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Original research article

Health science students' perceptions of poverty and health inequality

Pavlina Rutar [1]*, Mirko Prosen [2], Sabina Ličen [2]

[1] *Health center Tolmin, Tolmin, Slovenia*
[2] *University of Primorska, Faculty of Health Sciences, Department of Nursing, Izola, Slovenia*

Abstract
Introduction: The aim of this study was to investigate health science students' perceptions of poverty and health inequality to gain insight into the perspectives of future healthcare workers.
Design: A descriptive cross-sectional study.
Methods: Data was collected via an online survey that was developed based on a thorough literature review. Participants were students (n = 106) from undergraduate nursing and applied kinesiology programmes. Statistical analyses were conducted with IBM SPSS Statistics 29.0. using bivariate statistical analysis. The significance level was set at $p < 0.05$.
Results: 28.3% of students cited lack of opportunity as the main cause of poverty. There were significant differences in perception between nursing and kinesiology students ($p < 0.05$), particularly in relation to personal responsibility for poverty. On average, students scored 58/85, indicating a moderate yet significant awareness of social determinants of health.
Conclusion: The findings illustrate how different disciplines influence perceptions of poverty and emphasise the inclusion of empathy in health education. While views on the roots of poverty vary, a common nuanced understanding points to a move towards empathic, socially conscious healthcare education. The study highlights the importance of an education system that emphasises social determinants of health and empowers students to engage with the complexities of poverty and health inequality.

Keywords: Equality; Equity; Health science education; Nursing

Introduction

Poverty is a multifaceted problem that goes beyond the mere lack of income and means of production necessary for a sustainable life. According to the United Nations (2023), poverty includes malnutrition and hunger, limited access to education, healthcare, and other basic services, as well as marginalisation, social discrimination, and lack of participation in decision-making processes. It is recognised as a social determinant of health and a complex social process that contributes to poorer health outcomes (Hitchcock et al., 2021). The understanding of poverty is influenced by a country's customs, values, and cultural aspects, and although its conceptualisation has evolved over time and space, no country or region is immune (Čibej, 2015).

Poverty is defined both as absolute, based on the minimum income needed to survive, and as relative, when income is less than 60% of the median, which puts people below the at-risk-of-poverty threshold (Fritzell et al., 2015). Globally, 10% of the population lived in extreme poverty in 2021, and 11.7% of the Slovenian population was affected by poverty in that year (Liao et al., 2022; Statistical Office of the Republic of Slovenia, 2023). The International Council of Nurses (ICN, 2019) reports that 50% of the world's population does not have access to basic health services and 100 million people are driven into poverty due to health expenditure. The consequences of poverty include poor health, interpersonal violence, hunger, and educational problems (Hitchcock et al., 2021), while poverty also leads to behavioural problems and criminal allegations in adulthood (Duncan et al., 2017).

Research shows that poverty is often passed down from generation to generation. Children born into poverty are more likely to have lower educational attainment, poorer health, and lower income in adulthood (Duncan et al., 2017; Liao et al., 2022). Poverty also affects children's mental health and increases chronic physiological stress (De France et al., 2022). Parental investment in education is crucial to breaking this cycle of poverty (Liao et al., 2022).

While health standards are improving, health inequalities continue to rise. Poverty and social exclusion are linked. Individuals lack the means to lead a decent life or be included in social groups (Čibej, 2015). Stigmatisation, a key factor in poverty, leads to health inequalities as it perpetuates prejudice,

* **Corresponding author:** Pavlina Rutar, Health center Tolmin, Prešernova 6a, 5220 Tolmin, Slovenia;
e-mail: pavlina.rutar@gmail.com
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stereotypes, and discrimination (Earnshaw et al., 2022). Promoting social justice and developing social empathy are essential to combat these issues (Hellman et al., 2018). Nurses play an important role in combating these risks, and educational institutions are developing methods such as poverty simulations to strengthen empathy and understanding of social justice (Hellman et al., 2018; ICN, 2019).

In addition to examining the impact of poverty on health, it is also important to point out how health science students are trained to deal with these issues. At the Faculty of Health Sciences, undergraduate nursing students are trained in the social determinants of health, including poverty, in courses such as Sociology of Health and Illness. The Transcultural Nursing and Global Health course, which is part of the revised postgraduate curriculum, further builds on this foundation and equips students with the skills to provide culturally sensitive and equitable care to diverse patient populations. These courses are designed to help nursing students develop empathy and prepare them to mitigate health inequalities and stigmatisation in their practise (Faculty of Health Sciences, 2023). However, students from allied health disciplines, such as applied kinesiology, are less likely to be exposed to these topics. While they learn some content related to public health systems and communication at the postgraduate level, poverty and health inequities are not covered as extensively as in the nursing curriculum. This difference suggests that nursing students are better prepared to address these critical social determinants of health than their peers in allied health programmes (Neto et al., 2022).

