principles for policy development were suggested. Organizational mandate, membership knowledge and involvement, and partnerships were key to advocacy efforts taken. |
| Breton, E., Richard, L., Gagnon, F., Jacques, M., & Bergeron, P. (2008). | This qualitative case study described the factors underpinning the adoption of Quebec's Tobacco Act and the role played by various actors. External factors that provided the impetus and courses of action were identified. The relevance of buy in and unified voice are discussed. |
| Bryant, T. (2002). | This paper incorporated findings from two qualitative case studies to propose an analytic framework for policy change. The framework illustrated the different knowledge used, the ways that knowledge is used, and constraints that limit the use of knowledge by various actors in the policy process. Policy advocacy is conceptualized as knowledge-based action. There was privileging of certain types of actors and their knowledge in policy advocacy efforts. Government ideology (beliefs about the problem and solution) and group identity (attributes of the group) influenced political clout and what constituted valid knowledge and evidence by the government. Organizations may hold a status as a significant political constituency that the provincial government does not want to antagonize. |
| Bryson, J., Crosby, B., | This extensive literature review presented a propositional inventory related to initial conditions affecting |

| Author/Year | Purpose & relevant findings for review |
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| & Middleton Stone, M. (2006). | cross-sector collaboration by organizations. Addressing public policy issues necessitates collaboration by organizations in two or more sectors in order to remedy complex policy problems. Formation, process, structural, and governance components, constraints and contingencies, outcomes, and accountability issues related to collaborations were described. |
| Canadian Nurses Association. (2006). | This theoretical paper described the development of the CNA Social Justice Gauge. The Gauge was designed to guide the decision-making and policy work of the organization. The Gauge is rooted in defining attributes of social justice (both as a means and an end), and principles of recognition (broad systematic inequities and oppression are found in all societies) and responsibility (an inherent obligation to act responsibly). A series of steps was proposed for screening and judging whether policy proposals reflect the attributes of social justice. |
| Carr, M., & Riesco, M. (2007). | This discussion paper reviewed the events that led to the recent reintroduction and legislative changes for the practice of nurse-midwifery in Brazil. The Brazilian National Nurse-Midwifery Organization was formed to provide professional leadership. High cesarean rates and government interest to address escalating childbirth concerns facilitated leadership opportunities for the nursing profession and nursing organization to take action. |
| Chan, G., & Hackenschmidt, A. (2006). | This narrative paper discussed the implications of proposed regulatory recommendations for the Emergency Nurses Association (ENA) and its members. The recommendations derived from a vision paper developed by National Council of State Boards of Nursing (NCSBN) that aimed to bring uniformity, simplicity, and clarity to the regulation of advanced practiced registered nurses (APRNs). Nursing association priorities were derived through monitoring nursing practice and public policy that had implications for nursing. The authors underscored the disparity of opinions that exist within the profession, which then pose challenges to develop broad visionary statements. How members contribute to the work of the association was described. |
| Chomik, T. (2007). | This qualitative multiple case study (n=8) provided an in-depth examination of intersectoral activity to address the social determinants of health and health disparities in Canada. Opportunities and challenges to work collaboratively to address complex policy issues were described. Decisions regarding players at the policy decision tables and the roles assumed are linked to how an issue is framed or defined and a key factor |

| Author/Year | Purpose & relevant findings for review |
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| | influencing cross-sector work. |
| Crosby, B., & Bryson, C. (2005). | This qualitative case study illustrated the use of the Leadership for the Common Good Framework and explored policy advocacy processes for a collaborative project involving diverse stakeholders and organizations. Responding to major social needs whereby authority for issues is shared across jurisdiction and sector boundaries requires organizations to operate collaboratively. An organizing framework to examine cross-sector policy advocacy is proposed, which included shared-power dynamics, settings, stages of the policy cycle, and leadership tactics by organizations. |
| Curtiss, C. (2004). | The narrative paper described the role of oncology nurses and nursing organizations in end of life care. The report suggested that published positions from respected international and national organizations represent collective agreement by an organization and thus carry far more clout than individual personal opinions. |
| Daniels, N., & Sabin, J. (1997). | This theoretical paper described a priority-setting processes framework that is both legitimate and fair. Setting priorities is a moral decision that entails a legitimacy problem (who and under what conditions a decision is made) and a fairness problem (what is considered fair). Fair and legitimate decision features for priority setting include relevance (rest on reasons and based on evidence and principles that fair-minded people can agree); public accessibility (accessible rational for decisions); appeals mechanism (a way to revisit and/or revise decisions); and enforcement (monitoring or the process to ensure the first three conditions are met). |
| Des Jardins, K. (2001a). | This narrative paper examined nurses' the effects of lack of knowledge related to political processes and feelings of powerlessness on political involvement. National, state, and specialty nursing organizations have engaged in policy by providing background information to its members, mobilizing members (letter writing, grassroots lobbying), screening political candidates, and supporting education activities that address the political process, policy development, empowerment, and ethical decision making. Communication, collectivity, and collegiality are required to influence policy. Specialty interest groups and specialty organizations can break up the collective voice of nursing if the emphasis is placed on specific needs of the specialty rather than broad, social reform. Furthermore, nursing organizations often ignore issues such as environmental protection and social problems that affect public health on a national and international level |

| Author/Year | Purpose & relevant findings for review |
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| | because these issues did not directly involve their specialty. |
| Des Jardins, K. (2001b). | This narrative paper described the nursing profession's ethical obligation to advocate for human rights and health policy issues. The successful actions taken by the American Nurses Association for health care reform are described. However, the author argued that nurses' social and political responsibilities are sometimes forgotten in the midst of clinical guidelines and institutional policies. |
| De Vita, C., Montilla, M., Reid, B., & Fatiregun, O. (2004). | The qualitative study examined factors that enabled organizations to actively participate in the policymaking arena. Purpose and mission statements, structure, leadership, constituencies, and resources influenced the advocacy efforts of six types of child advocacy organizations (including professional associations). A conceptual framework was offered for developing capacity-building activities for advocacy work by organizations. |
| Donaldson, L. (2007). | This mixed methods study examined correlations between select organizational factors–budget size, staff size, age, local government funding, and leadership–and the advocacy behaviour of human service agencies. Findings showed that budget size, staff size, leadership, and local government funding are positively correlated to agency advocacy behaviour. Barriers and enhancements to agency advocacy behaviour were also discussed including government relationships and fear of retribution. |
| Donaldson, L. (2008). | This literature review and case study described the development of an advocacy program by NPO homeless services agencies. Organizational mandates and capacity, governance, perceived credibility, and membership relationships were identified as factors that impeded or facilitated advocacy efforts. |
| Donaldson, L., & Shield, J. (2009). | This mixed methods study reported the development of an instrument to measure the policy advocacy behaviour of nonprofit human service agencies. The authors determined that the Policy Advocacy Scale was reliable and valid. The tool was used for a pilot study to examine the advocacy behaviour of NPO human service agencies to change local level social policies. Organizational capacity (staff size, budget size, and leadership) was shown to influence advocacy. Government funding could bolster advocacy efforts, while fear of government retribution limited advocacy choices. |

| Author/Year | Purpose & relevant findings for review |
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| Fullerton, J., Durnell Schuiling, K., & Sipe, T. (2005). | This qualitative study explored the priorities of past and current presidents of the American College of Nurse-Midwifes (ACNM). Several priority issues for the organization were related to practice issues including professional identity, autonomy, education and standards of practice, retention, interprofessional practice, and documentation of nurse outcomes. Factors influencing the choice of priorities were implicit. Sparse membership, and a lack visibility and contributions by midwifes to health care inspired many of the priorities set by organization. Crisis such as the withdrawal of liability insurance and restructuring of health care accounted for priority choices made. |
| Fyffe. T. (2009). | This narrative paper reported findings from a critical examination of nursing policy experiences drawn from the United States and United Kingdom literature. Lessons learned about the profession's role in shaping and influencing policy were determined partly from nursing organizations' experiences. The authors reported that nursing organizations supported nurses in their political endeavours and were recognized as a political force. However, nursing inter-organizational conflicts and struggles to form a strong united approach may diminish the success of policy initiatives. Greater co-ordination of action was suggested to ensure that nursing is actively supported in influencing and shaping health and health care policy. |
| George, A. (2005). | This narrative paper described the experiences of the National Black Nurses Foundation in fulfilling its mission and vision through the development of programs and provision of services to minority and underserved communities in the United States. In order to facilitate changes in health systems and policy, nursing organizations must take their mission statements seriously, develop strategic partnerships, and be willing to transform their organizations. |
| Giang, T., Karpyn, A., Burton Laurison, H. Hillier, A., & Perry, D. (2008). | This quantitative research study explored access to healthy foods and the development of an evidence-based report as a key component for influencing policy. The creation and marketing of an evidence-based report was a critical component of an advocacy campaign that provides a strong, credible foundation for policy change. The steps taken to find partners, obtain and analyze the data, and disseminate the findings were described. |
| Gilson, L., Doherty, J., | This synthesis paper examined and synthesized evidence related to health system action taken for policy to |

| Author/Year | Purpose & relevant findings for review |
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| Loewenson , R., & Francis, V. (2007). | address the root causes of health inequity. The authors argued for cross-sector approaches involving government bodies and departments, society organizations, for-profit organizations, and communities. Experience has shown that organizations are generally more effective when working in alliance. Building wider coalitions of support for change engaged other potentially powerful actors who have their own circles of influence and offsets opposition from powerful actors. However, the ability to work collaboratively across jurisdictional and sector boundaries was influenced by the social, political, and economic environment. |
| Gonzalez, R. (2000). | This narrative paper reported the involvement of the American Nurses Association (ANA) and its members to address women's health issues. The strategies taken included lobbying members of Congress, educating political leaders, and forwarding legislation enactment support letters. The association also educated its members about public policy issues. The importance of collaborating with other groups as a way to gain strength and influence policy was discussed. |
| Green, A., Wieck, L., Willmann, J., Fowler, C., Douglas, W., & Jordon, C. (2004). | This narrative paper described a successful collaborative endeavour by organizations within Texas to address the nursing shortage. The strategic planning leading to the development and passing of legislation was described. Establishing partnership both within and outside the nursing profession was essential to the outcomes of the advocacy efforts. |
| Grogan, C., & Gusmano, M. (2009). | This case study explored Medicaid managed care reform and policy making in Connecticut. Efforts by safety-net providers and other NGOs to advocate for healthcare for the poor where described. The findings illustrated the relationship with government as a key factor influencing advocacy efforts. There was a two-way dependency between governments and NGOs. While NGOs had significant political resources and pursued major political strategies in response to perceived retrenchment, in some cases NGOs suppressed certain aspects of their advocacy and tempered the aggressiveness of their approach. |
| Haase-Herrik, K., & Herrin, D. (2007). | This narrative paper described the work of the American Organization of Nurse Executives in partnership with its practice partners in defining a new nursing role that is more responsive to the realities of a complex, technologically advanced, ever changing healthcare system. Using a systems model as the context, the authors proposed a workforce model with six domains of challenge. The interplay of the many factors and leverage points within the six domains of the workforce model informed suggestions for a new clinical nurse leader role. |

| Author/Year | Purpose & relevant findings for review |
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| Hahn, J. (2009). | This narrative paper reported the successes of the Legislative Coalition of Virginia Nurses, which was comprised of several individual and professional specialty-nursing associations. Drawing on their collective voice the group expanded prescriptive authority for advanced practice nurses, workforce data collection by the Virginia Board of Nursing, third-party reimbursement for nurse midwives, involvement of nurses in policy work (Health Reform Commission, Regulatory Reform Commission), onetime pay raise for nursing faculty in state universities, regional legislative receptions, establishment of key contacts with legislators, and effective grassroots advocacy. The range of advocacy strategies used was described (mostly targeting individual nurses) and the relevance of membership relationships when pushing policy issues. |
| Hall Long, B. (2009). | This narrative paper reflected on the value of the nursing profession's involvement in public policy. The author shared experiences as a nurse-legislator at the state level and suggested political involvement advanced both the profession and the public's health. Using cancer as an exemplar, the author reported that the formation of a cancer interest coalition involving nursing associations, nonprofits and the public was a key political strategy. In collaboration with other organizations the Delaware Nurses Association, Oncology Nursing Society, occupational health nursing and industrial hygienists' associations actively advocated over a period of 12 months for the Cancer Cluster Right to Know Law. |
| Hart, B., & Ky, R. (2008). | This narrative paper described actions taken by the Emergency Nurses Association (ENA) to address care of clients with mental health illness in emergency departments. The establishment of a working committee facilitated the development of practice and policy recommendations for consideration by the ENA Board of Directors. The association endorsed legislation related to mental health. Providing education to its members served as an additional strategy. |
| Harwin, J., & Barron, T. (2007). | This case study considered the role of NGOs in supporting the development of policy to enhance child welfare and protection services. Opportunities and barriers to contribute effectively to policy formulation and opportunities to develop capacity were described. Understanding by NGO members about government priorities and existing legislation was identified as essential to their participation. Fear of government retribution, organizational mandates and capacity, partnerships, and the political environment play a role in NGO advocacy efforts. |

