

Working Through and Around: Exploring Rural Public Health Nursing Practices and Policies to Promote Rural Women's Health

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Abstract

Purpose: To discuss findings from research in Ontario, Canada, that addresses the following objectives: 1) identify organizational attributes and local and provincial health policies that enable or impede the work of Ontario public health nurses to improve rural women's health, and 2) critically examine roles, job descriptions, and practices of Ontario PHNs that will improve rural women's health.

Sample: 20 frontline PHNs and 14 supervisors and managers in three Ontario public health units that serve people who live in rural locations.

Method: Six focus group interviews were conducted with PHNs and PHN managers in three rural Ontario public health units. Study participants were asked to describe policies and practices that guided their practice regarding rural women's health, identify organizational attributes that

enable or impede public health nursing practice regarding rural women's health, and indicate roles and practices for PHNs to improve rural women's health.

Findings: 1) Policies address rural women's health and rural public health minimally or not at all, 2) PHN practice is primarily focused on child bearing women and children to the exclusion of other populations of rural women such as seniors, 3) PHNs work through and around policies to address rural women's health more effectively, and 4) institutional, government, community, professional, and personal factors play significant roles in shaping public health nursing practice and policy regarding rural women's health.

Conclusions: This research facilitates understanding regarding policies, contexts, and values that shape rural PHN practice, and provides evidence for policies and practices that enhance and support public health nursing for more effective promotion of rural women's health. Clearly, more investigation is needed; this research forms the basis for ongoing inquiry in this area.

Keywords: Rural public health nursing, Rural women's health, Policy, Practice, Canada

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“Geography should never be an excuse for discrimination or inequity in health.” Allan Rock, Former Federal Minister of Health (The Ontario Rural Council [TORC] (2009, p.11).

Over the next ten years, jurisdictions throughout Canada can expect to experience rising rates of chronic preventable diseases such as obesity, diabetes, heart disease, stroke, tobacco-related illnesses, and environmental illnesses (Joint Task Group on Public Health Human Resources [JTGPHHR], 2005; Public Health Agency of Canada, 2012). All of these health issues are prevalent and growing in rural Canada (Canadian Institute for Health Information [CIHI],

2006). Although these issues are amenable to public health intervention, rural areas in particular are struggling to maintain essential public health services, including the retention of public health nurses (PHNs) (Canadian Nurses Association [CNA], 2005; JTGPHHR, 2005). As a result, the health of rural Canadians, especially those who experience vulnerabilities and inequities, such as rural women, is particularly at risk.

The Ontario government has recently highlighted the priority need for equity of access to health and health care in rural contexts (MOHLTC, 2010a, b; 2011). Understanding what are and should be practices and policies of rural PHNs regarding rural women's health could significantly enhance the present and future health of rural women, families, and communities. This information could also help to promote more accessible and better integrated programs (Community Health Nurses of Canada [CHNC], 2010; MOHLTC, 2010a, b) and more effective public health nursing services in underserved rural communities.

Rural people in Canada are sicker, die sooner, and experience severe health challenges, such as limited or no health care, compared to other Canadians (CIHI, 2006). Rural women, in particular, experience many health issues related to social isolation, poverty, disempowerment, limited knowledge, and other factors that PHNs could effectively help them address (Sutherns, McCallum, & Haworth-Brockman, 2008). Women in rural communities often have few or no health promotion resources, illness prevention services, or access to female health professionals (Leipert, Leach, & Thurston, 2012; Leipert, 2013). Thus, PHNs are essential health resources for rural women because they are mostly female and have pronounced expertise in health promotion and illness and injury prevention practice (Stamler & Yiu, 2012). PHNs may assist in addressing sensitive health issues for rural women who might not seek health services from male care providers or from physicians and pharmacists whose staff might be well known in the

community thereby risking compromised confidentiality (Leipert, Matsui, Wagner, & Rieder, 2008). Rural women have noted the immense need for and dearth of health promotion and illness prevention services in their communities. Yet, little research has been conducted on public health nursing practices and policies related to the health of rural women in Canada (Leipert et al., 2008; Leipert & Reutter, 1998).

Public health nurses provide services of health promotion, disease and injury prevention, health protection, health surveillance, population health assessment, and emergency preparedness (Canadian Public Health Association [CPHA], 2010; CHNC, 2010; Stamler & Yiu, 2012). They are often the only health care providers to provide these services in small rural communities (Leipert & Reutter, 1998). Increasing access to the social determinants of health and empowering under-resourced and vulnerable populations, such as rural women, are foundational to PHN practices (CPHA, 2010; Joint OPHA/Alpha Working Group on Social Determinants of Health, 2010; Stamler & Yiu, 2012). Yet in recent years, public health nursing in Canada has experienced a hollowing out, a decreasing of support, resources, regard, and recognition, that has serious implications for the health of rural people as well as for rural nursing (Falk-Raphael, 1999; Leipert, Landry, & Leach, 2012). Indeed, nurses at over half a dozen rural public health units in Ontario have been in labour disputes throughout the past five years, which in some cases has included strike action (Ontario Nurses' Association, 2012, 2013). Some rural areas have been particularly challenged due to decreased public health services or closure of offices in small towns, thereby requiring rural residents and PHNs responsible for those areas to drive lengthy distances to access or provide services (Ontario Nurses' Association, 2011).