Purpose and objective

The purpose of this study was to explore the understanding of poverty and health inequality from the perspective of future healthcare professionals. Specifically, the study aimed to examine perceptions of poverty and health inequality among nursing and applied kinesiology students to explore any differences in perceptions between these groups. In addition, the study aimed to uncover the factors that influence nursing and applied kinesiology students' attitudes towards poverty and health inequality. We investigated how health science students, specifically nursing and applied kinesiology students, perceive poverty and health inequalities. We also investigated whether there were statistically significant differences among health science students in their perceptions of poverty and health inequalities that could be attributed to different sociodemographic backgrounds and other relevant social characteristics.

Materials and methods

A non-experimental quantitative method was used in this study. The data were collected by means of a questionnaire.

Instrument description

Data collection was facilitated by an online survey, developed based on the findings of a comprehensive literature review (Demirtas et al., 2022). The survey is divided into two main sections: the first collects demographic information, as well as information on the educational level and occupational field of the participants' parents.

In the second section, attitudes towards poverty and health inequality are analysed on the basis of statements. Participants first indicate the perceived causes of poverty and then rate their views on the seventeen statements on a Likert scale. This scale ranges from 1 for "strongly disagree" to 5 for "strongly agree". The total score on the scale, which ranges from 17 to 85 (Me = 51), reflects the complexity of health science students' attitudes towards poverty and health inequalities. Higher scores generally indicate a more empathetic and proactive attitude towards recognising and addressing the social determinants of health and ensuring equitable access to healthcare. Five of these statements are reverse coded, with 1 meaning "strongly agree" and 5 meaning "strongly disagree".

Sample

The convenience sample included undergraduate students from nursing and applied kinesiology programmes. A total of 106 individuals, or 29% of full-time and part-time students enrolled in the Nursing and Applied Kinesiology programmes in the 2022/2023 academic year, completed the questionnaire in its entirety. The age range of respondents ranged from 18 to 47 years, with a mean age of 24.44 years (s = 7.69). Details of the demographic data can be found in Table 1.

Table 1. Demographic and other characteristics of the sample

Variable	*n*	%
Gender		
Male	27	25.5
Female	79	74.5
Residence		
Urban	50	47.2
Rural	56	52.8
Employment status		
Yes	25	23.6
No	81	76.4
Field of study		
Nursing	56	52.8
Applied kinesiology	50	47.2
Mode of study		
Full-time	82	77.4
Part-time	24	22.6
Year of study		
First year	51	48.1
Second year	26	24.5
Third year	29	27.4

Note: n – number; % – percentage.

In terms of their parents' educational background, respondents could choose between primary, vocational, and secondary school education, university/vocational school, university/professional master's, and scientific master's/doctorate. Among both nursing students (*n* = 19, % = 33.9) and applied kinesiology students (*n* = 17, % = 34.0), the highest proportion of mothers had a secondary school degree. Secondary education was also the most common highest level of education among fathers of nursing students (*n* = 18, % = 32.1) and fathers of applied kinesiology students (*n* = 16, % = 32.0). A notable trend among all parents of students in the study was a higher percentage of completed education in science (51.9% of mothers and 66.6% of fathers).

Data collection and data analysis

The data collection was conducted using the EnKlikAnketa web platform, an open-source online survey application. The

survey period ran from November 2022 to January 2023. Participation in the survey was anonymous and voluntary. After approval by the Vice Dean for Student Affairs, the link to the survey was emailed to students by the Office of Student Affairs. The respondents' data was collected in the EnKlikAnketa web server database.

The data from the completed surveys were imported, organised, and statistically analysed using IBM SPSS Statistics 29.0. The following statistical methods were used: descriptive statistics (frequency distribution, maximum and minimum values, mean values, and standard deviation), Chi-square Goodness-of-fit test, Chi-square test for independence and, due to the non-normal distribution of the data (Kolmogorov–Smirnov test, $p < 0.05$), the non-parametric Mann–Whitney *U*-test, the Kruskal–Wallis *H*-test, and Wilcoxon signed-rank test were used. The significance level was set at $p < 0.05$.

