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## Placed-Based Rural Public Health Policy

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Graduate Program in Nursing

A thesis submitted in partial fulfillment of the requirements for the degree in Master of Science

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# PLACE-BASED RURAL PUBLIC HEALTH POLICY

(Thesis format: Integrated Article)

by

Angela Jurich

Graduate Program in Nursing

A thesis submitted in partial fulfillment  
of the requirements for the degree of  
Masters of Science in Nursing

The School of Graduate and Postdoctoral Studies  
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London, Ontario, Canada

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## Abstract

Attention to place in public health policy development at the provincial level often overlooks the specific and unique needs of rural places. The principle aim of this research was to explore whether and how “place” was considered in the context of rural Ontario public health policy implementation for chronic disease prevention (CDP) programs. A secondary analysis of focus group and interview data along with the policy documents from three rural Ontario public health unit sites for the primary Renewal of Public Health Systems (RePHS) study was conducted. Based on a review of the literature on rural health policy and place-based policy, a framework of characteristics was developed and used to analyze the focus group/interview transcripts and policy documents. Qualitative description design and content analysis methods were used to guide this research. Study findings suggest that “place” is a key factor in the implementation of rural public health policy at the local level. The unique characteristics of each rural place with respect to capital, community involvement, evidence-informed decision-making, intersectoral collaboration, longevity and commitment, and skilled management were considered to be important considerations in rural public health policy implementation. This study is one of the first to describe how “place” is incorporated into rural public health policy implementation.

Keywords: place, place-based policy, rural health policy, public health policy

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## CHAPTER ONE

The impact of place on health has been a widely researched area of study (Andrews, 2002; Cummins, Curtis, Diez-Roux, & Macintyre, 2007; Curtis & Jones, 1998; Davidson, Mitchell, & Hunt, 2008; Leipert, 2005). Many researchers conclude that place of residence can have a significant impact on one's health (Canadian Institute for Health Information [CIHI], 2006; Forbes & Janzen, 2004; Hart, Larson, & Lishner, 2005; Williams & Kulig, 2012; Leipert, 2005; Romanow, 2002). Although a relationship between place and health has been identified, how to incorporate place into health policy, specifically how policies are implemented at the local level, is less understood. Policy is “a course of action or inaction chosen by public authorities to address a given problem or interrelated set of problems” (Pal, 2010, p. 2). Governments are increasingly recognizing the importance of local implementation of provincial policy, particularly health policy (Ministry of Health and Long-Term Care [MOHLTC], 2011). Place-based policy is an area of policy theory that considers how place impacts and influences health policy development and implementation (Bradford, 2005; 2008; Castle & Weber, 2006; Mueller & MacKinney, 2011).

### Background

Place-based policy is a new and developing approach to public policy development and implementation in Canada and the United States (Bradford, 2005; Cummins et al., 2007; Mueller & MacKinney, 2011). Place-based policy is a term used to describe public policy that is designed to meet the needs of particular “places”. Each community or place has unique social, environmental, behavioural, and contextual factors that impact policy development and implementation. Place-based policy theory



recognizes that each place is unique with respect to demographics, geography, resources, and needs, and that public policy should reflect these unique differences. Policies developed at the federal and provincial level often fail to meet the specific needs of local communities, particularly rural communities (Berkowitz, Ivory, & Morris, 2002; Mueller & MacKinney, 2011). Policy-makers may not consider how policies are implemented and managed in rural communities with limited financial resources and significant workforce shortages (Berkowitz et al., 2002). The role of the federal and provincial governments are to create policies that provide framework conditions and support for local initiatives (Organization for Economic Co-operation and Development [OECD], 2002).

Characteristics of place-based policy such as capital, local community involvement, evidence-informed decision making, intersectoral collaboration, longevity and commitment, and skilled management may facilitate policy development and implementation by sensitizing decision-makers to local context (Bradford, 2008).