| Author/Year | Purpose & relevant findings for review |
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| Heschel, R., Crowley, A., & Cohen, S. (2005). | This qualitative study traced events, enactment of laws, promulgation of regulations, and development of medication administration training programs for childcare providers. Several events led to the actions taken by a state nursing organization to address a concern about the training of unregulated workers in the administration of medication to children in daycare including: changes in a state nurse act (administration of medication defined as function of registered nurses), trends for the delegation of certain nursing tasks to other providers, a state nursing organization's reaction to a national trend to downsize nursing staff in health care institutions, discrepancy and tensions between child care regulations and the state nursing organization, introduction of a Bill and passing of an Act governing the administration of medications to children, prevailing beliefs about liability, and varying interpretations of nursing delegation versus professional activity. |
| Hobbs, J. (2009). | This qualitative study explored how nurses involved in the creation of the American Nurses Association social policy statement prioritized, organized and promoted certain skills in nursing and excluding others. The development of the association's social policy statement was an exercise in prioritizing, organizing, and promoting certain nursing skills, tools, and knowledge that was shaped by contextual influences and local realities. Factors shown to influence the policy included health care reform, new technologies and specialties, new and expanding health provider roles, dwindling support and resources for the organization, disparity among nurses about the role of the association, and loss of membership due to the emergence of specialty nursing groups. |
| Hoffman, A. (1999). | This mixed methods study measured changes in the constituency of an organizational field centered around the issue of corporate environmentalism, described the situated institutions (cognitive, normative, and regulative) that influenced organizational choices, and identified the broader environmental triggers that shaped the environmental management policy debate. The analysis informed understanding about the limited choices imposed upon organizations involved in policy change. An issue and relevant stakeholders (the community of organizations engaged in the policy issue) comprised an organization field where beliefs, norms, and rules about a policy problem were channeled and shaped. Key disruptive events or 'shocks' triggered changes to beliefs, norms, and rules and to the organizational field contributing to actions taken for policy change. These events took multiple forms including milestones (e.g., summits), catastrophes (e.g., oil |

| Author/Year | Purpose & relevant findings for review |
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| | spills), and legal/administrative happenings (hearings, release of white papers). |
| Holleman, G., Eliens, A., Van Vlietm, M., & Van Achterberg, T. (2006). | This literature review examined the activities of professional nursing associations in the promotion of evidence-based practice. The authors suggested that low levels of participation for the uptake of nursing organizations' initiatives (e.g., Promotion of evidence-based practice) may partly be explained by the limited involvement or commitment of its members. The types of strategies associations use to gain buy in from their members were described. |
| Iacono, M. (2001). | The narrative paper provided an overview of the steps the American Society of Peri-Anethesia Nursing (ASPAN) followed to develop its strategic plan. Developing a strategic plan at the national and component levels required leaders to ask, what do we want to be like, and look like in the future, and what do we have to do now to achieve that success? Strategic planning was about change and worked best when an organization considered what it needed to change internally and what external factors may affect its plans. |
| Jacobs, S., & Boddy, J. (2008). | This qualitative historical study examined the professional and sectoral milieu and the policy initiatives undertaken to advance nursing in New Zealand during the late 1900's to the early 21st century. An account was provided about how the nursing profession drew on social and political events to advance the nurse practitioner role. A political focus to improve efficacy and efficiency, government support for legislative and policy initiatives (that enabled nurses to more effectively deliver primary health care), organizational mandates, release of key documents by government and nursing leaders, interprofessional jurisdictional disputes, and intra-professional conflicts shaped the choices and actions taken by various nursing organizations involved in the policy debate. |
| Jones, B. (2001). | This discussion paper reported how the regulatory arrangement and the way in which nursing is subject to regulatory control is dependent on social constructs, culture, politics and the perceived position of the profession. Proponents of the regulation of practice and the registration of nurses, maintain its importance in patient advocacy, provision of standards, and the enhancement of the status of the profession. While agreeing that standards should exist, others have concern about the way in which the regulation is exercised. More specifically, regulation could support the social role of nurse as that of follower and doer rather than thinker |

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| | and leader. |
| Jones, M. (2004). | This descriptive paper reported the approach taken by the Royal College of Nursing in policy formulation for nurse prescribing. Key ingredients for success included identifying a clear objective of nurse prescribing, harnessing popular opinion, drawing close potential allies and turning them into supporters, effective use of the media to gain public understanding of the issue, and manipulating the political process. Internal conflict among the profession was an obstacle that had to be overcome as part of the endeavours to secure nurse prescribing. |
| Kishi, A., & Green, A. (2008). | This descriptive paper examined statewide efforts to address a nursing shortage in Texas. Strategies for positively affecting the legislative, regulatory, and health policy processes related to nursing workforce development were explored. Contributions made by the nursing organizations involved were described and the ingredients for establishing successful, strategic partnerships were also identified. |
| Laraia, B., Dodds, J., & Eng, E. (2003). | This multiple case study reported how anti-hunger advocacy organizations (AHAO) are effective and under what conditions. An effective organization was conceptualized as an agent of change with a reputation among organizations for taking action and making its resources available to them. A conceptual framework was developed that identified 17 organizational characteristics representing capacity, performance, and achievement. These factors were strongly linked and contributed to organizational effectiveness. Both capacity (governance) and performance are influenced by the values and beliefs that members of an organization hold and the extent to which there is agreement of those beliefs. Capacity and performance in turn, influences an organization's effectiveness. |
| Long, R. (2005). | This descriptive paper described critical care nurses' roles in public policy. The authors emphasized the contributions nurses and their organizations brought to policy issues. Nursing organizations engaging in public policy require support from their members. The author further suggested that nursing organizations have tended to focus on safe policy issues. |
| Mafrica, L., Ballon, G., Culhane, B., McCorkle, | This descriptive paper reported the development of the Oncology Nursing Society (ONS) strategic plan. The authors underscored the relevance of monitoring the external environment as a basis for informing |

| Author/Year | Purpose & relevant findings for review |
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| M., Miller, C., Murphy, & Worrall, L. (2002). | organizational priorities. Particular emphasis was placed on monitoring social trends, the healthcare industry, and what is happening within the nursing profession and organizations themselves. |
| Mahlin, M. (2010). | This descriptive paper argued that professional associations ought to assume an advocacy role in addressing systemic problems in health care institutions and bureaucracies. The author suggested that the virtual impossibility for individual nurses to change or to recognize the systemic problems that affect their patients. Since the goal of patient advocacy is to support and care for patients, then systemic problems must be addressed and this can be achieved only collectively. Obstacles can be overcome when speaking as a collective voice through nursing organizations. |
| Mattie, A., & Ben-Chitrit, R. (2007). | This narrative paper explored the development of patient safety legislation and provided a historical review and analysis of the events leading to the passage of the final bill. Emphasis was placed on the importance of government receptivity and timing. External events including a presidential election, war, budget deficits, and competing health care issues overshadowed patient safety legislation. |
| Mitton, C., & Donaldson, C. (2001). | This extensive literature review and quantitative research categorized previous program budgeting and marginal analysis (PBMA) exercises and examined the impact of PBMA in regional health authorities internationally. PMBA was described as based on economic principles (opportunity, cost and marginal analysis) that were used to assist decision-making at micro (within programs) and macro (across programs) levels. The use of PBMA was widespread and was reported to be successful for setting priorities and shifting resources (e.g., programs and services). |
| Mitton, C., & Patten, H., Waldner, S., & Donaldson, C. (2003). | This participatory action research reported the development of a formal approach to priority setting at the macro-level of a health region. A conceptual framework was developed that depicted macro-marginal analysis (MMA) priority-setting. The framework was based on economic principles and built on the program budgeting and marginal analysis framework. Areas for service growth and areas for resource release based on pre-defined locally generated criteria could be identified. |
| Naegle, M. (2003). | This narrative paper provided an overview of the American Nurses' Association's actions on impaired nursing practice. Factors driving action by the nursing association included societal expectations and |

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| | increased demand for accountability. A first line of action by nursing organization often includes the development of policy/position statements. Thus the nursing organization first formed partnerships with other nursing organizations in order to collaboratively develop and articulate a nursing position. Actions also included educating nurses. Workplace issues such as the nursing shortage, continuing elimination of registered nurse positions, and subsequent increased demands on registered nurses in the workplace often take greater precedence over other issues. |
| Nathan, S., Rotem, A., & Ritchie, J. (2002). | This evaluation study examined the role of organizations outside government in advocating for health equity and the capacities and conditions related to their success. Organizations were found to work collaboratively and in conflict with government based on organizational strengths and changing environments. Several factors were found to enable NGOs to actively participate in the policymaking arena including, which are presented in a framework that depicts effective advocacy as a dynamic process characterized by flexibility and opportunism in response to organizational strengths and capacities. |
| Paluzzi, P., Gaffikin, L., & Nanda, J. (2000). | This mixed methods study, which aimed to evaluate a domestic violence education program, described strategies implemented by the American College of Nurse-Midwives (ACNM). The project aimed to address domestic violence by influencing practicing midwives and midwives in training. Factors that support the success of the initiative to develop policy and provide training to nurses for domestic violence prevention including policy reforms that provided official endorsement of efforts to proceed with initiative, provision of a consistent message by the nurses, champions in the organization and development of an ad-hoc committee to work with the Board to direct policy were described. |
| Panda, B. (2007). | This mixed methods case study examined NGO's approaches to advocacy efforts. The authors operationalized bottom up and top down approaches to advocacy. Radical, conformist, and proactive approaches employed by NGOs were described. The findings suggested that organizations most often use a combination of approaches, but tend to use bottom up approaches more often. |
| Peacock, S., Mitton, C., Bate, A., McCoy, B., & Donaldson, C. (2009). | This theoretical paper proposed a framework for priority-setting based on an integration of tools and methods drawn from different academic traditions including program budgeting and marginal analysis (PBMA), multi-criteria decisional analysis and accountability for reasonableness. The model described the inputs and |

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| | outputs from the PBMA process and a number of barriers and facilitators to the uptake of PBMA. |
| Perry, D. (2005). | This mixed methods study reported findings from two studies undertaken to identify how nursing testimony and advocacy strategies influenced policy-makers choices. One study investigated views of legislative aids and the second study evaluated a nursing presentation given to state legislators. The Massachusetts Nurses Association was cited as a very effective lobbying group because it had a visible presence in the state house and because it brought in local nurses to lobby with their own legislators on issues. Findings also suggested that testimonies from nurses would be welcomed on issues such as housing and health. |
| Phaladze, N. (2003). | This qualitative study gathered descriptive data from major key players concerning the knowledge of the policy process and resource allocation for management and care of clients with HIV/AIDs in Botswana and to identify nurse characteristics associated with motivation to influence policy in HIV/AIDs management and care. Factors internal and external to the organization influenced the association's engagement in HIV policy including a lack of visibility and credibility, the employment of top down approaches by government that excluded nursing, and dominance over health policy by the medical profession. |
| Potempa, K. (2005). | This narrative paper described the issues and events of a collaborative endeavour by the Oregon Nursing Leadership Council that culminated in the development of a comprehensive statewide plan to resolve the nursing shortage. The Council, comprised of five major nursing leadership groups in the state, were challenged by group behaviours that kept the Council from addressing its goals including the tendency to work predominantly through hidden agenda and covert alliances in intergroup relations. Fundamental issues that kept the Council initially stuck in a state of inertia included conflicting views and organizational interests, and representing constituents. Motivated by concern for the public welfare and the survival of THE profession, individuals surrendered their own narrow organizational goals to achieve a more effective collective good. |
| Public Health Agency of Canada. (2007). | This commissioned report examined international experiences documented by academics, policy-makers, and practitioners to identify the problems, conditions, approaches, and roles played by various actors working collaboratively to address the social determinants of health. Working collaboratively to address complex health problems required different approaches at different levels of governance and were more |

