Policies and Practices of Rural Public Health Nurses to Promote Rural Women's Health

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Purpose of the Study

- Analyse policy documents relevant to rural public health nursing in Ontario regarding rural women's health
- Identify organizational attributes that enable or impede the work of public health nurses to improve rural women's health
- Critically examine public health nurses' (PHN) roles and practices that will improve rural women's health

Study Background

- Rural people have higher morbidity and mortality rates than urban counterparts e.g. up to 16 years less life expectancy (CIHI, 2006)
- Rural women are especially vulnerable e.g. by 2021 one in four seniors will live in a rural setting, most will be women (Health Canada, 2002)
- "Reducing the health gap…is only possible if the lives of girls and women – about half of humanity – are improved and gender inequities are addressed. Empowering women is key…" (WHO, 2008, p. 22).
- Rural people prefer care from people they know and trust (Leipert, 2012; Sutherns, McPhedran, & Haworth-Borckman, 2004)

Study Background

- Re: rural PHNs:
  - have unique expertise in health promotion, illness & injury prevention, social determinants of health
  - the only professional with such expertise in rural areas
  - the only female health care provider in many rural areas
  - hollowing out of public health, public health nursing, and rural PHNs in Canada in recent years
  - very little research available re: rural PHNs and rural women's health.

(CHNAC, 2010; CPHA, 2010, Leipert, 1999, 2010; Leipert & Reutter, 2005)

Study Methods

- 57 number of policy documents analysed – government, health unit, rural, women's health, nursing, public health nursing
- 14 PHN administrators & supervisors (including 1 MOH) and 20 PHNs interviewed in 3 public health units southwest Ontario
- Each group interviewed separately in focus groups of 2 hour duration.

Governance Structure of Public Health Units in Ontario

Findings: Interviews with Public Health Nurses

- Practices becoming centralized in urban setting – due to cost saving, and health unit interpretation of provincial policies.
  Result: - less accessible to rural communities
  - less knowledgeable about rural health issues
  - less able to tailor services to rural needs
  - PHNs have little influence in this centralization
- Rural women's health addressed programmatically and traditionally e.g. reproductive and child health; gaps in health services e.g. no care focused on middle-aged or older women
- PHNs work through and around policies to address rural women's health e.g. visits, transport of clients, cultural issues

Quotes by Public Health Nurses

"Sometimes we do things…we ask for forgiveness, not permission."

"I was giving a screening kit…to…this woman and her 6 sisters came to the home because they had things to talk about. 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."

"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."

Findings: Interviews with PHN Managers & Administrators

- Are key intermediaries in translating provincial and health board level policies to PHN practice.
- History, personal and professional relationships, education level, status, and power affect the nature and enactment of roles regarding policies.
- Supportive managers are key to effective rural PHN practice, e.g. within and around policy.

Quotes by Managers and Supervisors

"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."

"When [PH]nurses were pulled out of schools, the school board and physicians…said we want our nurses back. We tried pamphlets and they didn't want the pamphlets, they wanted the nurses back. So, now, they cost share…the salaries of the nurses because they want the one-on-one counselling…precisely [because of] the isolation of the schools from services."

Findings: Organizational Attributes

- Inconsistent and insecure funding for programs ie. "flavor of the month"
- Evidence is primarily quantitative/epidemiological; qualitative evidence (e.g. PHN day to day lived experience) undervalued, discounted, ignored
- Some disconnect between policy and what PHNs perceive needs to be done e.g. urban vs. rural, health promotion, community development, individual vs. population care, etc.
- Prevention favored over [individual] health promotion e.g clinics vs. home visiting

Discussion

- Centralizing of public health services – urban centric policies don't work in rural areas. "One size does not fit all."
- Undermining of PHN credibility, ability, effectiveness, satisfaction, and morale.
- [In] effective rural policy formulation, implementation, and evaluation:
  - Where are the public health nurses?
  - Where are the rural women?
  - Where is health promotion?

"Geography should never be an excuse for discrimination or inequity in health".

Allan Rock
Former Minister of Health