In the 2011 Report of the Chief Medical Health Officer of Ontario (Ministry of Health and Long-Term Care [MOHLTC], 2011), increasing access to the social determinants of health and

reducing inequities were identified as key areas where increased public health efforts must be made. Public health nurses are crucial providers of public health care in Canada generally (JTGPHHR, 2005) and in rural areas in particular (Kulig, Macleod, Stewart, & Pitblado, 2012; Leipert, 1999). Thus, more knowledge about their practices and policies is needed to support and enhance their work in order to address key areas of public health concern, including rural women's health.

The objectives for this research were to: 1) identify organizational attributes and local and provincial health policies that enable or impede the work of Ontario public health nurses to improve rural women's health, and 2) critically examine roles, job descriptions, and practices for Ontario PHNs that will improve rural women's health. Rural is defined as communities "with a population of less than 30,000 that are greater than 30 minutes away in travel time from a community with a population of more than 30,000" (MOHLTC, 2010a, p. 4).

Study Design

Methodology

This study was guided by interpretive description methodology (Thorne, 2008). Interpretive description methodology is "designed to create ways of understanding clinical phenomena that yield application implications" (Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004, p.1) by capturing themes and patterns within participants' experiences to inform clinical understanding. Rural PHNs and rural women have historically been included in few research endeavors (Sutherns & Haworth-Brockman, 2012), thus this project provided enhanced opportunities for respectful and meaningful inclusion, as well as the important potential of gaining significant new rural health knowledge.

Sample, Recruitment, and Data Collection

Ethical approval for the study was obtained from Western University Health Sciences Research Ethics Board (Protocol number 18295E). The three health units in this study were selected for their rural characteristics, such as isolation and low economic status, as well as for their interest and ability to participate in the research. The health units included in the study serve some of the most rural populations and settings in the province. All three health units had higher percentages of older adults over 65 years, higher overweight and obesity, and higher avoidable mortality from preventable disease than the provincial average (Table 1).

Table 1

*Characteristics of Public Health Unit Catchment Areas**

	Ontario (Provincial Average)	Health District #1	Health District #2	Health District #3
Population over 65 (%)	12.7	10% higher than provincial average	30% higher than provincial average	50% higher than provincial average
Visible Minorities (%)	25.9		1.5 - 3.5****	
Aboriginal Population (%)	2.4		1.0 – 3.5****	
Overweight/Obese %	27.6/17.4	Both above provincial average	Both above provincial average	Both above provincial average
Avoidable Mortality from preventable causes (per 100,000)**	71.5	Above provincial average	Above provincial average	Above provincial average
Rural Area Population*** (%)	14.1	Double the provincial average	Double the provincial average	Quadruple the provincial average
Census population of major city (n)	N/A	25,000 to 35,000	65,000 to 75,000	15,000 to 25,000

Notes: *Numbers have been approximated to protect the identity of the communities (Statistics Canada, 2012, 2014). **Age-standardized rate of premature deaths could potentially have been prevented through primary prevention efforts. *** Areas with fewer than 1000 residents and a population density with fewer than people/square foot. **** Range is for all three health districts combined.

Public health nurses and managers were recruited by contacting managers in health units in Ontario that serve rural populations. The managers informed staff about the study and invited

their participation. All PHNs and managers who volunteered for the study and who could meet for a focus group at the time that best suited the majority of those interested participated in the research. Group interviews were then conducted with 20 frontline PHNs and 14 health unit managers at their health unit locations.

The PHNs and managers at each of the three health units were interviewed separately, for a total of six group interviews, three with PHNs and three with managers or supervisors. In audio-recorded interviews of one to two hours in length, participants were asked to describe policies and practices regarding rural women's health, identify organizational attributes that enable or impede public health nursing practice regarding rural women's health, and indicate roles, job descriptions, and practices for PHNs that could help to improve rural women's health. Examples of the interview questions included: What health needs do rural women in your areas have? How do health unit policies and practices affect your work with rural women, positively or negatively? How would you change these policies and practices to better support rural women's health? What organizational attributes (resources or lack of resources, understanding of rural women's needs, inclusion of public health nursing in practice and policy development, etc.) enable or impede the work of public health nurses to improve rural women's health? What should public health nurses do to better address rural women's health? The semi-structured interview guide was emailed to each health unit prior to the interview to allow participants additional time to reflect upon the questions.