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| | successful at the community level than at national and global levels. The way in which an issue was framed often determined who would lead efforts and who would be involved to address a policy change. Strong connections with political leaders, administrators, and the media were key to securing support for collaborative approaches to health policy issues. Factors that influenced partnerships included shared philosophical frameworks, organizational capacity (knowledge & skills), mutual trust and respect, and defined roles and contributions to be made. |
| Randolph, S., & Cox, A. (2003). | This narrative paper described the American Association of Occupational Nurses (AAOHNs) evaluation of its governance structure and change to a Carver Model of Governance. Work overlap and slower response times posed challenges for an organization and environment that required and increasing valued immediate responses and solutions. Good governance requires high-level policies, clear expectations from the Board, and continuous monitoring and evaluation to ensure the organization is in compliance with policies. |
| Reiger, P., & Moore, P. (2002). | This narrative paper described the role of professional organizations regarding cancer-related policy and political issues using the Oncology Nursing Society as an exemplar. Several detailed strategies for advocating were described, which included providing support, resources, and education to their members, establishing networks and partnerships, and lobbying political leaders more directly. Advocacy intended to make changes at local, state, and national levels. Factors influencing advocacy included resources, governance structures, membership, and partnerships, and government legislative events. |
| Rheaume, A. (2003a). | This qualitative case study examined nursing education reform in New Brunswick. Processes of upgrading nursing education to a baccalaureate degree and the conflict this change created between the Nurses Association of New Brunswick and the New Brunswick Nurses Union were examined. Several factors were shown to influence the course of action and framing of the issue including: division in opinion among nurses; conflict between the nursing association and union; exclusion of relevant stakeholders (nurses) from decision tables; government mandate related to the authority of nursing education; government interest to reduce costs; and the clarity and relevance of the associations goals for nurses. Divisiveness among nurses and their professional organizations delayed the development of policy. |
| Rheaume, A. (2003b). | This qualitative case study examined the changing division of labour between nurses and nursing assistants |

| Author/Year | Purpose & relevant findings for review |
|---|---|
| | in the province of New Brunswick. Health care reforms and baccalaureate entry to practice for nurses contributed to expanding responsibilities for nursing assistants. Subsequently leaders of nursing organizations were inspired to respond to concerns about the ease with which some patient related tasks are moved to nursing assistants. |
| Ritsatakis, A., & Makara, P. (2009). | This commissioned report analyzed noncommunicable disease (NCD) policy development in eight countries over several decades to broaden understanding of the policy-making process and conditions that influenced it. The synthesis provided evidence-based practical guidance for decision-makers, civil servants, and interested parties in the field of NCD policy development. The report illustrated how different stakeholders influenced the development of policies. The conditions that provide both opportunities and constraints for stakeholders tackling a policy issue were identified. Working collaboratively required identification and inclusion of diverse and relevant stakeholders, agreement of expectations and roles, mutual understandings by stakeholders of others' positions, and strengthening links among governance levels. |
| Romig, C. (2000). | This descriptive article reported the involvement of Association of Operating Nurses (AORN) in the development of regulations for the Patient Safety Act legislated in 1999. Strategies taken to develop a unified statement to represent a nursing position regarding the mandated nurse-to-patient ratios were described. The issue of nurse-to-patient ratios was complicated and members of the nursing profession were not united on what the rations should be in any health care setting. |
| Rowell, P. (2003). | This narrative paper described the American Nurses Association documents and activities that promoted patient safety. Three specific roles to promote patient safely included developing and disseminating foundation documents; lobbying and regulating; and advocating for patients and issues. A professional commitment to safe care, the organization's broad mandate, varying views about the role of legislation in mandating ratios, and intra-professional relationships played roles in the organization's choices and actions. |
| Sabatier, P. (1987). | This theoretical paper described the seminal policy Advocacy Coalition Framework (ACF). The framework. ACF depicts the relationships among policy actors (policy subsystem) advocating for a common policy issue, and the factors that influenced those interactions. Both stable factors (resistant to change such as beliefs, values, rules, and distribution of resources) and dynamic factors (conditions external to the coalition that |

| Author/Year | Purpose & relevant findings for review |
|---|---|
| | fluctuate such as economic conditions, and actions by other policy subsystems) affect the composition of those engaged in the issue, as well as the constraints and opportunities various actors will face who are dealing with the policy problem. |
| Sarna, L., & Aguinaga Bialous, S. (2004). | This descriptive paper reported findings from a review of the Oncology Nursing Society's (ONS) tobacco control policies. Specific polices addressing tobacco use have been developed by a variety of national and international nursing organizations that can guide nursing practice, education, and research, and support advocacy efforts needed to affect health care policy and legislation. However, none of the policies included specific strategies, timeframes, or funding for implementation and had not been evaluated. As part of their advocacy, members of ONS provided testimony to the United States government about the importance of enhancing existing tobacco control policies to support the critical role that nurses can play in tobacco control. |
| Sattler, B. (2003). | This discussion paper reported the environmental health risks posed by the healthcare industry and the solutions that have been forged by both individuals and organizations through policy work at the local, state, federal, and international levels. State, national, and international nursing associations have developed position statements, developed and integrated environmental health competencies into curriculums, and educated nurses, political leaders, and the public about environmental harms and safer practices. The importance of working collaboratively with diverse stakeholders was described. |
| Sattler, B. (2005). | This discussion paper described the types of environmental policy and authorities. A snapshot was provided about how nursing organizations were exerting influence at the local, state, and national health care policy levels. Nurses are a trusted profession, have relevant skills and knowledge about environmental health, and have been instrumental in developing practice and policy resolutions. The importance of working in coalitions contributed to successful endeavours. |
| Sherman, R. (2008). | This study explored the driving factors that influenced the decisions of Chief Nursing Officers to promote the involvement of their organizations in the Clinical Nurse Leader Project. Five major factors were identified to from a framework designed to explain organizational participation: organizational needs, a desire to improve patient care, an opportunity to redesign care delivery, the promotion of the professional development of nursing staff, and the potential to enhance physician-nurse relationships. Forging |

| Author/Year | Purpose & relevant findings for review |
|---|---|
| | relationships was reported as critical to success of initiative. |
| Sibbald, S., Singer, P., Upshur, R., & Martin, D. (2009). | This research proposed a conceptual framework for successful priority setting based on findings from three independent studies. The framework underscored essential processes and outcomes of priority setting. Five successful processes included stakeholder engagement, use of explicit process, information management, consideration of values and context, and revision or appeals mechanism. Five successful outcomes included stakeholder understanding, shifted priorities/reallocation of resources, decision-making quality, stakeholder acceptance and satisfaction, positive externalities. |
| Smith, T. (2009). | This discussion paper examined the events surrounding the failure of the entry into practice proposal in the original four states in American that had been selected for early implementation. External factors triggering responses taken by the American Nurses Association were described. The importance of membership buy-in and intra-professional collaboration was essential to the successes and failures from efforts. |
| Stokowski, L., Sansoucie, D., MacDonald, K., Stein, J., Robinson, C., & Lovejoy, A. (2010). | This narrative paper discussed the challenges and opportunities of two small specialty nursing organizations, the National Association of Neonatal Nurses (NANN) and National Association of Neonatal Nurse Practitioners (NANNP), to advocate and influence legislative affairs. Membership provided the strength of the organization. Forming partnerships was reported as a key ingredient for successful advocacy work by these organizations. |
| St. Pierre Schneider, B., Menzel, N., Clark, M., York, N., Candela, L., & Xu, Y. (2009). | This discussion paper described nursing initiatives and leadership roles to position health at the core of urban sustainability. A case was built about why nursing should be involved in urban sustainability and attention was drawn to the efforts made by various state and the American Nurses Association for improved environmental conditions. Nursing organizations often collaborate with others to influence environmental health policy decisions. |
| Thompson, M., & Fortress, E. (1980). | This theoretical paper described cost-effectiveness analysis (CEA), a priority-setting theory. CEA is a technique to indentify the best use of resources prospectively. Similar to the other economically principled priority-setting frameworks, CEA involves a series of steps that entails the identification of values, specifying alternatives, measuring effects, identifying appropriate indicators to gauge values, calculating the |

| Author/Year | Purpose & relevant findings for review |
|---|---|
| | cost-effective ratio, and performing sensitivity analysis. Differing from cost-benefit analysis, CEA does not require the assignment of dollars values as weighting criteria, and thus can be applied to decision areas when monetary values are not easily discernable. The theory suggests priority setting involves a series of rational or calculated steps, criteria for evaluating, and judgment. |
| Van Achterberg, T., Holleman, G., Van de Ven, M., & Grypdonck, M. (2006). | This study explored the role and current activities of professional nursing associations in the promotion of EBP in the Netherlands. Being seen as stakeholders by government organizations or other discipline enabled organizations to put issues on their agenda and stimulate innovation among its members. Board members were unsure how well the Board's ideas reflected those of members. Suggested minimal engagement might be attributable to the fact that nursing organizations were just catching up with the increased attention given to the evidence-based practice issue. Co-operation between nursing different nursing organizations as well as other with organizations could reduce barriers and contribute to the success of the initiative. |
| Van de Velde Coke, S. (2009). | This paper reported findings from an extended review commissioned by the Academy of Nurse Executive that yielded a comprehensive pan-Canadian snapshot of the impact of changes on senior nursing leaders and their roles. Several factors influence nursing practice and healthcare including healthcare system redesign and governance restructuring, self-regulatory legislation, care delivery and models of care, work redesign, demographics of practicing nurses, fiscal reform, patient safety issues, and nursing knowledge development. These represent a series of nursing concerns that informed the priority areas of ACEN and provided a platform for strategic planning. |
| Vitols, M., Du Plessis, E., & Ng'Andu, O. (2007). | This narrative paper described the development of the Caring for the Caregivers project in Zambia. The authors underscored the importance of intra-professional collaboration among nursing organizations as a way to build capacity for advocacy efforts for HIV/AIDs. The collaboration created opportunities for professional assistance, growth and development, identification of relevant needs and goals, and thorough preparation. It also facilitated readiness in terms of motivation and capacity to initiate and develop projects. |
| Whyte, N., & Stone, S. (2000). | This descriptive paper documented the work of the Registered Nursing Association of British Columbia (RNABC) to promote primary health care. Factors influencing decision-making and tactics taken to push a primary health care agenda from a nursing perspective were described. Getting buy in and building |

| Author/Year | Purpose & relevant findings for review |
|---|---|
| | relationships, understanding the political context, and garnering evidence to support the organization's position were key strategies leading to success. Aligning the work with the organizations' new regulatory framework and securing senior level support from the Board of Directors were instrumental in moving forward. |
| Wieck, L., Oehler, T., Green, A., & Jordon, C. (2004). | This descriptive paper reported a collaborative initiative to implement health policy to improve the work environment by incorporating the American Nurses Association (ANA) staffing principles into state rules and regulations. The political and regulatory arenas were used to bring together historically competing groups to work toward a mutually acceptable policy initiative that increased nurses' ability to influence staffing in hospitals in the State of Texas. The authors underscored the importance of intra-professional collaboration to gain strength and the importance of a unified message. |
| Williams, G. (2006). | This quantitative study profiled the issues and activities of critical care nurses and their professional organizations to obtain both an update of the issues and a wider global perspective. The organizations' priorities were informed by the needs of its members, which were identified as staffing levels, working conditions, and access to quality education. Cooperation and collaboration among nursing organization affiliates were shown to advance an organizations objects and initiatives. |
| Zakocs, R., & Earp, J. (2003). | This quantitative study examined well four organizational characteristics (structure, resources, motivation, or political capacity) explained local NGOs' use of a variety of advocacy tactics aimed at promoting state gun control laws. The study found support that motivation and political capacity were most important for understanding advocacy. |

## Appendix B

## Participant Demographic Profile

Participants will be asked to complete the following demographic information form as part of the interview process.

What is your present position with the organization? □ Staff □ Volunteer

Please specify the title of your position: _____

Please provide a brief description your current role: _____

_____

_____

How long have you worked or volunteered with the organization? ____years ____months

How long have you worked or volunteered in your present position? ____years ___months

How long have you worked or volunteered in the policy area?_____years _____months

How long have you worked or volunteered in the policy area in this organization? ____years_____months

What is your educational background? (please check all that apply)

□ High School

□ Diploma, specify: _____

□ Degree, specify: _____

□ Masters, specify: _____

□ PhD, specify: _____

How long have you been practicing in your profession or field? (i.e., how long have you been a nurse, lawyer, etc.) _____years _____months

Have you received education or specialty training about community environmental health? □ Yes □ No

If yes, please describe: _____

_____

_____

## Appendix C

## Interview Guide

[Participants will be asked to complete background information on paper document prior to the interview - Appendix B]

Before I begin the interview I would like to thank you for your participation. Your perceptions are important to help others understand how nursing organizations set priorities and take action for a policy issue. I am particularly interested in how your organization makes choices about policy about community environmental health policy. When I refer to community environmental health I mean natural and physical environmental conditions and related behaviours that influence health. These conditions and related behaviours are amenable to policy interventions. I will begin with some questions about how your organization decides to address a policy issue. I will then ask you some questions about your perspectives about your organizations' involvement with community environmental health policy. There is no right or wrong answer. Please remember that you do not have to answer any questions that make you uncomfortable. The interview will take less than one hour.

1. How does your organization become aware of a policy issue?

2. How does your organization decide which policy issues it will become involved with?

3. How do your nursing members inform the policy choices and actions of your organization?

4. What role do you think nursing organizations should play in community environmental health?
Probe: What distinction do you see between the role for individual nurses and those for nursing organizations for community environmental health?

5. What public credibility does your organization have with respect to its role in community environmental health?
Probe: Does anyone ever question "what nursing has to do with environmental health?

6. What political credibility does your organization have with respect to its role in community environmental health?

7. How does your organization's governance structure influence your policy choices and action for community environmental health?
Probe: composition of BOD; how members become part of the BOD; processes used (e.g., Carver Model)

8. There are 13 nursing organizations in Canada: 12 provincial/territorial and 1 national. How does the [provincial/national] jurisdictional mandate of your organization influence its policy choices and actions for community environmental health?
*Probe:* ask about opposite level

9. How does regulatory and/or policy mandate of your organization influence its policy choices and actions for community environmental health?

10. What are major external influences on your organization's policy priorities and actions for community environmental health?

11. How do system shocks such as catastrophes, crisis, or government changes influence your organization's policy priorities and actions for community environmental health?

12. Would you describe an example of when your organization decided to address a community environmental health issue and/or when they decided NOT to address a community environmental health issue?
*Probes:*
What triggered your organization's decision to consider addressing the community environmental health issue?
What were the main factors that influenced the choices made?