Results

The Cronbach's alpha value of 0.7 indicates acceptable internal consistency for all 17 items (Field, 2018).

The first part of the questionnaire contained a question in which the students could select possible reasons or causes for poverty. We used the Chi-square Goodness-of-fit test to determine whether there was an even distribution in the selection of these causes. The results show that students' opinions on the main causes of poverty were not evenly distributed ($\chi^2(4) = 16.592$, $p = 0.002$), indicating a significant deviation from an even selection of all options offered. "Lack of opportunities" was chosen more frequently than expected (residual = 11.4), while "Fate" was chosen less frequently (residual = –13.6), indicating a tendency among students to attribute poverty to societal factors rather than individual or fatalistic causes.

Table 2 shows the estimates for the cause of poverty separately by study programme.

Table 2. Causes of poverty

Variable	Nursing		Applied kinesiology	
	n	%	*n*	%
Personal problems/illness	12	21.4	9	18.0
Injustice	16	28.6	9	18.0
Lack of opportunities	16	28.6	14	28.0
Fate	3	5.4	3	6.0
Sometimes people are to blame	9	16.1	15	30.0
χ^2	8.894			
df	4			
p	0.351			

Note: n – number; % – percentage.

To test whether there are differences between students from different fields of study and to determine the cause of poverty, we performed a chi-square test for independence. The results showed that there were no statistically significant differences between health sciences students from different fields of study ($\chi^2(4) = 8.894$, $p = 0.351$).

The second part comprises 17 items that describe attitudes towards poverty and health inequality. Respondents rated these statements on a 5-point Likert scale, ranging from 5 (strongly agree) to 1 (strongly disagree). The Wilcoxon signed-rank test yielded a statistically significant result ($p < 0.001$), indicating that the median score of health science students (Me = 58) on the scale assessing attitudes towards poverty and health inequality was significantly higher than the hypothesised median score (Me = 51). This indicates that students recognise the need to address social determinants and ensure equitable access to healthcare. This confirms a proactive attitude that is consistent with the research investigation into their perceptions of poverty and health inequality.

Table 3 shows the items rated by the respondents using descriptive statistics.

The results show that students rated the statement "People who live in poverty are more susceptible to mental health problems" the highest, with a mean score of 4.10 ($p = 0.753$). Conversely, they disagreed with the statements "The protection of personal data in the health records of economically disadvantaged people is less important" and "Ethical behaviour is less important in the treatment of people living in poverty", with a mean score of 1.64 ($p = 0.853$) and 1.75 ($p = 0.969$) respectively.

The Mann–Whitney *U*-test and the Kruskal–Wallis *H*-test were used to determine statistically significant differences between the views of the respondents (see Table 4).

The median attitude scores toward poverty were consistently at 58, indicating a neutral stance overall, with the interquartile range (IQR) reflecting the spread of scores among respondents. Statistically significant differences were not observed across gender ($p = 0.574$), residence ($p = 0.314$), year of study ($p = 0.430$), mode of study ($p = 0.279$), or the educational level of parents (mother: $p = 0.724$, father: $p = 0.443$).

However, a significant difference in attitudes was found between fields of study; nursing students (median = 59) differed from applied kinesiology students (median = 57) with a *p*-value of 0.004, suggesting that nursing students may hold slightly more proactive attitudes toward addressing poverty.

Table 3. Health science students' views on poverty and health inequalities – descriptive statistics

Items *People who live in poverty…*	Min	Max	$\bar{x}$	s
… need more health services than other social groups	1	5	3.52	0.896
… utilise health services more frequently than other social groups	1	5	2.85	0.908
… are a burden on the healthcare system	1	5	2.24	0.893
… are more susceptible to infectious diseases	1	5	3.65	0.898
… are more susceptible to mental health problems	2	5	4.10	0.753
… do not have access to community services that would ensure better health	1	5	3.44	0.838
… are discriminated against in terms of access to health services	1	5	3.14	1.035
… have very easy access to health facilities in the regions where they live	1	5	2.80	0.994
… have very easy access to clean water, sanitation, and decontamination to improve their health	1	5	2.55	0.975
… should be entitled to contributions to statutory health insurance	1	5	3.56	1.041
… have less access to reliable and sufficient health information	1	5	3.67	0.835
Measures should be developed for people living in poverty to facilitate their access to health services	1	5	3.96	0.702
Supplementary health insurance leads to inequalities in medical treatment for people who do not have it	1	5	3.62	0.984
The protection of personal data in the health records of economically disadvantaged people is less important	1	4	1.64	0.853
Ethical behaviour is less important in the treatment of people living in poverty	1	4	1.75	0.969
Healthcare professionals take into account the cultural background of people living in poverty in their work	1	5	2.93	1.033
Health services used by people living in poverty are of equal quality	1	5	3.54	0.925

Note: $\bar{x}$– average, Min – minimum, Max – maximum, s – standard deviation.