Analysis

The interview recordings were transcribed verbatim and the transcripts checked with the audio recordings to ensure accuracy. Transcripts were analysed individually, as a whole as well as by distinct health unit (i.e. PHN and manager transcripts from the same health unit).

Transcripts were interpreted alongside community assessments for each health unit catchment, which included information such as demographic information, major types of employment, and salient health challenges. In interpretive description, “the researcher constantly explores such questions as: Why is this? Why not something else? What does this mean?” (Thorne et al., 2004, p. 11). Using these questions and content analysis (Patton, 2002), the transcribed interviews were analyzed line-by-line by a minimum of two researchers to determine consistent codes and themes that addressed policies and practices pertaining to rural public health nursing practice regarding rural women’s health (e.g. types of work PHNs may or may not engage in), organizational attributes that enabled and impeded PHNs work regarding rural women’s health (e.g. support of managers), and PHN roles, job descriptions, and practices that helped or could help to improve rural women’s health (e.g. need for more support and respect). In addition, the research team met during analysis to discuss emerging codes and their meanings. The qualitative software program NVivo 9 (QSR International, 2010) assisted with the organizing, labeling, and retrieving of codes and themes during analysis (Ulin, Robinson, & Tolley, 2005).

Findings

“You put a nurse in (the community), you’re going to address a million issues... And because you’re a nurse, [they] ... tell you all their problems. It’s fabulous.” Carla, rural public health nurse.

The findings are categorized into three main themes: 1) promoting rural women’s health through PHN practice in community, 2) policy and managerial valuing of PHN practices to support rural women’s health, and 3) evidence used to inform policy, funding, and practice.

Pseudonyms are used to represent the names of study participants.

Promoting Rural Women's Health through PHN Practice in Community

PHNs in the study repeatedly and emphatically emphasized the importance of their presence in rural communities, noting that rural women are often isolated, have limited voice and power, and limited opportunities for health promoting activities. PHN Amy described a rural community she served as

... a very traditional, patriarchal community, so women do not have a voice...I [once asked] what [programs and activities are] available for women. And the supervisor [of community programs] laughed at me and he said, 'Well you'll have to [drive an hour to the city] for that.'

Being present in rural communities provided PHNs with privileged information regarding available health resources as well as health needs. Chantal, a manager, described a benefit of her team working directly in a rural community, rather than from a distant location, "The more we worked in that community, the better we got a sense of what the needs were." This deepened understanding of health needs allowed Chantal and her team to identify relevant health resources that might benefit the community. As a result, the health unit was successful in obtaining external funding to bring nurse practitioner services to that rural location.

Study participants also believed that being visible and located within rural communities was important to address mental health issues. Betty explained that that the personal nature of home visiting has been an effective way for public health nurses to confidentially assess rural mental health needs, provide mental health education, and encourage clients to access resources. She stated, "Mental health is still very, very stigmatized ... [There have been] people that we've visited ... with undiagnosed PPD (post-partum depression) and ... you... get them to the point where they [agree to see] the doctor". In sensitive situations such as these, study participants

perceived that if PHNs were not positioned in the rural community and engaging in direct client contact, such as through home visits, trust could be compromised and women would be less likely to be receptive to, know about, or access mental health and other services.

Study participants also commented on the significance of long term, consistent staffing in rural communities so that familiarity, trust, and effectiveness could be enhanced. Hazel, a manager, referred to parental preferences in her rural area, “*(what) they really wanted was one (nurse) that they could go to...They developed a trust ... they got confidence in one person and that’s something that they felt they really needed...out there...in the county.*”

PHNs and managers repeatedly mentioned that limited ability to address social determinants of health, such as poverty, isolation, and lack of resources, was a primary concern regarding rural women’s health. Hazel, a manager, reported, “[Our county dwellers don’t] have a lot of resources and the [PHN] might be the only person that they’re counting on for their information.” The opportunity to be present in the community and getting to know its residents was extremely valued by the public health nurses in addressing health determinants. Alexis noted,

It...speaks to what we do, making connections and empowering people...giving them the opportunity to be able to take that next step to advocate for themselves ... We’re the ones who make that connection to acknowledge their humanity... their suffering.

Managers in the study noted the multi-faceted roles of PHNs in under-served rural areas. Nancy, a senior health unit manager, stated, “*waiting lists [for health] services ... [are] a huge problem. And so the public health nurses end up really filling a role with...supportive counseling and screening and being able to identify people that need to be prioritized.*” Another manager, Helen, recalled,

When [PHNs] were pulled out of schools, the school board and physicians...said “We want our nurses back!” We tried pamphlets and they didn’t want pamphlets, they wanted the nurses.... So, now, they cost share...the salaries of the nurses because they want the one-on-one counseling...precisely [because of] the isolation of the schools from services.