13. Describe the benefits for nursing organizations to be involved in community environmental health?

14. Describe the risks for nursing organizations to be involved in community environmental health?

## Appendix D

### Stages of Framework Analysis, Application of Principles of Interpretive Description, and Analysis Outcomes

| Framework Analysis Stages | Principles of Interpretative Description (ID) (Rationale) & Outcomes |
|---|---|
| **Stage One: Familiarization** | |
| **Purpose:** The intent at this stage was to learn about the data and to gain a sense of the whole<br><br>***Learning about the data:***<br>▪ Transcripts were imported into NVivo; all transcripts were reviewed and audio-tapes listened to; transcription errors were corrected and personal identifiers removed<br><br>▪ Five transcripts from participants that held different positions i.e., senior management, Board director) and roles (e.g., work in different departments) within the association were selected; these transcripts were systematically re-read; the NVivo annotation feature[34] was used to make notes about what a phrase or paragraph was about using verbatim words from the text (e.g., "value added" or "policy screens") or phrases that provided a summary of the text meaning (e.g., "leadership strategies") (this process is similar to printing off transcripts and writing notes in the margins); recurrent annotations were apparent after three of the five transcripts were reviewed<br><br>▪ Memoing (notes made using the memoing feature of NVivo) (e.g., spotlighting nursing knowledge-recurrent references to what nurses know and do) and journaling was started (manual notes and diagrams) | ***Principles of ID:***<br>▪ Came to know individual cases (participants) intimately<br><br>▪ Repeated immersion in the data prior to coding, classifying, or creating linkages<br><br>▪ Avoided early application of small units of analysis)<br><br>▪ Provided a means to retrace the development of abstractions to ensure the analytic directions were defensible<br><br>▪ Navigated within and beyond the original conceptual framework with which I entered the investigation in order to fully engage the processes of inductive reasoning and to challenge my preliminary interpretations (i.e., when findings looked too similar to the |

[34] NOTE: There are no rules for using the annotation and memo features in NVivo. For this study the annotation feature was used to make notes about the data (process similar to printing off the transcripts and writing initial thoughts in the margins).

| Framework Analysis Stages | Principles of Interpretative Description (ID) (Rationale) & Outcomes |
|---|---|
| ▪ Node constructed for "potential quotes" to flag pieces of data that articulated important insights, vivid anecdotes, or "pithy" summaries about an important point<br><br>***Organizing the data:*** data was organized or "bundled" using an organizing framework developed from the annotations; the intention for this early organization was to provide a way to look at the data from different angles, come to know the data more intimately, and to develop ideas about ways to code the data<br><br>▪ The annotations from the five interviews were printed, reviewed as a whole in order to gain a sense of key ideas and recurrent words and phrases, and then sorted into an initial list of organizing nodes (remain close to the data); the words from the annotations were used to create labels for the nodes; brief descriptions were developed for each node<br><br>▪ The list was compiled into a preliminary organizing framework consisting of 51 nodes (example nodes: nursing knowledge; staff roles; audiences targeted); some organizing nodes mirrored concepts from the conceptual framework that had been used to develop the interview questions (e.g., membership, governance, credibility) but others were different (spotlighting nursing knowledge)<br><br>▪ The organizing framework was then applied to three of the annotated transcripts; the transcripts were systematically re-read and when a concept or idea was mentioned within a piece of text it was coded under the relevant organizing nodes; data bundled under these nodes were then reviewed to determine if the data corresponded with the label and organizing node description; when discrepancies or inconsistencies were found, labels and/or descriptions were refined; nodes were collapsed when there was significant | conceptual framework with which I entered the study I questioned whether I was trying to "fit" data)<br><br>▪ Strove for breadth rather than precision in the earliest coding and organizing processes to permit groups of data bearing similar characteristics to be examined and re-examined for a range of alternatives.<br><br>***Outcomes:***<br>▪ Gained a sense of the richness, depth, and diversity of the data<br><br>▪ Gained a general sense of recurrent actions, views, and ideas<br><br>▪ Data brought together that may or may not be thematically related in order to interrogate those collections; placing data in different groupings provided a way to explore at different angles to appreciate different implications<br><br>▪ Developed a framework to organize or "bundle" data to prepare for more in-depth exploration and unpacking; details and distinctions within each node could be compared to develop initial descriptive codes |

| Framework Analysis Stages | Principles of Interpretative Description (ID) (Rationale) & Outcomes |
|---|---|
| conceptual overlap between nodes (e.g., text organized under "collaborating for a policy issue", "working outside of nursing", and "engaging with multiple stakeholders" were collapsed into one node); after application of the organizing framework the list of organizing nodes was reduced to 38 nodes<br><br>▪ The refined organizing framework was applied to the remaining interviews; At this phase large pieced of text were often put in multiple nodes, which provided a way to look at the data from different angles.<br><br>▪ Nodes were further refined through an iterative process of applying the nodes, reviewing the bundled data, and verifying the label and their descriptions; after application of the organizing framework there were 30 broad organizing nodes | ▪ Audit trail started; annotations provided a track record that traced the development of the organizing framework; memos provided a way to track early ideas about emerging concepts, codes, potential themes, and their relationships, as well as personal, substantive, or methodological issues. |
| **Stage Two: Development & Refinement of a Descriptive Coding Framework** | |
| **Purpose:** The intent at this stage was to develop a descriptive coding framework and organize data into descriptive groups<br><br>***Unpacking the Data***<br>▪ Data under organizing nodes were thoroughly read and a list was constructed of recurring ideas, concepts, and their relationships; these notes were recorded as memos in NVivo<br><br>***Identification of Descriptive Codes***<br>▪ A list of the key ideas and concepts were written on pieces of paper. Referencing my memo notes, the concepts were organized into groupings that were judged to be conceptually linked (e.g., concepts related to policy advocacy were placed together); this process helped to visualize an initial list of descriptive themes and their links; reference was also made to the research questions to assist with organization | ***Principles of ID: (same as stage one)***<br><br>***Outcomes:***<br>▪ Thoroughly considered a number of ways that emerging concepts could be organized and described<br><br>▪ A preliminary descriptive coding framework was developed served as the starting point for the first level of coding<br><br>▪ Data were organized into descriptive categories in preparation for more inferential or interpretative analysis |

| Framework Analysis Stages | Principles of Interpretative Description (ID) (Rationale) & Outcomes |
|---|---|
| ***Construction of a Preliminary Descriptive Coding Framework***<br>▪ A preliminary descriptive coding framework was constructed in NVivo based on the concepts and their links; a descriptive node was constructed for each concept; the concepts were organized according to different levels of generality resulting in a hierarchy of seven main descriptive nodes and sub-nodes (e.g., policy advocacy had four sub-nodes); when uncertainty existed about conceptual links the nodes were left as stand alone nodes (e.g., evidence node); the intention was to refine the nodes and their links as data analysis proceeded; node labels often mirrored the labels of the organizing nodes and remained close to the data; descriptions were applied to each descriptive node<br><br>***Application of Descriptive Coding Framework***<br>▪ Interviews were re-read and the descriptive coding framework applied; sentences, phrases, and paragraphs were examined and coded under the relevant descriptive nodes; text was coded under more than one node if applicable<br><br>***Refinement of Descriptive Coding Framework***<br>▪ As data analysis proceeded data under the nodes were examined to determine if the data corresponded with the label and descriptive node description; when discrepancies or inconsistencies were found, labels and/or descriptions were refined; nodes were collapsed when there was conceptual overlap between nodes; the final descriptive coding framework consisted of five broad descriptive codes and several sub-themes<br><br>Note: A copy of the original bundling of data was left intact, which could be re-visited at any point during the analysis process | ▪ Audit trail continued: The development and refinement of descriptive nodes could be traced; Memos and journaling provided a track record that traced the development of descriptive themes and the preliminary descriptive coding framework |
| **Stage Three: Charting** | |

| Framework Analysis Stages | Principles of Interpretative Description (ID) (Rationale) & Outcomes |
|---|---|
| **Purpose:** The intent at this stage was to organize and visually display data in matrices so that substantive content could be viewed and compared across the data<br><br>***Plotting the Descriptive Patterns***<br>▪ Descriptive patterns were plotted in charts or matrices; the matrices were organized such that the rows represented participants and documents, while the columns represented key dimensions of the concepts; the context and the language of the text was retained as much of possible, however, the text was reduced (e.g., using abbreviations - nursing organization=nsg org; removing articles such as "the") in order to keep the tables a manageable size; APA formatting guidelines were used to clarify differences between the use verbatim text and summaries or to note when key words or sentences were removed (e.g., three dots=word removed; four dots=sentence(s) removed); square brackets were used around words or summaries that were inserted to indicate parts of text that were not verbatim; each text passage was assigned a number that corresponded to the NVivo numbering of quotes so the passage could be easily linked back to its transcript<br><br>▪ The development of each matrix was an iterative process that involved importing text from the descriptive node into the matrix, judging the meaning of the text, and developing and adjusting column headings; first, the node data was read noting the range of views, actions, outcomes, etc.; decisions were made the about key dimensions of the concept that would serve as column headings (e.g., the chart for the descriptive theme building organizational capacity had three columns - enhancing human resource capacity, developing enabling work environments, and outcomes); text corresponding to the key point were assigned to the column; substantial context and original language was retained for each entry; data under each column was then read across all interviews/documents and one to five bolded words that described the key points were placed in squared brackets | ***Principles of ID:***<br>▪ Provided a means to retrace the development of abstractions to ensure the analytic directions are defensible<br><br>▪ Moved in and out of the detail in an iterative manner so the context of the data was respected<br><br>▪ Used various supports to process the data and enhance the capacity to engage in inductive imagining<br><br>▪ Explicitly acknowledged the analytic processes that occurred in transforming raw data into findings<br><br>**Outcomes:**<br>▪ Data was visually displayed so that the substantive content and dimensions of a concept could be viewed across all participants; studying and assigning a description to each piece of data facilitated a the higher level of conceptualization<br><br>▪ Descriptive patterns and their key dimensions were identified<br><br>▪ Writing was instrumental in advancing my thinking about the meaning and |

| Framework Analysis Stages | Principles of Interpretative Description (ID) (Rationale) & Outcomes |
|---|---|
| and inserted in front of each piece of text (e.g., key points under enhancing human resource capacity included recruitment and hiring practices); main points in the matrices could then be easily visualized and gaps noted; some interviews were re-visited to explore whether data may be missing or the NVivo text search feature was used to locate additional data; some memos were written directly into the matrices to serve as visual cues and reminders for follow-up; this organization of the data entailed a higher level of abstraction represented by labels that moved beyond the original text (conceptual interpretation)<br>***Writing Summaries***<br>▪ Summaries of key themes were written for each matrix; memos and journal notes were kept to track emerging ideas; in some cases diagrams were drawn to help map relationships | relationships between the data; for example, writing summaries inspired thinking about how strategies could be organized and the relationship of factors to the other descriptive patterns<br>▪ Memoing, journaling, drawing diagrams, and charting inspired insights and ideas for higher level of interpretation including relationships among descriptive codes; clear links from the data to the original context could be made; the connection between the original data and the classification taking place were visible; a line of logical reasoning and decision points could be retraced among and between pieces of data |
| **Stage Four: Mapping and Interpretation of Individual Cases** | |
| **Purpose:** The intent at this phase of the analysis was to examine relationships among descriptive categories and identify case patterns<br><br>***Looking Across the Data Set***<br>▪ Finding the links between two or more of the descriptive categories was a continuous and iterative process that was assisted by looking across all the matrices, following up on hunches, and simultaneous writing, memoing, and journaling<br><br>▪ More complex patterns were identified as the data were compared and organized; Patterns were interrogated; Queries tracked through memos were | ***Principles of ID:***<br>▪ Identified relationships among the various groupings through iterative inductive reasoning to conceptualize the patterns as a coherent whole<br><br>▪ Challenged pre-conceived investment in descriptive patterns<br><br>▪ Provided sufficient information for readers to follow the analytic reasoning |

| Framework Analysis Stages | Principles of Interpretative Description (ID) (Rationale) & Outcomes |
|---|---|
| investigated; identified linkages across matrices were brought together (e.g., a description about priority setting included data from several descriptive nodes such as values & beliefs; awareness of policy issues; processes for decisions);<br><br>▪ Final case patterns described included:<br>o ***Organizational Attributes*** – Incorporation Statutes and mandates; corporate structures; and operational structures<br>o ***Priority Setting for Community Environment Health*** – values and beliefs: monitoring and organizing evidence; screening policy priorities; and adjudicating policy priorities<br>o **Advocating for CEH** – building organizational capacity; building social capital; inspiring a mass of support; lending to and leading in policy change; exercising political acumen; and pushing policy positions | process<br><br>***Outcomes:***<br>▪ Relationships across the various patterns were identified for each case<br><br>▪ Audit trail continued: explicit descriptions about progression of analysis process recorded; memos tracked decision points |
| **Stage Five: Mapping and Interpretation Across Cases** | |
| **Purpose:** The intent at this phase of the analysis was to examine similarities and differences across the cases in order to identify cross-case patterns<br><br>***Plotting Cross-Case Patterns***<br>▪ Following a similar process for building matrices described for individual case analysis, matrices were constructed to compare all the patterns identified for the cases.<br><br>▪ Matrices were organized such that the rows represented case patterns (e.g., building organizational capacity), while the columns represented the cases with an added column to map similarities and differences among the cases; summaries of the key findings for each case were plotted and compared with key similarities and differences noted; | ***Principles of ID:***<br>▪ Identified relationships among the various cases through iterative inductive reasoning to conceptualize the patterns as a coherent whole<br><br>▪ Provided sufficient information for readers to follow the analytic reasoning process<br><br>**Outcomes**<br>▪ Described the way nursing associations |

| Framework Analysis Stages | Principles of Interpretative Description (ID) (Rationale) & Outcomes |
|---|---|
| ▪ An explanation for "how factors influence" was achieved by comparing the similarities and differences of the organizational attributes and the nature and scope of priority setting and policy advocacy among the 3 cases; explanations were based on explicit reasons given by participants as well as those inferred by me; arriving at the explanations required a combination of reading through synthesized data, following leads, interrogating patterns, re-visiting transcripts and documents, and critically thinking about the data | set priorities and take action for CEH<br><br>▪ Identified factors that influence the way nursing associations set policy priorities and take action for community environmental health; identification of these factors have application potential to address barriers or enhance supports for enhanced priority setting and policy advocacy |

## Appendix E

## Information for Small Group Discussion

May 03, 2012

Hello Doris, Pegi, and Rachel

Please find below a description of a framework that represents the integrated results from the study: Priority Setting and Policy Advocacy for Community Environmental Health: A Comparative Case Study of Three Canadian Nursing Organizations. Also attached is a diagram that depicts the key factors that were shown to influence priority setting and policy advocacy for community environmental health across the **three** associations.