Table 4. Attitudes toward poverty according to demographic data and other respondent characteristics: Mann–Whitney *U*-test and Kruskal–Wallis *H*-test

Variable	Me	IQR	U / χ^2 test	Z/df	*p*-value
Gender					
Male	58.00	4	659.00	–0.562	0.574
Female	58.00	4			
Residence					
Urban	58.00	4	1076.00	–1.007	0.314
Rural	58.00	7			
Field of study					
Nursing	59.00	4	590.50	–2.867	0.004
Applied kinesiology	57.00	7			
Year of study					
First year	59.00	5	1.688	2	0.430
Second year	57.00	5			
Mode of study					
Full-time	57.50	4	704.00	–1.082	0.279
Part-time	59.50	6			
Educational level of the mother					
Primary school education	58.00	10			
Vocational	58.50	6			
Secondary school	58.00	5	2.841	5	0.724
University/University of Applied Sciences	58.00	5			
University/Professional Master	57.00	5			
Scientific Master/Doctorate	63.00	0			
Educational level of the father					
Primary school education	57.00	4			
Vocational	57.50	7			
Secondary school	58.00	6	4.783	5	0.443
University/University of Applied Sciences	59.00	5			
University/Professional Master	57.00	9			
Scientific Master/Doctorate	60.00	0			

Note: Me – median; IQR – Interquartile Range; Mann–Whitney *U*-test; χ^2 Kruskal–Wallis *H*-test; df – degree of freedom.

Discussion

Widespread global poverty is a major challenge, yet many health science students are not sufficiently familiarised with the complexities of poverty and the care needed for those affected during their education (Watts et al., 2021). This study explored how health science students perceive poverty and health inequalities and showed that views differ across disciplines. Nursing students overwhelmingly attributed poverty to systemic issues such as inequality and lack of opportunity, reflecting broader societal concerns about the structural barriers that perpetuate socioeconomic inequalities. In contrast, applied kinesiology students were more inclined to view individual responsibility as a contributing factor. This divergence underscores a fundamental difference in understanding the roots of poverty and suggests that disciplinary focus may shape students' perspectives on social issues.

Socioeconomic status plays an important role in healthcare access, health outcomes, and overall well-being. Patients living in poverty face numerous barriers, including financial limitations, lack of access to preventative care, and social stigmatisation, all of which lead to poorer health outcomes (Hitchcock et al., 2021). These barriers often lead to delayed treatment, higher rates of chronic disease, and further entrenchment of the cycle of poverty (Newdick, 2017). The limited health literacy of people experiencing poverty exacerbates these challenges, as they are less likely to understand health information and navigate the healthcare system effectively (Mojžíšová et al., 2017).

The causes of poverty are complex, with systemic issues such as unemployment, low wages and a lack of social support structures playing a major role. Structural barriers such as access to quality education and health services also mean that poverty persists across generations (Demirtas et al., 2022; Šupínová et al., 2023). The interaction between poverty and health is obvious, as people living in poverty often do not have the financial means to take advantage of preventive measures or afford necessary treatments. This leads to a higher incidence of chronic diseases, poor mental health, and an overall lower life expectancy (Earnshaw et al., 2022). Healthcare professionals, especially nurses, need to recognise these systemic problems and adapt their care to the social determinants of health by providing tailored interventions that take into account the patient's socioeconomic background.

The significant difference between nursing students' and applied kinesiology students' views on the role of personal responsibility in poverty underscores the importance of curriculum design in shaping students' perceptions. The inclusion of "fate" as a cause of poverty was the least favoured, possibly reflecting the secular nature of Slovenian society compared to more religious contexts (STA, 2017). This finding is consistent with Demirtas et al. (2022), who observed a strong belief in fate among nursing students, indicating cultural and contextual influences on perceptions of poverty.

However, this study also underscores the need for improved education regarding poverty and social determinants of health for students from allied health disciplines, such as applied kinesiology. While nursing students receive a more comprehensive education in these areas, students from allied health disciplines may benefit from curricula that emphasise social justice and systemic inequities. By expanding the focus on the social determinants of health beyond nursing programmes, institutions can help students in the allied health professions develop the same level of empathy and understanding, equipping all future health professionals with the tools they need to provide equitable care and address the complex challenges faced by people experiencing poverty (Earnshaw et al., 2022; Kruse and Khoury, 2022).