However, study participants noted that recent provincial public health policy directing a more centralized approach to offering programs and services was problematic for rural PHNs and rural residents. The closure of satellite public health offices in rural communities meant that PHNs were no longer readily accessible in rural settings, thereby hindering assessment, relationship building, and intervention inherent to successful public health nursing practice and rural health. PHN Jill shared one of her concerns of satellite office closures, *“We [PHNs] won’t have any visibility, which is a real issue for public health because people [won’t] know how to access us.”* As geographic areas become larger with the closure of rural offices, the ability of nurses to reach clients, and vice versa, will be even more compromised.

In addition, centralization meant that rural residents would now be required to travel to distant centres to obtain public health nursing services. This, too, posed challenges, especially for residents with limited finances and transportation (such as for those with no vehicle or who use horses and buggies), many of whom were the most in need of PHN services. PHN Jill commented on rural transportation issues facing her clients, *“There are challenges with transportation...because most of [our clients] are [at least an hour’s drive away]”*. Several PHNs acknowledged having driven clients to services in their own cars. Sharon and Anita explained this policy-practice disconnect, *“We get reminded we’re not to be taking people in our*

own vehicles...”, “[But] depending on the situation, if we’re out there...there is just no other way”.

Additional issues related to the fact that most public health programs for women were targeted at those in their childbearing years, leaving young women, women with no children or whose children were older, older women and others, with limited or no public health services and programs. PHN Bronwyn explained,

The provincial [public health] mandate [to provide pap smears] is actually for young people under the age of 24.... A lot of health units do [enforce the age restriction], but our philosophy here...is that if you need public health service...then we’ll give it to you. So we recently did a ... drop-in pap clinic. And we did 40 paps [pap smears]... all older women...over 40.

Policy and Managerial Valuing of PHN Practices to Support Rural Women’s Health

Study participants reported that some provincial policies lacked relevance to rural areas. For example, labour and employment policies tended to be developed with an urban focus and, as such, often did not relevantly support rural public health nursing practices. Sharon, a rural PHN, noted, “Some of the legislation that comes out [has] certain ... standards [to protect us nurses] ... And one of our rules ... is about [avoiding] risky premises ... but the definition [of risky premises] is the [same] definition of a rural setting!” Betty added,

You go to leave from teaching a pre-natal class at 9:30 at night. It’s jet black, there aren’t lights and you have to go out to your car. Well you’re supposed to have a personal alarm with you, but who’s going to hear it?” ... “(It’s a good thing) we’ve got our baby scales (to protect us)!

Thus, although the rural contexts in which PHNs work may threaten their or their clients' safety, PHNs in the study found that urban-centric provincial policies offered little or no useful understanding or support for their risky rural work.

Accordingly the needs and contexts of clients sometimes required that PHNs forego policy to provide appropriate and safe care. Sherry recalled a situation, in which she had to disregard health unit policy to ensure that her client received necessary care,

A person came in the middle of winter for clinic and (the government official from the city) said "Oh you need to go back home and get your health card." The (client) said to me, "Well that will take me 6 hours to drive (home in the snow by horse and buggy)." So needless to say, I drove (the client), probably broke all sorts of policy and procedures.

A manager elaborated poignantly on the harsh realities and demands of rural community nursing practice, *"I have covered those (community nursing activities)...and ... it's almost like third world medicine."*

PHNs felt that their work was continually being shifted away from one-to-one services towards a population-based practice that often did not fit with rural practice and rural needs. They noted that one-to-one practice was often more effective in rural settings due to the unpredictability and individuality of health needs in sparsely populated areas, and the need for confidentiality and privacy in rural care. As PHN Sharon commented, *"[People] know everybody...in the doctor's office...[They] don't ...want to access care from [a physician] who's known [them] all [their] life"*. PHNs noted that home visits are essential in ensuring that services can be provided in confidential ways. However, such practice was deemed by health units as contradictory to a changing provincial population-based policy focus, and thus discouraged. For

example, PHNs noted that policy was becoming more restrictive regarding eligibility for home visits. PHN Sheryl commented, *“People that [aren’t] considered at risk aren’t... getting those home visits anymore whereas everybody used to be offered a home visit post-partum. And you would pick up lots of things [during these routine visits].”* Thus local implementation of provincial public health policies made it difficult or impossible to appropriately address rural health needs.