The three questions I would like you to consider for our telephone conference include:

1. Do these findings resonate with your experiences? Explain.

2. Are you surprised by any of the results? If yes describe.

3. Do you have any additional comments or suggestions?

I am looking forward to our discussion. If you have questions or concerns you can reach me via the information provided below.

Warm regards,

JoAnne MacDonald
[redacted]

## Conceptual Framework: Federal, Provincial, and Organizational Structures and Institutional Pressures Influencing Nursing Associations' Priority Setting and Socio-Ecological Engaged Community Environmental Health Advocacy

### Introduction:

A comparative case study was undertaken from March 2011 until December 2011 to examine factors that influence nursing associations' priority setting and policy advocacy for community environmental health. Socio-ecological whole-systems' change thinking and institutional theory guided the study. Forty-one in-depth interviews were completed. Documents were reviewed. Qualitative analysis yielded a conceptual framework of structures and institutional pressures that affect decisions and actions taken by nursing associations for community environmental health. The findings were further interpreted in the context of broader theoretical and empirical literature.

The purpose of the next and final phase of this study is to have a small group discussion with the Executive Directors from the participating Nursing Associations to discuss the integrated results from the three cases.

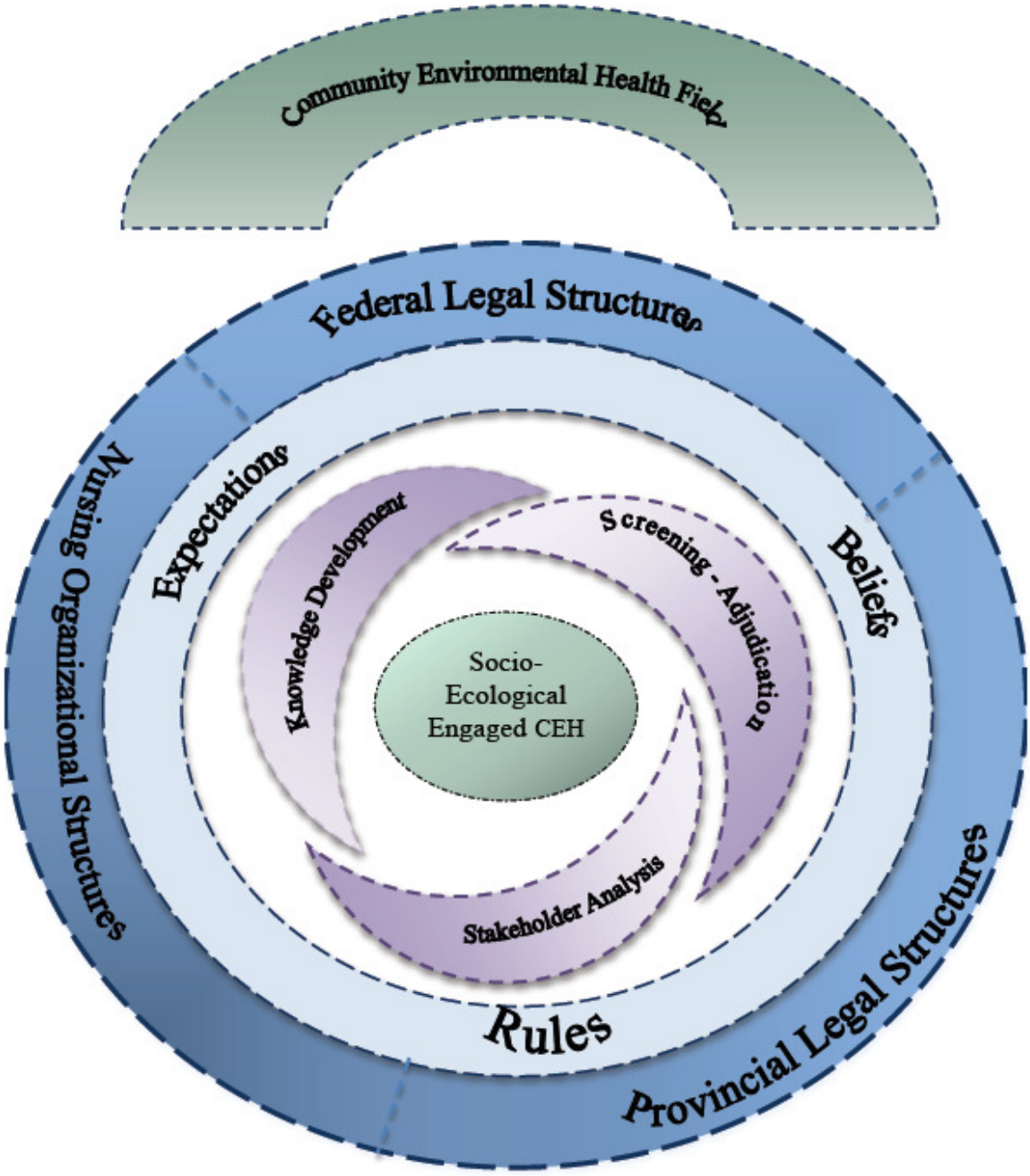
### Overview of the Framework:

Overall, the framework (Figure 6.1) describes how inter-related factors influence nursing associations' priority setting and socio-ecologically engaged community environmental health policy work. These factors include federal, provincial, and organizational structures and institutional pressures. The framework suggests that nursing associations' priority setting and policy advocacy for community environmental health occurs within a community environmental health policy field that determines possibilities for engagement. In addition, federal, provincial, and organizational structures and institutional pressures both create opportunities or narrow the associations' options. The model represents a dynamic process whereby structures organize how decisions and actions are taken. Through these structures, rules, expectations, and beliefs (institutional pressures) operate to influence nursing associations' priority setting and, in turn, their policy advocacy for community environmental health.

Major components of the framework appear as five layers and include:

1. Nursing associations' socio-ecologically engaged community environmental health advocacy;
2. Priority setting processes;
3. Institutional pressures including rules, expectations, and beliefs;
4. Organizing structures including federal, provincial, and organizational structures; and
5. Community environmental health field

**Figure 6.1 Federal, Provincial, and Organizational Structures and Institutional Pressures Influencing Nursing Associations' Priority Setting and Socio-Ecological Engaged Community Environmental Health Advocacy**



An explanation of the components of the framework is described in the following section.

## FRAMEWORK COMPONENTS AND THEIR INTER-RELATIONSHIPS

### 1. SOCIO-ECOLOGICALLY ENGAGED COMMUNITY ENVIRONMENTAL HEALTH

- At the core is **nursing associations' socio-ecologically engaged community environmental health** (represented by an oval), which refers to the ways in which nursing associations attempt to influence community environmental health policies that promote or improve reciprocal human-ecological health. Common categories of community environmental health policies that nursing associations attempt to influence include those that affect the healthfulness of settings (e.g., such as homes, workplaces, schools, or communities); those that influence the quality of ecological systems (e.g., such water, air, land); and those that target local, sub-national, national, or international governments responsible for human and ecological health. Nursing associations attempt to influence these policies through socio-ecologically engaged community environmental health practices, which includes:
    - Employing a range of strategies (e.g., building organizational capacity; exercising social acumen [fostering relationships, establishing relevancy, protecting reputation]; inspiring a mass of support [e.g., building individual & collective capacity]; lending support to and leading in policy change; lobbying government; and exercising political acumen [exploiting opportunities; framing])
    - Exploiting cross-scale (e.g., jurisdictions) and cross-level[35] (municipal, provincial, national) interactions
    - Planning and sustaining efforts

### 2. PRIORITY SETTING PROCESSES

- **Priority setting processes** (represented by three crescents) lead to socio-ecologically engaged community environmental health advocacy.
- Priority setting processes include:
    - **Knowledge development:**
        - Monitoring a broad range of sources including government departments responsible for the environment and corporations and industries that affect

[35] Scales refer to analytic dimensions of a phenomenon (e.g. jurisdictional scale), while levels refer to the units of analysis that are located at different positions on a scale (e.g. municipal, provincial, and national jurisdictional levels). Other scales include spatial (e.g. geographic spaces such as provinces) and temporal (e.g. different time frames such as durations and frequencies) scales.

environmental conditions is necessary to keep attuned of emerging and current community environmental health issues.

- Information that is organized, synthesized, and presented to the governing body in a user-friendly format renders community environmental health more visible amid other policy priorities and facilitates screening and adjudication processes.

- **Screening & adjudication:**
  - Common criteria used to judge whether a policy issue would be of interest to the associations include their mandate/mission statements and whether the environmental issue has an equity and/or social justice dimension.
  - Other criteria used to determine priorities are unique to the associations and reflect their organizational context (e.g., member-driven associations put more weight on membership demands and regulatory bodies put more weight on regulatory and public protection issues)
  - Common criteria to judge which community environmental health issues would receive higher priority include opportunities (e.g., judged partly by public and government attention and receptivity), organizational capacity (e.g., manpower, finances, time, expertise), and a potential for impact (e.g., judged partly by population reach).
  - Other criteria used to determine the order of importance are unique to the associations. For instance, evaluations of policy progress for a community environmental health issue by both the government and the association provide a gauge to determine continued involvement. Order of priority may also be based on public and nurse demand or sense of urgency (e.g., judged partly through number of times association contacted, references in media, or pending government Bills).
- **Stakeholder analysis:**
  - Stakeholder analysis includes the assessment and identification of appropriate community environmental health allies. Nursing associations tend to join stakeholders who share similar views and values. Fear of tarnishing reputation may restrict the selection of potential partners to those whose values and approaches align with the associations.
  - Stakeholder analysis also includes assessment of the risks and benefits for participating in community environmental health and the role the association will play. Perceived risks that will deter engagement include: potential losses (e.g., loss of membership support), retributions (e.g., exclusion from inclusion in other healthy public policies), or unintended consequences (e.g., create repercussion for other nursing associations if action taken within another associations' primary provincial and jurisdictional territory)

### 3. INSTITUTIONAL PRESSURES

- Three **institutional pressures** (represented by the center ring) frame and give validation to the way the nursing associations work and interact with others in their community environmental health efforts and include rules, expectations, and beliefs. These pressures define what are feasible, acceptable, and legitimate priority setting and policy advocacy options for community environmental health work. More than one institutional pressure can be at play in shaping priority setting and socio-ecologically engaged community environmental health.
    - **Rules** represent regulative pressures that exert their influence through formal and informal forms of coercion or threats. Formal coercion includes legislation that restricts the allocation of resources for public policy. Informal coercion includes fear of potential losses, government retribution, or creation of unintended problems for other nursing associations). Both formal and informal coercion limits the types of community environmental health issues addressed. Coercion also diminishes cross-level efforts across different scales. For instance, there may be lack of coordination across levels of the spatial scale (e.g., lack of coordination of efforts across different provinces) or across levels of the jurisdictional scale (e.g., lack of coordinated efforts at municipal, provincial, national levels of polity).
    - **Expectations** represent normative pressures that exert their influence through expectations about appropriate forms of behaviours for the association and appropriate relationships. Normative prescriptions about professional and reasonable behaviour influences the selection of partners with whom nursing associations will ally with, which potentially reduces opportunities for participating in community environmental health initiatives (e.g., avoid associating with those that tie themselves to trees). Issues perceived by the association to be on the "periphery" of nursing or outside normative expectations of what they believe the public expects nurses do are avoided to protect the associations' credibility and to preserve the trust awarded to them by the public. In addition, unwritten expectations to respect spatial and jurisdictional boundaries create tensions among the nursing associations (e.g., divisiveness about action for community environmental health) and limit the coordination of cross-scale and cross-level efforts.
    - **Beliefs** represent cognitive pressures that exert their influence through taken for granted assumptions and conformity to the status quo. Organizational beliefs about community environmental health guide the selection of and weight given to evidence when making choices, which can either broaden or limit the community environmental health issues addressed. Associations can support one of two different views about community environmental health. First, there is a view that the environment is a static and separate entity from human health. Associations

that support this view endorse evidence that clearly identifies the human health risks and impacts, and thus the direct relevancy to nursing (e.g., will take action because evidence maps the impacts of pesticides to human health). In the absence of evidence of the human health impacts, this view may limit the types of community environmental health issues addressed. Second, there is a view that the environment and human health are inseparable inter-dependent entities. Associations that support this view endorse evidence about environment degradation even in the absence of definitive health links (e.g., will take action on coal-fired plants even if the evidence of the impacts to human health are not yet conclusive or are controversial)

## 4. ORGANIZING STRUCTURES

- **Organizing Structures** (represented by the outside ring) include federal and provincial Incorporation Statutes and organization structures, which systematize the way nursing associations make decisions and take actions. Organizing structures include federal and provincial Incorporation Statutes, regulatory functions, federated corporate structures, governance, and policy capacity.
    - **Federal and provincial Incorporation Statutes:** A public policy mandate is a prerequisite for engagement in community environment health. A public policy mandate can be granted to nursing associations in two ways. First, in the case of member-driven organizations, Corporate Statutes permit membership to self-proclaim a public policy mandate. Second, in the case of regulatory-driven organizations, regulatory Acts (i.e., Registered Nurses' Act) may include a bifurcated mandate or an organizational end that permits the regulatory body to engage in healthy public policy. The absence of a public policy mandate inhibits action for community environmental health.
    - **Regulatory functions:** Regulatory functions limit nursing associations' community environmental health policy work. Regulatory functions such as licensing and disciplining of members are privileges granted by governments to associations through legislation (i.e., Registered Nurses' Acts). Member-driven organizations can also grant regulatory functions to their associations, such as the administration of exams. Unlike regulatory-driven organizations, associations with member-granted regulatory functions do not have any legal accountability to government related to the regulation of nurses. Regardless of whether regulatory or member-driven, having regulatory functions can impose restrictions for community environmental health work in two ways. First, legislation may impose restriction on the allocation of resources that can be used for public policy work, as is the case with regulatory-driven organizations (i.e., regulatory mandate legally takes precedence). Second, fear of repercussions from government (e.g., exclude from other policy dialogues) or members (e.g., loss of support) also

deters action for community environmental health by both regulatory-driven and member-driven associations.