In our study, the idea that "sometimes people are to blame for their poverty" was introduced, a sentiment that was more prevalent among applied kinesiology students. This addition revealed notable differences in subjective understanding of the causes of poverty between study programmes, which may reflect the different pedagogical and philosophical orientations of these disciplines. Malul (2019) and Lei et al. (2021) emphasise the prevalence of social and structural explanations for poverty among students and the importance of addressing these broader determinants in educational programmes.

Interestingly, our analysis found no correlation between socio-demographic variables and perceptions of poverty, challenging common stereotypes and assumptions about gender and empathy (Belošević, 2015). The lack of significant differences emphasises the unifying effect of health science education on students' views on poverty and health inequalities, regardless of their background.

The study also examined students' attitudes toward poverty and health inequality, revealing a general tendency toward empathy and advocacy for equitable access to health care among nursing students. These attitudes reflect the caring ethos of nursing and highlight the profession's commitment to patient-centred care and social justice (Hitchcock et al., 2021; Jug, 2015).

The inclusion of ethics, psychology, and sociology in the nursing curriculum is likely to contribute to a more nuanced understanding of poverty and health inequalities and suggests that comprehensive education can promote empathy and a commitment to social justice (Faculty of Health Sciences, 2023). This educational approach is consistent with the increasing recognition of the social determinants of health and the need for healthcare professionals to be able to effectively address these determinants (Neto et al., 2022). The concept of social justice, which is integral to healthcare, requires collaboration between different sectors to mitigate the negative impact of social and economic inequalities on health (Hellman et al., 2018). The Sustainable Development Goals emphasise the importance of equity as a cornerstone for a sustainable future and highlight the role of healthcare professionals in advocating for and implementing equitable practises (International Council of Nurses Code of Ethics, 2021).

Innovative educational tools such as the Community Action Poverty Simulation (CAPS) provide valuable insight into the lived experiences of those experiencing poverty, promote empathy, reduce stigmatisation, and foster a deeper understanding of the challenges of poverty (Hitchcock et al., 2021). Kruse and Khoury (2022) have emphasised the transformative potential of such simulations in improving students' attitudes towards poverty and advocate for their wider use in healthcare education.

This study highlights the important role that health sciences education plays in shaping students' perceptions of poverty and health inequalities. The observed differences between nursing and allied health students suggest that more comprehensive education on the social determinants of health is needed across all health disciplines. By integrating these topics into curricula, educational institutions can equip future healthcare professionals with the tools necessary to provide equitable and compassionate care to populations affected by poverty.

Limitations of the study

This study is subject to several limitations. First and foremost, the sample size was limited to students from a single institution, which limits the ability to generalise these findings to the broader student population within health science disciplines. Although the faculty offers several study programmes, participation in the study was voluntary, so the sample consisted solely of nursing and applied kinesiology students. Broader representation via the inclusion of students from additional health science faculties would improve the generalisability of the results.

For future research, it would be beneficial to include a broader range of health science programmes and participants involved in patient care in the study. This would not only ensure a more representative sample but would also allow an initial assessment of the measurement properties of the scale and thus strengthen the general validity and applicability of the study. In addition, the cultural context in which the survey was conducted could influence the openness of participants' responses, which could lead to bias.

Conclusion

This study highlights the different perceptions of poverty and health inequality among nursing and applied kinesiology students. Nursing students are more likely to attribute poverty to systemic issues such as inequity and lack of opportunity, while applied kinesiology students are more likely to emphasise individual responsibility. These findings underline the need for a more integrated and uniform approach to educating future healthcare professionals about the social determinants of health.

By integrating these topics into the curricula of all health science programmes, including nursing and allied health disciplines, educators can foster a deeper understanding of the systemic factors that contribute to health disparities. This approach would help reduce stigmatisation, improve empathy, and equip healthcare professionals with the skills necessary to provide equitable and compassionate care to people experiencing poverty. Addressing these educational deficits will not only improve healthcare professionals' attitudes towards vulnerable populations, but also the quality of care they provide. By promoting a healthcare environment that prioritises social justice and equality, we can help ensure that people have better access to essential healthcare services, regardless of their socio-economic background.

Ethical aspects and conflict of interest

The study was approved by the Vice-Dean for Students Affairs of the University of Primorska, Faculty of Health Sciences. The authors have no conflict of interest to declare.

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