Perspectives about current and future directions for public health nursing practice and policy sometimes varied between managers and PHNs. PHNs in one health unit attributed this disconnect to several factors: management not understanding or valuing the work of front line public health nurses in rural settings, PHNs feeling/being disrespected, and overly directive nurse-manager relationships. PHN Carol commented, *“I don’t know whether they truly ... understand what we do ... on a day-to-day 8:30 to 4:30 basis”*, and PHN Lauren stated, *“We have to be believed too. Like when we’re saying that this is how things are ... we have to have at least internally [at health unit level], if not provincially and federally, some buy-in to our frontline opinion and that doesn’t seem to happen.”* In a PHN interview, when asked about satisfaction with working with administration, the response by the group was a lengthy silence before a PHN finally commented, *“[We can] wait for [administration] retirements and fly under the radar.”*

Having a supportive management team that valued public health nursing and nurse-manager relationships grounded in mutual respect clearly facilitated PHNs’ ability to interpret health policies and work effectively. However, this wasn’t always the case, as Sheryl noted, *“...that used to be a regular thing that you would take your presentation of what you’re doing in your program to the Board of Health and do your presentation [at one of their regular Board*

meetings] but that like I haven't really heard of that being done [recently]". Other PHNs then commented that "*[Now] you're insubordinate [if you contact Board members]*", "*Even though we are residents of the municipalities who they are representing on our Board*". As a result of attempts at silencing and marginalization, PHNs did, from time to time, work around health unit policies in order to serve rural areas in ways that may not be authorized by managers or supported by policy, but that were necessary for effective rural health promotion. Betty commented, "*Well sometimes...we do things. We ask for forgiveness, not permission (laughs)*", and Lauren stated, "*There's really... a ceiling, a definite concrete lead-filled ceiling to get major change happening. But in the meantime, we're all trying to fly under the radar and do what we think is best.*"

Several managers recognized the limited resources available to nurses in rural health units as well as PHN role constraints based on public health policy. Participants noted that policy change was both a valuable and a sensitive process, and one that could be fraught with consequences. Manager Jeff stated, "*Change requires us to...lobby...it can be done but it has to be done carefully and sensibly and it has the potential to place you in conflict and hot water with the folks who you are reporting to.*" PHN Lauren added, "*(Management is) not protected by [a] union ... so their jobs are literally on the line if they speak out of turn and out of line.*"

Evidence Used to Inform Policy, Funding, and Practice

Study participants consistently reported that quantitative, epidemiological data were the primary and priority sources of evidence, "There's a lot of focus on ... what can be evaluated, so numbers...deliverables...things that ... can be tracked." "proof", "impact", "efficiency", and "effectiveness". PHN Gwenyth commented, "[Managers are] always about the numbers...", and

Manager Hazel noted, “Now one of the things we’re in the process of doing right now is ... re-aligning our nursing teams to ... match the neighborhood stats.”

The perceived reliance on quantitative data conflicted somewhat with the type of data PHNs thought was important regarding their practices to promote rural women’s health. They noted that rural women’s health needs were often best served by public health nurses’ relationship building with rural residents and ability to take advantage of vicarious rural contacts to promote health, activities that do not lend themselves to quantitative representation. PHNs recommended evidence that included relational and personal knowledge. Amy provided an illustrative example of the nature and importance of relational practice,

I was giving a screening kit...to...this woman and her six sisters came to the home.... And it was just this big discussion [for] an hour and a half. These women would not access services for months and months unless public health was out there and that’s so important.”

Another PHN recalled,

When I first started working here, you had your own neighbourhoods... people would get to know you, “Oh she’s our nurse” ... So sometimes if there was someone you were concerned about you could ... go up to the house and knock on the door and say “I’m the visiting nurse...and someone down the street mentioned (you) to me”. You could ... do that because people knew ...(you)....

PHNs doubted that their practices were effectively acknowledged or represented by quantitative data. For example, quantitative data that note one visit do not reveal the time and nature of relationship building and trust so essential to rural practice, thereby providing limited understanding and valuing of the nature and impact of rural PHN practice. When numbers only

were used to define effective practice, PHNs believed the number of clients seen took precedence over the value of and time for each public health nurse-client interaction.

PHNs perceived that program funding was based on community statistics, ever-changing and inconsistent provincial funding, and new public health policy mandates. PHNs explained that reliance on these allocations was inappropriate, given the small rural populations that need consistent services and personnel to foster trust and effectiveness, and that funding instability, or “*flavour of the month*” funding as they termed it, adversely affected PHN care. Alexis explained, “*There’s no stability with our funding ... we get something started...we reach out...make connections, then [funding is cancelled] ... So we leave a hole. It’s very frustrating, and it really impacts our care...even more in the rural community.*” Amy explained,

It ... affects your relationship with the health care providers because they lose the trust in your service when you cut (the funding and the program). ... In (one of our small towns, the sexual health program) was there and then (it was) stopped and it was like pulling teeth to get the health care providers, the physician, to buy into it again.

Participants perceived that valuing and retrieving evidence that more accurately and clearly represents their rural practices and rural needs, such as qualitative, case study, and storytelling data, would enhance understanding and support of rural practice and rural women’s health.

Discussion

Study findings suggest a number of significant issues and implications. First, women’s health was viewed and addressed in public health programs and services largely with a focus on women of reproductive years and children. Other women and girls, such as school aged, teens, and young women, women without children or whose children are not of preschool age, older

women, and women with special needs such as those with disabilities, received limited (ie. focused on reproductive services or falls) or no obligation within public health nursing practice and policy.