- **Federated corporate structure:** Reaching consensus for political goals such as community environmental health is more challenging within a federated corporate structure. Members of federated organizations may experience apathy and lack of interest in the parent organization's choice of political goals, conflict or competition between provincial and federal bodies, and divisiveness about whose needs and interests should be served (i.e., does the national association exists to meet provincial needs or should provincial associations be responsible to conduct work at the provincial level on behalf of the national association). Failure to reach consensus diminishes efforts for community environmental health.
- **Governance 'ends' and 'executive limitation' policies:** The design of governance 'ends' and 'executive limitation' policies influence the associations' flexibility and capacity to respond to community environmental health in a dynamic policy environment.
    - High-level ends that provide direction to the organization and allow home office operations to decide the means to achieving those ends (e.g., operations including what specific community environmental health issues will be addressed and how) support possibilities for home offices to respond in a timely manner to emerging community environmental health issues. Boards involved in operational level decisions, on the other hand, can lead to organizational stress, bottlenecks (i.e., when Board directors cannot keep up to staff activities), and inability for home offices to do their work. Decisions for community environmental health are therefore delayed or not made.
    - 'Executive limitation' policies that articulate what the Board will not tolerate (instead of what it can do) in the pursuit of ends are saved from making countless separate decisions and empower home offices to respond to emerging community environmental health issues. Boards retaining approval power over operational matters can stifle responses and interfere with innovativeness and effectiveness. Essentially home office operations can become paralyzed until the Board has time and sees fit to give approval for community environmental health issues. Disagreement about policy versus operational roles also contributes to tensions between the Board and home offices, which interferes with and can render operations ineffective and unable to address community environmental health issues.
- **Policy Capacity:** Lack of policy capacity including incomplete and inadequate synthesis of evidence, lack of cross-departmental collaboration, absence of community environmental health networks or opportunities to join initiatives, and lack of access to actors to carry out the work (e.g., members) diminish or delay

decision-making, prevent nursing associations from engaging in community environmental health initiatives, and contribute to tensions when significant demands or expectations are placed on directors and staff. Lack of policy capacity diminishes planned and sustained community environmental health efforts.

### 5. COMMUNITY ENVIRONMENTAL HEALTH FIELD

- The **community environmental health field** (represented by an overarching arch) represents the community of stakeholders brought together through their interest and objects related to community environmental health issues of concern. It is through this field that dialogue and debate occurs whereby the type of evidence and issues that are important, the legitimate cross-scale and cross-level levels for action, the appropriate strategies to take, and the relevant stakeholders to be involved gets communicated. The field is not static as new issues, evidence, stakeholders, or events reconfigure dialogues and relationships.

# Appendix F Ethics Approval

**File Number:** **Date (mm/dd/yyyy):** 04/23/2010

Université d'Ottawa University of Ottawa
Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

## Ethics Approval Notice

### Health Sciences and Science REB

**Principal Investigator / Supervisor / Co-investigator(s) / Student(s)**

| First Name | Last Name | Affiliation | Role |
|---|---|---|---|
| Nancy | Edwards | Health Sciences / Nursingy | Supervisor |
| Barbara | Davies | Health Sciences / Nursingy | Co-Supervisor |
| Jo-Anne | MacDonald | Health Sciences / Nursingy | Student Researcher |

**File Number:**

**Type of Project:** PhD Thesis

**Title:** Priority Setting & Policy Advocacy for Community Environmental Health: A Comparative Case Study

| Renewal Date (mm/dd/yyyy) | Expiry Date (mm/dd/yyyy) | Approval Type |
|---|---|---|
| 04/23/2010 | 04/22/2011 | Ia |

**(Ia: Approval, Ib: Approval for initial stage only)**

**Special Conditions / Comments:**
N/A

1

**File Number:** **Date (mm/dd/yyyy):** 04/0232010

Université d'Ottawa University of Ottawa
Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement and other applicable laws and regulations in Ontario, has examined and approved the application for ethical approval for the above named research project as of the Ethics Approval Date indicated for the period above and subject to the conditions listed the section above entitled "Special Conditions / Comments".

During the course of the study the protocol may not be modified without prior written approval from the REB except when necessary to remove subjects from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the study (e.g. change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, information/consent documentation, and/or recruitment documentation, should be submitted to this office for approval using the "Modification to research project" form available at: http://www.rges.uottawa.ca/ethics/application_dwn.asp

Please submit an annual status report to the Protocol Officer 4 weeks before the above-referenced expiry date to either close the file or request a renewal of ethics approval. This document can be found at: http://www.rges.uottawa.ca/ethics/application_dwn.asp

If you have any questions, please do not hesitate to contact the Ethics Office at extension 5841 or by e-mail at: ethics@uOttawa.ca.

**Signature:**

[redacted]

Germain Zongo
Protocol Officer for Ethics in Research
For Daniel Lagarec, Chair of the Sciences and Health Sciences REB

## Appendix G

### Letter of Introduction and Request for Permission For Organization to Participate in the Study

### Priority Setting and Policy Advocacy for Community Environmental Health: A Comparative Case Study of Three Canadian Nursing Organizations

**PhD Student Researcher:** Jo-Anne MacDonald RN PhD (c), School of Nursing, University of Ottawa
Telephone: [redacted] or Email: [redacted]

**Thesis Supervisors:**
Dr. Nancy Edwards, Faculty of Health Sciences, School of Nursing, University of Ottawa
Telephone: [redacted] or Email: [redacted]

Dr. Barbara Davies Faculty of Health Sciences, School of Nursing, University of Ottawa
Telephone: [redacted] or Email: [redacted]

**Dear [Name of Executive Director]:**

My name is Jo-Anne MacDonald and I am a PhD student in Nursing at the University of Ottawa, Ontario. I am seeking permission for your organization to participate in a research study.

**What is the study about?**

The purpose of the study is to examine factors that contribute to or constrain nursing organizations' priority setting and policy advocacy using community environmental health as an exemplar. Community environmental health was chosen as an exemplar policy issue because it is a contemporary issue, poses a serious threat to health, and has implications for nurses' work.

**Study Design**

This is a case study design with three nursing organizations. Each organization will be studied separately, and then the findings from each of the cases will be compared to identify cross-cutting themes about factors that influence policy choices and actions. I will collect data through interviews, document reviews, and a small group discussion.

**Why was your organization chosen to participate?**

Organizations selected for participation included those with different provincial and national mandates, Board structures, and regulatory and public policy mandates.

**What will your organization be asked to do?**

If [INSERT NAME OF ORGANIZATION] agrees to participate, your organization will be asked to:

**1. Letter of Support**

- Provide a letter of support about the willingness of your organization to participate in the study. The letter will be given to the Protocol Officer for Ethics in Research in the Research Grant and Ethics Services office at the University of Ottawa.

**2. Permission to be on Site**

- Give permission for the doctoral student, Jo-Anne MacDonald, to be on the premises of your organization to conduct research at times convenient to you and your staff. It is anticipated that a one to two week period of concentrated time will be required to conduct interviews and review documents.

**3. Permission Related to Staff and Members of the Organization**

- Give permission for Jo-Anne MacDonald to invite eligible staff and members of the organization who meet at least one of the following criteria: (a) have experience with priority setting and policy advocacy work (minimum one year) during the past 5 years; and/or (b) have experience working for community environmental health with the organization; and (c) speaks English.
- Give permission for interviews to occur during the organization's working hours.

**4. Permission Related to Documents**

- Assist with the identification and access to organization documents for Jo-Anne MacDonald to review that meet the following eligibility criteria: (a) one of five types of organizational documents: (i) policy documents (e.g., Constitution and By-Laws, flow charts for decision-making); (ii) strategic plans; (iii) communications (media releases to nurses, the public, or politicians); (iv) minutes including Board of Director or Council and committee; and (v) reporting documents (e.g., annual reports); and (b) produced from January 2005 until September 2010. Some of these documents may be in the public domain, while others may not.

- Data sought from documents include: (a) processes for priority setting for policy (b) priority setting outcomes related to community environmental health; (c) actions undertaken on behalf of community environmental health; (d) outcomes from actions taken on behalf of community environmental health; (e) nursing organizational factors that influence priority setting or policy advocacy choices and actions including references to governance structures (e.g., processes for decision-making), jurisdictional mandates (e.g., territorial responsibilities), membership relationships (e.g., communications with other nursing organizations), and professional mandates (e.g., rationale or values guiding policy decisions); and (f) external system factors

that influence priority setting or policy advocacy choices and action including references to legislative authority or events occurring outside the organization.

**What are the Risks?**

- Policy is a contentious issue and social or political repercussions are possible for individuals and/or organizations when views are expressed. Dissension is possible among co-workers, colleagues from other organizations, nurses, and/or stakeholders with whom your organizations' work.
- Jo-Anne MacDonald's presence may cause a distraction to the organization's workplace.
- Your staff and volunteers may feel uncomfortable or inconvenienced when answering questions or discussing personal views. Discomfort may be experienced for those participating in the small group discussion.
- Participants' time is not compensated.

.
Your participation in this research is voluntary and your organization can withdraw from the study at any time. Care will be taken to minimize disruption to the workplace.

**What are the benefits?**

Your organization may benefit by knowing its participation and the expertise of your staff helped to develop knowledge about factors that influence nursing organizations' priority setting and policy advocacy. Your organization and all participants of the study will be provided with a five page Final Integrated Case Report that presents key findings from the research. Actionable recommendations will be identified for enhanced priority setting and policy work by nursing organizations.

**Privacy and Confidentiality**

Your organization's name will not be kept anonymous in research reports or publications. The identity of participants from your organization cannot be guaranteed. Steps will be taken to protect the identity of the staff and members of the organization. All participants will be referred to by a code that will be assigned to them. The list matching the names and code numbers will be kept separately in a locked cabinet. Only Jo-Anne MacDonald will have access to codes that can be linked to participant identities. Personal identifiers that can be linked to participants will be removed. Only aggregated and anonymized results will be reported.

While all participants may agree to keep matters discussed by the group in confidence there is always a risk that the agreement may not be honored. You may refuse to answer any questions. Additional steps will be taken to protect the confidentiality of the information you provide. The interviews will be conducted in a place of privacy. Transcribers who have access to the audiotapes will be required to sign a confidentiality form. Information sent to the transcriber will be encrypted. During the conduct of the study, data will be kept in a private office in a locked cabinet of the PhD student research investigator's home, in a

locked brief case, or her personal computer that is password protected. Upon completion of the study, all raw data (transcriptions and audio-tapes) will be kept in my supervisor's office, Dr. Nancy Edwards for a period of 5 years following completion of this research (December 2016). At that time, all paper documents will be shredded, audio-files erased, and all confidential computer data files erased. The information provided will be used only for the purpose of the study.

**Additional Information:**

If you have any questions regarding your rights as a research participant or the conduct of this research you can contact the University of Ottawa Protocol Officer for Ethics in Research, University of Ottawa, [redacted]

Sincerely,

Jo-Anne MacDonald RN PhD(c)

## Appendix H

### Organizational Permission for Participation in the Study

### Priority Setting and Policy Advocacy for Community Environmental Health: A Comparative Case Study of Three Canadian Nursing Organizations

[NAME OF ORGANIZATION] agrees to participate in the research study: *Priority Setting and Policy Advocacy for Community Environmental Health:*
*A Comparative Case Study of Three Canadian Nursing Organizations.*
This research study is being conducted by Jo-Anne MacDonald (PhD Candidate, University of Ottawa), under the supervision of Professors Dr. Nancy Edwards (University of Ottawa) and Dr. Barbara Davies (University of Ottawa).