Such limited PHN care for women is problematic for rural areas for several reasons. Rural areas are comprised of a variety of ages of girls and women, with a growing population of older women (CIHI, 2006). Indeed rural communities could be described as feminized aging communities, as the large cohort of baby boomers remain or move there for retirement and husbands tend to die before wives (Keating, 2008); by 2021 one in four seniors will live in a rural setting (Health Canada, 2002). The rural areas in the three health units in this study include some of the highest numbers of seniors in the province. These populations require and would significantly benefit from the health promotion expertise that public health nurses can provide. Perhaps most significantly, PHNs can travel to clients, rather than clients having to travel to care, thereby helping to ensure that even the most vulnerable and isolated women can receive effective assessment and intervention support.

The health promotion expertise of PHNs is unique and essential in rural settings, as few and often no other health care professionals exist there with this type of expertise (Leipert, 1999; Leipert & Reutter, 1998; Stamler & Yiu, 2012). All three health units in this study had high rates of avoidable mortality from preventable causes. In underserved rural communities that have few resources, such as female health care providers, expanded public health policies and practices would result in significant health promotion resources for vulnerable rural populations, such as women and girls.

Second, participants suggest that policy decisions to centralize public health services in distant urban centers with resultant closure of rural offices are having a significant impact for

rural communities, particularly women, as well as for PHNs themselves. Centralization compromises access to effective knowledge about the needs, resources, and determinants of health of each unique rural setting and the rural women who live there, decreases access to and by PHNs, and hinders health promotion services for vulnerable rural women and girls who can't or won't reach out for support. The most vulnerable, such as those experiencing poverty or abuse, those living with physical or mental impairments, and those with limited access to transportation including certain cultural groups such as Amish women, will be especially exposed to geographic marginalization from health services. This neglectful reduction of access to health care and resources for the most vulnerable is unacceptable. The health of these people requires enhanced access to local rural PHN offices, not centralization of services, as the PHNs and some managers in this study emphasized.

Third, findings reveal that the culture of respect, valuing, and inclusion accorded to rural public health nursing varies among health units. In two health units in the study, PHNs and managers worked collaboratively to try to interpret implementation of provincial public health and local health unit policy as effectively as possible for rural settings. However, in the third health unit, the limited power and voice of PHNs resulted in compromised rural health care for women because PHNs were not able to nurse to their full scope of practice and were instructed to follow the health unit's prescriptive directives instead of executing and promoting their work with professional autonomy. This situation also resulted in extreme dissatisfaction and low morale among PHNs. When managers' exclusion and negation of PHNs' frequent and vehement recommendations advising against the closure of satellite rural offices was discussed during the interview, several PHNs became emotionally upset as evidenced by tears, voices vibrating with frustration, and statements indicating hopelessness and despair.

A primary implication of limited rural PHN power, voice, and expertise is that rural policy, practice, and public health becomes weakened and compromised. Furthermore, nurses are hindered in their ability to fulfill their professional requirement of advocating for health and populations (CNA, 2008). Their practice and work life become unsatisfactory and untenable, moral distress results, and recruitment and retention of PHNs becomes even more problematic (Stewart, et al., 2010). All of these implications result in negative consequences for women who live and work in rural settings.

Fourth, this study revealed that when policies were inappropriate for rural women or rural PHNs, nurses would work through and around these policies to help to ensure that rural women could be supported. Indeed, PHNs felt ethically bound to provide care to their rural populations. Obviously, rural PHNs have commendable commitment and expertise regarding the promotion of rural health, and these merit greater valuing and inclusion in rural policy and practice. However, these findings suggest that effective work by rural PHNs may often remain, and be made to remain, invisible, thereby preventing the sharing, valuing, and support of such practices by other PHNs, managers, and in other rural settings. Concealment of and lack of support for rural expertise and practice serve to disempower and undervalue the professional knowledge and capacity of rural PHNs and impedes the development of healthy rural public policy, practice, and health.

Suggestions for effective rural PHN practice and policy regarding rural women's health include the following:

- Public health units, local boards of health and public health departments at the provincial level should promote meaningful and respectful involvement of PHNs on policy committees, in program development, and regarding other decision-making activities.

- Meaningful and valued inclusion of rural women in developing, interpreting, implementing, and evaluating health policy at the local, regional, and provincial level is needed for effective promotion of rural women's health.
- The development and implementation of provincial level public health nursing consultants and other leadership positions would assist in ensuring consistent, effective, and ethical policies and practices essential to rural women's health and rural public health nursing practice, locally as well as province-wide, and in advocating for needed support, voice, and power to and by rural public health nurses.
- Value and use multiple sources of evidence, both qualitative and quantitative data, to inform provincial and public health unit policy development and implementation to appropriately develop, interpret, implement, and evaluate rural public health practice and policy.
- Public health nurses must maintain and continue to develop firm commitment to political action and advocacy. They need to support each other in these actions, at the health unit, regional, and provincial levels, to ensure effective public health programs and services in rural settings and sufficient and appropriate support for rural PHN practice.

Conclusion

This study, although limited to three health units, has nonetheless revealed that development, interpretation, and implementation of health policies and practices at provincial, regional, and local levels result in both possibilities and problems. Power, position, voice, respect, ethics, inclusion/exclusion, evidence, the needs and resources of rural women and rural PHNs, as well as many other factors, must be respectfully considered and effectively incorporated into rural health if appropriate public health nursing practice, policy, and relevant rural health promotion for women and all rural people are to be achieved and maintained. Opting

out of these commitments is not an option. Rural women, rural public health, and rural public health nursing require and deserve better.

Supporting Agencies

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References

Canadian Institute for Health Information. (CIHI). (2006). *How healthy are rural Canadians? An assessment of their health status and health determinants*. Ottawa, ON, Canada: Author.

Canadian Nurses' Association. (CNA). (2005). Chronic disease and nursing: A summary of the issues. Retrieved from http://cna-aicc.ca/~media/cna/page-content/pdf-en/bg3_chronic_disease_and_nursing_e.pdf

Canadian Nurses' Association (CNA). (2008). *Code of ethics for registered nurses*. Ottawa, ON, Canada: Author.

Canadian Public Health Association. (CPHA). (2010). *Public health –Community health nursing practice in Canada: Roles and activities* (4th ed.). Ottawa, ON, Canada: Author.

Community Health Nurses of Canada. (CHNC). (2010). *A synthesis of Canadian community health nursing reports*. Retrieved from <http://www.chnc.ca/nursing-publications.cfm>

Falk-Rafael, A. (1999). The politics of health promotion: Influences on public health promoting nursing practice in Ontario, Canada from Nightingale to the nineties. *Advances in Nursing Science*, 22(1), 23-29. <http://dx.doi.org/10.1097/00012272-199909000-00004>

Health Canada. (2002). *Canada's aging population*. Ottawa, ON, Canada: Minister of Public Works and Government Services Canada.

- Joint OPHA/Association of Local Public Health Agencies Working Group on Social Determinants of Health. (2010). *Activities to address the social determinants of health in Ontario local public health units*. Retrieved from http://opha.on.ca/getmedia/f583a096-18e4-4f6b-ad14-76de85b31d42/Survey_Report-SDOHinOntarioHealthUnits-20Dec10.pdf.aspx?ext=.pdf
- Joint Task Group on Public Health Human Resources. (JTGPHHR). (2005). *Building the public health workforce for the 21st century*. [Archived] Retrieved from Government of Canada Publications. Retrieved from <http://publications.gc.ca/site/eng/home.html>
- Keating, N. (Ed.). (2008). *Rural ageing: A good place to grow old?* Bristol, UK: The Policy Press. <http://dx.doi.org/10.1332/policypress/9781861349019.001.0001>
- Kulig, J., Macleod, M., Stewart, N., & Pitblado, R. (2012). Rural health. In L. Stamler & L. Yiu (Eds.), *Community health nursing: A Canadian perspective* (3rd ed.) (pp. 363-374). Toronto, ON, Canada: Pearson.
- Leipert, B. (1999). Women's health and the practice of public health nurses in northern British Columbia. *Public Health Nursing, 16*, 280-289.
<http://dx.doi.org/10.1046/j.152546.1999.00280.x>
- Leipert, B. (2013). Rural and remote women and resilience: Grounded theory and photovoice variations on a theme: An update. In C. Winters (Ed.), *Rural nursing: Concepts, theory, and practice* (4th ed.; pp. 95-117). New York, NY: Springer.
- Leipert, B., Leach, B., & Thurston, B. (2012). *Rural women's health*. Toronto, ON, Canada: University of Toronto Press.