The purpose of the study is to examine factors that contribute to or constrain nursing organizations' priority setting and policy advocacy using community environmental health as an exemplar.

Your participation will consist of the following:

1. Letter of Support

- Provide a letter of support about the willingness of our organization to participate in the study. The letter will be given to the Protocol Officer for Ethics in Research in the Research Grant and Ethics Services office at the University of Ottawa.

2. Permission to be on Site

- Give permission for the doctoral student, Jo-Anne MacDonald, to be on the premises of our organization to conduct research at times convenient to the staff. It is anticipated that a one to two week period of concentrated time will be required to conduct interviews and review documents.

3. Permission Related to Staff and Members of the Organization

- Give permission for Jo-Anne MacDonald to invite eligible staff and members of the organization who meet at least one of the following criteria: (a) have experience with priority setting and policy advocacy work (minimum one year) during the past 5 years; and/or (b) have experience working for community environmental health with the organization; and (c) speaks English.

- Give permission for interviews to occur during the organization's working hours.

4. Permission Related to Documents

- Assist with the identification and access to organizational documents for Jo-Anne MacDonald to review that meet the following eligibility criteria: (a) one of five types of organizational documents: (i) policy documents (e.g., Constitution and By-Laws, flow charts for decision-making); (ii) strategic plans; (iii) communications (media releases to nurses, the public, or politicians); (iv) minutes including Board of Director or Council and committee; and (v) reporting documents (e.g., annual reports); and (b) produced from January 2005 until September 2010. Documents may include those in the public domain and those not accessible to the public.

- Data sought from organizational documents will include: (a) processes for priority setting for policy (b) priority setting outcomes related to community environmental health; (c) actions undertaken on behalf of community environmental health; (d) outcomes from actions taken on behalf of community environmental health; (e) nursing organizational factors that influence priority setting or policy advocacy choices and actions including references to governance structures (e.g. processes for decision-making), jurisdictional mandates (e.g., territorial responsibilities), membership relationships (e.g., communications with other nursing organizations), and professional mandates (e.g., rationale or values guiding policy decisions); and (f) external system factors that influence priority setting or policy advocacy choices and action including references to legislative authority or events occurring outside the organization.

**Acceptance:** [NAME OF ORGANIZATION] agrees to participate in the study Priority Setting and Policy Advocacy for Community environmental Health: A Comparative Case Study of Three Canadian Nursing Organizations conducted by Jo-Anne MacDonald, University of Ottawa, whose research in under the supervision of Dr. Nancy Edwards and Dr. Barbara Davies.

**Permission to be On-Site**

[NAME OF ORGANIZATION] agrees to allow Jo-Anne MacDonald on the premises to conduct interviews.
___ Yes

___ No

**Permission Related to Organizational Documents**

[NAME OF ORGANIZATION] agrees to assist Jo-Anne MacDonald with the identification of organizational documents in the public domain that are relevant to the study as described.

____ Yes

____ No

[NAME OF ORGANIZATION] agrees to assist Jo-Anne MacDonald with the identification and access to organizational documents not in the public domain that are relevant to the study as described.

____ Yes

____ No

[NAME OF ORGANIZATION] agrees to allow Jo-Anne MacDonald to copy text from organizational documents not in the public domain but identifiers must be removed or blackened out (e.g., personal names).

____ Yes

____ No

[NAME OF ORGANIZATION] agrees to allow Jo-Anne MacDonald to cite text from organizational documents not in the public domain but identifiers must be removed (e.g., names) and the text proper cited.

____ Yes

____ No

_____ _____

Name of Senior Administrator Date Signed

_____

Signature of Senior Administrator

_____ _____

Signature of Researcher Date Signed

## Appendix I

### Permission from Potential Participants to be Contacted for Participation in the Study

### Priority Setting and Policy Advocacy for Community Environmental Health: A Comparative Case Study of Three Canadian Nursing Organizations

Dear Colleague,

Below you will find a letter from a PhD student investigator from the University of Ottawa, Ontario who is conducting research about factors that influence nursing organizations' priority setting and policy advocacy using community environmental health as an exemplar. She has asked me to send this letter. She is asking for your permission to be contacted about participating in the study. You are under no obligation to participate.

Kind regards,
[INSERT NAME OF NURSING ORGANIZATION]

---

Dear Colleague

I am a PhD student in Nursing at the University of Ottawa, Ontario. I am seeking participants to invite for a research study entitled: *Priority Setting and Policy Advocacy for Community environmental Health: A Comparative Case Study of Three Canadian Nursing Organizations.* I am conducting this research under the supervision of Dr. Nancy Edwards and Dr. Barbara Davies.

The purpose of the study is to examine factors that contribute to or constrain nursing organizations' priority setting and policy advocacy using community environmental health as an exemplar. Community environmental health was chosen as an exemplar policy issue because it is a contemporary issue, poses a serious threat to health, and has implications for nurses' work.

I am very interested in hearing about your experiences and expertise with priority setting and policy advocacy with the organization, and/or your involvement with community environmental health. I would like to contact you by telephone or in person (which ever you prefer) during [INSERT TIME] to discuss the study with you and your willingness to participate.

If you are willing to be contacted, please complete the form below and mail it back in the pre-stamped addressed envelope or fax to: [number]. You can also reach me by phone [number] or email: [redacted]

**Contact Information**

**Your Name: _____**

By which means would you like to be contacted? Please tick all that apply.

□ Phone number _____

□ Email address _____

Sincerely,

Jo-Anne MacDonald RN PhD (c)

## Appendix J

### Letter of Introduction and Consent Form for Executive Directors' Participation

### Priority Setting and Policy Advocacy for Community Environmental Health: A Comparative Case Study of Three Canadian Nursing Organizations

**PhD Student Researcher:** Jo-Anne MacDonald RN PhD (c), School of Nursing, University of Ottawa
Telephone: [redacted] or Email: [redacted]

**Thesis Supervisors:**
Dr. Nancy Edwards, Faculty of Health Sciences, School of Nursing, University of Ottawa
Telephone: [redacted] or Email: [redacted]

Dr. Barbara Davies Faculty of Health Sciences, School of Nursing, University of Ottawa
Telephone: [redacted] or Email: [redacted]

**Dear [Name of Executive Director]:**

My name is Jo-Anne MacDonald and I am a PhD student in Nursing at the University of Ottawa, Ontario. I am inviting you to participate in a research study.

**What is the study about?**

The purpose of the study is to examine factors that contribute to or constrain nursing organizations' priority setting and policy advocacy using community environmental health as an exemplar. Community environmental health was chosen as an exemplar policy issue because it is a contemporary issue, poses a serious threat to health, and has implications for nurses' work.

**Study Design**

This is a case study design. Three nursing organizations with different jurisdiction mandates (provincial/national), governance structures (elected/appointed Board members), legislative authorities (regulatory/public policy mandates), and membership composition (mandatory/voluntary) were invited to participate.

Each organization will be studied separately, and then the findings from each of the cases will be compared to identify cross-cutting themes about factors

that influence policy choices and actions. I will collect data through interviews, document reviews, and a small group discussion with one participant from each nursing organization.

**Why have you been asked to participate?**

You have been asked to participate because of your experience and expertise in priority setting and policy advocacy with the organization, and/or your involvement with community environmental health.

**What will you be asked to do?**

If you agree to participate you will be asked to:

1. **Identification of Participants**

- Assist with the identification of additional staff or organizational members who may be potential participants, or identify a designate to assist with this task.

2. **Interview**

- Participate in a 60 minute face-to-face or telephone interview with the PhD student Jo-Anne MacDonald. The interview will take place at a time and place that is convenient to you. All questions will be asked in English.
- During the interview you will be asked to respond to questions related to your perceptions and experiences about how priorities are set and how your organization takes action for policy related to community environmental health and factors that influence those choices and actions.

3. **Small Group Discussion**

- Participate in a small group discussion via a telephone conference lasting up to 60 minutes to provide verbal feedback about the findings and interpretations.
- Review a three to five page Draft Report that is a summary of the integrated results from the three cases. The report will be provided two weeks in advance of the group discussion. Questions will be provided with the summary report to guide areas for you to consider as you review the findings and interpretations. It is anticipated this will take up to 30 minutes.

**What are the Risks?**

- Policy is a contentious issue and social or political repercussions are possible for individuals when views are expressed. Dissension is possible among your co-workers, colleagues from other organizations, nurses, and/or stakeholders with whom you work.
- You may feel uncomfortable or inconvenienced when answering questions or discussing personal views. You may also experience discomfort when participating in the small group discussion.
- Your time is not compensated.

.

Your participation in this research is voluntary. You may decline to answer any questions, withdraw comments, ask that the audio-tape be turned off, or withdraw from the study at any time. Care will taken to be conscientious of the time taken for interview and telephone call.

**What are the benefits?**

You may benefit by knowing your participation and the expertise you provided helped to develop knowledge about factors that influence nursing organizations' priority setting and policy advocacy. You may also benefit by knowing your knowledge and expertise shared during the small group discussion assisted with the validation of the results from this study. Your organization and all participants of the study will be provided with a five page Final Integrated Case Report that presents key findings from the research. Actionable recommendations will be identified for enhanced priority setting and policy work by nursing organizations.

**Privacy and Confidentiality**

The concealment of your identity cannot be guaranteed if you participate because of the small number of staff and members in your organization. Your participation in the small group discussion precludes concealing your identity. Steps will be taken to protect your identity. You will be referred to by a code that will be assigned to the information you provide. The list matching the names and code numbers will be kept separately in a locked cabinet. Only Jo-Anne MacDonald will have access to codes that can be linked to participant identities. Personal identifiers that can be linked to you will be removed. Only aggregated and anonymized results will be reported.

While all participants may agree to keep matters discussed by the group in confidence there is always a risk that the agreement may not be honored. You may refuse to answer any questions. Additional steps will be taken to protect the confidentiality of the information you provide. The interviews will be conducted in a place of privacy. Transcribers who have access to the audiotapes will be required to sign a confidentiality form. Information sent to the transcriber will be encrypted. During the conduct of the study, data will be kept in a private office in a locked cabinet of the PhD student research investigator's home, in a locked brief case, or her personal computer that is password protected. Upon completion of the study, all raw data (transcriptions and audio-tapes) will be kept in my supervisor's office, Dr. Nancy Edwards for a period of 5 years following completion of this research (December 2016). At that time, all paper documents will be shredded, audio-files erased, and all confidential computer data files erased. The information provided will be used only for the purpose of the study.

**Additional Information:**

If you have any questions regarding your rights as a research participant or the conduct of this research you can contact the University of Ottawa Protocol Officer for Ethics in Research, University of Ottawa, [redacted]

If you would like to proceed, please complete and sign this consent form and fax to [number] or mail it to:

Jo-Anne MacDonald
[redacted]

There are two copies of the consent form: one for you and one for the researcher.

**Acceptance:** [NAME OF PARTICIPANT] agrees to participate in the study Priority Setting and Policy Advocacy for Community environmental Health: A Comparative Case Study of Three Canadian Nursing Organizations conducted by Jo-Anne MacDonald, University of Ottawa, whose research in under the supervision of Dr. Nancy Edwards and Dr. Barbara Davies.

1. I agree to an individual interview. Yes ___ No ___

   I agree to allow my interviews to be audio-taped. Yes ___ No ___
   If no I agree to allow Jo-Anne MacDonald to take notes: Yes ___ No ___

2. I agree to participate in a small group discussion. Yes ___ No ___

   I agree to allow the small group discussion telephone conference to be audio-taped. Yes ___ No ___

   I agree to be quoted but all personally identifying information shall be moved or altered so that the quote cannot be linked to my identity. Yes ___ No ___
   I do not wish to be quoted at all. Yes ___ No ___

Participant's Name _____ Date: _____

Participant's Signature _____ Date: _____

Researcher's Signature: _____ Date: _____

## Appendix K

### Letter of Introduction and Consent Form for Current Organizational Members to Participate

### Priority Setting and Policy Advocacy for Community Environmental Health: A Comparative Case Study of Three Canadian Nursing Organizations

**PhD Student Researcher:** Jo-Anne MacDonald RN PhD (c), School of Nursing, University of Ottawa
Telephone: ([redacted] or Email: [redacted]

**Thesis Supervisors:**
Dr. Nancy Edwards, Faculty of Health Sciences, School of Nursing, University of Ottawa
Telephone: [redacted] or Email: [redacted]

Dr. Barbara Davies Faculty of Health Sciences, School of Nursing, University of Ottawa
Telephone: [redacted] or Email: [redacted]

**Dear [Name of Participant]:**

My name is Jo-Anne MacDonald and I am a PhD student in Nursing at the University of Ottawa, Ontario. I am inviting you to participate in a research study.

**What is the study about?**

The purpose of the study is to examine factors that contribute to or constrain nursing organizations' priority setting and policy advocacy using community environmental health as an exemplar. Community environmental health was chosen as an exemplar policy issue because it is a contemporary issue, poses a serious threat to health, and has implications for nurses' work.

**Study Design**

This is a case study design. Three nursing organizations with different jurisdiction mandates (provincial/national), governance structures (elected/appointed Board members), legislative authorities (regulatory/public policy mandates), and membership composition (mandatory/voluntary) were invited to participate.