- Leipert, B., Landry, T., & Leach, B. (2012). Closing the gap: Rural women's organizations and rural women's health in Canada. In B. Leipert, B. Leach, & W. Thurston (Eds.), *Rural women's health* (pp.62-79). Toronto, ON, Canada: University of Toronto Press.
- Leipert, B., Matsui, D., Wagner, J., & Rieder, M. (2008). Rural women and pharmacologic therapy: Needs, issues, and solutions in rural Canada. *Canadian Journal of Rural Medicine*, 13(4), 171-179.
- Leipert, B., & Reutter, L. (1998). Women's health and community health nursing practice in geographically isolated settings: A Canadian perspective. *Health Care for Women International*, 19, 575-588. doi: 10.1080/073993398246133
- Leipert, B., & Reutter, L. (2005). Developing resilience: How women maintain their health in northern geographically isolated settings. *Qualitative Health Research*, 15(1), 49-65. <http://dx.doi.org/10.1177/1049732304269671>
- Lincoln, Y., & Guba, E. (1985). Establishing trustworthiness. In Y. Lincoln & E. Guba (Eds.), *Naturalistic inquiry* (pp. 293-331). Newbury Park, CA: Sage.
- Ministry of Health and Long-Term Care. (MOHLTC). (2010a). *Rural and northern health care report: Recommendations*. Retrieved from http://www.health.gov.on.ca/en/public/programs/ruralnorthern/docs/recommendations_rural_northern_EN.pdf
- Ministry of Health and Long-Term Care. (MOHLTC). (2010b). *Rural and northern health care report: Executive summary*. Retrieved from http://www.health.gov.on.ca/en/public/programs/ruralnorthern/docs/exec_summary_rural_northern_EN.pdf
- Ministry of Health and Long-Term Care. (MOHLTC). (2011). *2009 Annual Report of the Chief Medical Officer of Health of Ontario to the Legislative Assembly of Ontario*. Retrieved

from http://www.health.gov.on.ca/en/common/ministry/publications/reports/cmoh_09/cmoh_09.aspx

Ontario Nurses' Association. (2011). ONA calls for transparency from Grey Bruce Health Unit: Secrecy, lack of communication shown as service availability decreased. Retrieved from http://www.ona.org/news_details/grey_bruce_unit_closes_walkerton_office_20111201.html

Ontario Nurses' Association. (2012, April 30). Haldimand-Norfolk Public Health Nurses Forced on Strike: Updates Here! [Media release]. Retrieved from http://www.ona.org/news_details/haldimand-norfolk_PHN_strike_20120423.html

Ontario Nurses' Association. (2013, March 1). Huron County Public Health Nurses at Mediation: Legal Strike Deadline is Tomorrow. [Media release]. Retrieved from http://www.ona.org/news_details/Huron_PHN_legal_strike_20130301.html

Patton, M. (2002). *Qualitative research & evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.

Public Health Agency of Canada. (2012). Preventing chronic disease strategic plan 2013-2016. Retrieved from http://www.phac-aspc.gc.ca/cd-mc/diabetes-diabete/strategy_plan-plan_strategique-eng.php

QSR International Pty Ltd. (2010). NVivo qualitative data analysis software Version 9. Burlington, MA.

Stamler, L., & Yiu, L. (2012). *Community health nursing: A Canadian perspective*. Toronto, ON, Canada: Pearson.

Statistics Canada (2012). Census profile. Ottawa, ON, Canada: Author. Retrieved from <http://www12.statcan.gc.ca/census-recensement/2011/dp-pd/prof/index.cfm?Lang=E>

- Statistics Canada (2014). Health profile. Ottawa, ON, Canada: Author. Retrieved from <https://www12.statcan.gc.ca/health-sante/82-228/search-recherche/lst/page.cfm?Lang=E&GeoLevel=PR&GEOCODE=35>
- Stewart, N., D'Arcy, C., Kosteniuk, J., Andrews, M., Morgan, D., Forbes, D., ...Pitblado, R. (2010). Moving on? Predictors of intent to leave among rural and remote RNs in Canada. *Journal of Rural Health*. <http://dx.doi.org/10.1111/j.1748-0361.2010.00308.x>
- Sutherns, R., McCallum, M., & Haworth-Brockman, M. (2008). A thematic bibliography and literature review of rural, remote, and northern women's health in Canada 2003-2006. *Resources for Feminist Research*, 32 (3/4), 142-178.
- Sutherns, R., & Haworth-Brockman, M. (2012). Looking back and forging ahead: Rural women's health research and policy in Canada. In B. Leipert, B. Leach, & W. Thurston (Eds.), *Rural women's health* (pp.31-45). Toronto, ON, Canada: University of Toronto Press.
- The Ontario Rural Council. (TORC). (2009). *The TORC Report on Rural Health*. Retrieved from <http://ruralontarioinstitute.ca/file.aspx?id=1fb3035d-7c0e-4bfa-a8d7-783891f5c5dc>
- The Ontario Seniors' Secretariat. (2013). Ontario's action plan for seniors. Retrieved from <https://dr6j45jk9xcmk.cloudfront.net/documents/215/ontarioseniorsactionplan-en-20130204.pdf>
- Thorne, S. (2008). *Interpretive description*. Walnut Creek, CA: Left Coast Press.
- Thorne, S., Reimer Kirkham, S., & O'Flynn-Magee, K. (2004). The analytic challenge in interpretive description. *International Journal of Qualitative Methods*, 3(1), 1-21.
- Ulin, P., Robinson, E., & Tolley, E. (2005). *Qualitative methods in public health: A field guide for applied research*. San Francisco, CA: Jossey-Bass.