Each organization will be studied separately, and then the findings from each of the cases will be compared to identify cross-cutting themes

about factors that influence policy choices and actions. I will collect data through interviews, document reviews, and a small group discussion with one participant from each nursing organization.

**Why have you been asked to participate?**

You have been asked to participate because of your experience and expertise in priority setting and policy advocacy with the organization, and/or your involvement with community environmental health.

**What will you be asked to do?**

If you agree to participate you will be asked to:

- Participate in a 60 minute face-to-face or telephone interview with the PhD student Jo-Anne MacDonald. The interview will take place at a time and place that is convenient to you. All questions will be asked in English.
- Respond to questions related to your perceptions and experiences about how priorities are set and the role of your organization related to community environmental health. You will also be asked about factors that shape those choices from your perspective.

**What are the Risks?**

- Policy is a contentious issue and social or political repercussions are possible for individuals when views are expressed. Dissension is possible among your co-workers, colleagues from other organizations, nurses, and/or stakeholders with whom you work.
- You may feel uncomfortable or inconvenienced when answering questions or discussing personal views.
- Your time is not compensated.

.
Your participation in this research is voluntary. You may decline to answer any questions, withdraw comments, ask that the audio-tape be turned off, or withdraw from the study at any time. Care will taken to be conscientious of the time taken for interview.

**What are the benefits?**

You may benefit by knowing your participation and the expertise you provided helped to develop knowledge about factors that influence nursing organizations' priority setting and policy advocacy. Your organization and all participants of the study will be provided with a five page Final Integrated Case Report that presents key findings from the research. Actionable recommendations will be identified for enhanced priority setting and policy work by nursing organizations.

**Privacy and Confidentiality**

The concealment of your identity cannot be guaranteed because of the small number of staff and members in your organization. Steps will be taken to protect your identity. You will be referred to by a code that will be assigned to the information you provide. The list matching the names and code numbers will be kept separately in a locked cabinet. Only Jo-Anne MacDonald will have access to codes that can be linked to participant identities. Personal identifiers that can be linked to you will be removed. Only aggregated and anonymized results will be reported.

Steps will be taken to protect the confidentiality of the information you provide. The interviews will be conducted in a place of privacy. Transcribers who have access to the audiotapes will be required to sign a confidentiality form. Information sent to the transcriber will be encrypted. During the conduct of the study, data will be kept in a private office in a locked cabinet of the PhD student research investigator's home, in a locked brief case, or her personal computer that is password protected. Upon completion of the study, all raw data (transcriptions and audio-tapes) will be kept in my supervisor's office, Dr. Nancy Edwards for a period of 5 years following completion of this research (December 2016). At that time, all paper documents will be shredded, audio-files erased, and all confidential computer data files erased. The information provided will be used only for the purpose of the study.

**Additional Information:**

If you have any questions regarding your rights as a research participant or the conduct of this research you can contact the University of Ottawa Protocol Officer for Ethics in Research, University of Ottawa, [redacted]

If you would like to proceed, please complete and sign this consent form and fax to [number] or mail it to:

Jo-Anne MacDonald
[redacted]

There are two copies of the consent form: one for you and one for the researcher.

**Acceptance:** [NAME OF PARTICIPANT] agrees to participate in the study Priority Setting and Policy Advocacy for Community environmental Health: A Comparative Case Study of Three Canadian Nursing Organizations conducted by Jo-Anne MacDonald, University of Ottawa, whose research in under the supervision of Dr. Nancy Edwards and Dr. Barbara Davies.

I agree to an individual interview. Yes ___ No ___

I agree to allow my interviews to be audio-taped. Yes ___ No ___

If no I agree to allow Jo-Anne MacDonald to take notes: Yes ___ No ___

I agree to be quoted but all personally identifying information shall be moved or altered so that the quote cannot be linked to my identity. Yes ___ No ___
I do not wish to be quoted at all. Yes ___ No ___

Participant's Name _____ Date: _____

Participant's Signature _____ Date: _____

Researcher's Signature: _____ Date: _____

## Appendix L

### Letter of Introduction and Consent Form for Past Organizational Members to Participate

### Priority Setting and Policy Advocacy for Community Environmental Health: A Comparative Case Study of Three Canadian Nursing Organizations

**PhD Student Researcher:** Jo-Anne MacDonald RN PhD (c), School of Nursing, University of Ottawa
Telephone: [redacted] or Email: [redacted]

**Thesis Supervisors:**
Dr. Nancy Edwards, Faculty of Health Sciences, School of Nursing, University of Ottawa
Telephone: ([redacted] or Email: [redacted]

Dr. Barbara Davies Faculty of Health Sciences, School of Nursing, University of Ottawa
Telephone: [redacted] or Email: [redacted]

**Dear [Name of Participant]:**

My name is Jo-Anne MacDonald and I am a PhD student in Nursing at the University of Ottawa, Ontario. I am inviting you to participate in a research study.

**What is the study about?**

The purpose of the study is to examine factors that contribute to or constrain nursing organizations' priority setting and policy advocacy using community environmental health as an exemplar. Community environmental health was chosen as an exemplar policy issue because it is a contemporary issue, poses a serious threat to health, and has implications for nurses' work.

**Study Design**

This is a case study design. Three nursing organizations with different jurisdiction mandates (provincial/national), governance structures (elected/appointed Board members), legislative authorities (regulatory/public policy mandates), and membership composition (mandatory/voluntary) were invited to participate.

Each organization will be studied separately, and then the findings from each of the cases will be compared to identify cross-cutting themes about factors

that influence policy choices and actions. I will collect data through interviews, document reviews, and a small group discussion with one participant from each nursing organization.

**Why have you been asked to participate?**

You have been asked to participate because of your past work with [NAME OF ORGANIZATION], your experience and expertise in priority setting and policy advocacy, and/or your involvement with community environmental health.

**What will you be asked to do?**

If you agree to participate you will be asked to:

- Participate in a 60 minute face-to-face or telephone interview with the PhD student Jo-Anne MacDonald. The interview will take place at a time and place that is convenient to you. All questions will be asked in English.
- Respond to questions related to your perceptions and experiences about how priorities are set and how the organization took action for policy related to community environmental health. You will also be asked about factors that shape those choices from your perspective.

**What are the Risks?**

- Policy is a contentious issue and social or political repercussions are possible for individuals when views are expressed. Dissension is possible among your colleagues, nurses, and/or stakeholders with whom you work.
- You may feel uncomfortable or inconvenienced when answering questions or discussing personal views.
- Your time is not compensated.

.

Your participation in this research is voluntary. You may decline to answer any questions, withdraw comments, ask that the audio-tape be turned off, or withdraw from the study at any time. Care will taken to be conscientious of the time taken for interview.

**What are the benefits?**

You may benefit by knowing your participation and the expertise you provided helped to develop knowledge about factors that influence nursing organizations' priority setting and policy advocacy. You will be provided with a five page Final Integrated Case Report that presents key findings from the research. Actionable recommendations will be identified for enhanced priority setting and policy work by nursing organizations.

**Privacy and Confidentiality**

Steps will be taken to protect your identity. You will be referred to by a code that will be assigned to the information you provide. The list matching the names and code numbers will

be kept separately in a locked cabinet. Only Jo-Anne MacDonald will have access to codes that can be linked to participant identities. Personal identifiers that can be linked to you will be removed. Only aggregated and anonymized results will be reported.

Steps will be taken to protect the confidentiality of the information you provide. The interviews will be conducted in a place of privacy. Transcribers who have access to the audiotapes will be required to sign a confidentiality form. Information sent to the transcriber will be encrypted.
During the conduct of the study, data will be kept in a private office in a locked cabinet of the PhD student research investigator's home, in a locked brief case, or her personal computer that is password protected. Upon completion of the study, all raw data (transcriptions and audio-tapes) will be kept in my supervisor's office, Dr. Nancy Edwards for a period of 5 years following completion of this research (December 2016). At that time, all paper documents will be shredded, audio-files erased, and all confidential computer data files erased. The information provided will be used only for the purpose of the study.

**Additional Information:**

If you have any questions regarding your rights as a research participant or the conduct of this research you can contact the University of Ottawa Protocol Officer for Ethics in Research, University of Ottawa, [redacted]

If you would like to proceed, please complete and sign this consent form and fax to [number] or mail it to:

Jo-Anne MacDonald
[redacted]

There are two copies of the consent form: one for you and one for the researcher.

**Acceptance:** [NAME OF PARTICIPANT] agrees to participate in the study Priority Setting and Policy Advocacy for Community environmental Health: A Comparative Case Study of Three Canadian Nursing Organizations conducted by Jo-Anne MacDonald, University of Ottawa, whose research in under the supervision of Dr. Nancy Edwards and Dr. Barbara Davies.

I agree to an individual interview. Yes ___ No ___

I agree to allow my interviews to be audio-taped. Yes ___ No ___
If no I agree to allow JoAnne MacDonald to take notes: Yes ___ No ___

I agree to be quoted but all personally identifying information shall be moved or altered so that the quote cannot be linked to my identity. Yes ___ No ___
I do not wish to be quoted at all. Yes ___ No ___

Participant's Name _____ Date: _____

Participant's Signature _____ Date: _____

Researcher's Signature: _____ Date: _____

## Appendix M

## CONFIDENTIALITY AGREEMENT FOR TRANSCRIBER

### Priority Setting and Policy Advocacy for Community Environmental Health: A Comparative Case Study of Three Canadian Nursing Organizations

1. I will not use the data for purpose(s) other than that described in the project contract.

2. I will not release the data to anyone other than Jo-Anne MacDonald.

3. I will keep the data (in paper or electronic form) in a locked or password secured location to which only I will have access.

4. I will, upon completion of project, destroy the original and all copies of the transcripts and tapes, including electronic files.

Print Name: _____

Signature: _____

Position: Transcriber

Date: _____

**Terms of the Project Contract:**

**Outcome:**
1. Agree to the terms of the confidentiality agreement.
2. Transcribe oral data to typed text.
3. Provide Jo-Anne MacDonald with the transcribed text.

**Guidelines for Interviews:**
1. Identify what the interviewer says by using I: (interviewer)
2. Identify the person answering the questions by using the audio file identifier (e.g., NO1-01).
3. Double space between each text segment
4. Do not use quotation marks
5. Number the pages
6. The transcript should look like the example below

Length of Interview: 45 minutes

I: Tell me about ……..Do you see a potential role for nursing organizations in community environmental health policy?

NO1-01: I think……..

I: So, you …..

NO1-01: I guess so ……

**Focus of the transcript**

The main focus of the transcript should be on what the interviewees say. You may need to re-listen to tape segments. However, do not spend too much time determining exactly what was said by the interviewer. A general sense of what the interviewer asks will suffice. It is more important to spend time and writing down the exact wording of what the interviewees says.

**Identifiers**

If the interviewee or the interviewer states an identifier (e.g., person's name, an organizational position, and a place) put the identifier in brackets in capital letters [JOANNE]. These identifiers will be removed by the PhD student investigator.

**Sections or Terms Unable to Hear or Understand**

If you cannot hear or understand what is said please:

1. Make an education guess if possible. Point out that you are making a guess by putting the segment of text in brackets and capital letters [SOUNDS LIKE….] [ABREVIATION, SOUNDS LIKE: CNA]

2. Write down the reason you cannot make something out if you are unable to make a guess. For example:

[INAUDIBLE] [BAD TAPE QUALITY] [BACKGROUND NOISE FOR ABOUT 30 SECONDS, INAUDIBLE] [EVERYBODY TALKING AT ONCE, VERY EXCITED, MUCH LAUGHING. CANNOT MAKE OUT WHAT IS BEING SAID] [OVERLAPPING VOICES]

**Tone of Voice and Emotional Content**

If you think the emotional content is important to convey the meaning then put what is 'heard' in brackets in capital letters. For example:

[LAUGHTER], [QUIET VOICE], [LONG PAUSE], [SPEAKING VERY QUICKLY]. [SOUNDING TEARFUL], [SOUNDS SARCASTIC], [SOUNDS UNSURE], [HESITANT]

**Punctuation**

Use punctuation to reflect what you are hearing. For example, use a comma when people pause in mid-sentence, a question mark when they are making a statement but raise their voice, and a period when the person is finishing a sentence.

**Fillers**

Please do not transcribe oral 'whiskers' – for example "huhms"; "eh" and other 'fill' words.

**Information about the Project**

I will provide a copy of the Interview Guide to help give you an idea of the general nature of the project. Since this is a qualitative study, the questions and probes are not always asked exactly as phrased, or in the same order. There may be questions that are skipped, and other questions that are asked by the interviewer.

**Telephone Conference Call Instructions**

1. Identify the facilitator says by using an F:
2. Identify the speakers by name Jo:
3. If you are unsure or unable to identify the participant please insert a question mark [?]
   If you can make an educated guess you can add the identifier [?Jo]
4. Follow the instruction above if you are unable to hear or understand a segment of the tape.
5. Double space between each text segment.
6. Quotation marks are not needed
7. Number the pages
8. The transcript should look like the example below

Length of Telephone Conference: 57 minutes

F: Were you surprised……

Jo: I thought it was unusual …….

? : Yes, I agree….

**If you have questions please contact JoAnne MacDonald for clarification or assistance**