Place of residence can have a significant impact on one's health and wellbeing (CIHI, 2006), which must be a consideration in policy development and implementation. Canada's rural population has been declining since 1970 due to outmigration of younger residents for education and employment opportunities (Bollman, 1999; Bryant & Joseph, 2001). It is estimated that over six million Canadians are considered to be rural-dwelling (Bryant & Joseph, 2001; CIHI, 2006). However, across rural Canada, population and living conditions can differ significantly, from small towns and villages, to agricultural and farming land, to undeveloped areas, to remote and wilderness regions (Williams & Kulig, 2012; Ministry of Northern Development, Mines and Forestry [MNDMF], 2010). These differences between rural communities can pose challenges for how policy is

implemented at the local level (Racher, Vollman, & Annis, 2004; Williams & Kulig, 2012). Rural communities experience many demographic, economic, and social threats related to geographic isolation, outmigration, population aging, and diminishing natural resources (CIHI, 2006; Kumar, Acanfora, Hennessy, & Kalache, 2001; Ryan-Nicholls, 2004). According to Romanow (2002), geographic location is a significant determinant of health in rural populations.

Chronic diseases are the leading cause of death and disability in Ontario (Statistics Canada, 2009). Older adults make up a considerable portion of the rural population and many are living with one or more chronic illness (CIHI, 2006; Robinson, Pesut, & Bottorff, 2010). In Canada, one third of the senior population resides in rural areas and that number is expected to grow in the future as the “baby boomer” generation continues to age (Dandy & Bollman, 2008). The aging rural population can be attributed to the younger generations leaving rural communities for education and job opportunities, and the older generations’ attraction to peaceful and spacious rural areas as they retire (Dandy & Bollman, 2008). As a result, many rural Canadian communities are facing a shift in their economic base (CIHI, 2006). In comparison to urban residents, rural dwellers in Canada have a greater likelihood of being of low socioeconomic status, having lower educational attainment, being involved in jobs that pose a hazard to their health, and exhibiting high risk health behaviours (CIHI, 2006; Forbes & Janzen, 2004; Mainous & Kohrs, 1995; St. John, Havens, van Ineveld, & Finlayson, 2002). Rural people often have poorer health status with higher levels of morbidity and mortality (CIHI, 2006; Hart et al., 2005; Romanow, 2002). In addition, rural residents have lower life expectancy and higher levels of physical impairment and chronic illness (Forbes &

Janzen, 2004; Mainous & Kohrs, 1995). Rural communities have higher proportions of people who smoke and a greater portion of individuals who are overweight and obese (CIHI, 2006). Public health programs and services can have an important role in chronic disease prevention and health promotion at the local level.

In Ontario, there are 36 public health units (MOHLTC, 2011). Among the roles of public health are: to educate the public about healthy-lifestyles, communicable disease control and education, immunization, health inspections of food delivery facilities, health education for all age groups to promote healthy growth and development, and certain screening services (MOHLTC, 2011). Policies such as the Ontario Public Health Standard (OPHS) (Ministry of Health and Long-Term Care [MOHLTC], 2008), provincial legislation setting out the minimum required public health programs, influence the services delivered by public health units (MOHLTC, 2008). Public health program delivery occurs predominantly at the community level and in considerably different cultural environments (MOHLTC, 2012).

The culture of a “place” refers to the geographic, social and economic features that shape the way community members view the world (Farmer et al., 2012). Culture can be defined as “learned and shared knowledge, norms, behaviours, values, attitudes and beliefs of a social group” (Farmer et al., 2012, p.246). Culture not only varies from place to place but it can also vary within a place (Farmer et al., 2012). The culture(s) within and across communities can have an impact on the effectiveness of health interventions and outcomes at the local level (Farmer, 2012).

As part of a Canadian Institutes of Health Research funded study, investigators on the Renewal of Public Health Systems ([RePHS], 2010) study are conducting a multi-

phase case study of implementation of public health renewal policies in British Columbia and Ontario including the OPHS in six Ontario public health units. This thesis is a qualitative secondary analysis study and encompassed data collected from the three rural Ontario public health units in the first phase of the RePHS (2010) study. The purpose of this study was to examine how place is discussed in the context of rural public health policy implementation.

### **Significance**

Place is often overlooked or not considered in health policy implementation (Liepert & Reutter, 2005). Rural communities have unique differences, however, studies indicate that rural dwellers are involved in more high risk health behaviours and experience more chronic illness than their urban counterparts. Public health programs in Ontario, such as the chronic disease prevention (CDP) program, can address the health of rural dwellers by implementing policies that are place specific. The OPHS (MOHLTC, 2008) are currently being implemented in Ontario, which creates an ideal opportunity to examine how place is being considered in public health policy implementation for the CDP programs. This study is significant in three key ways. First, findings from this research study may contribute to knowledge development and understanding in the area of place-based policy. It is anticipated that such knowledge will foster enhanced understanding of policy, specifically place-based policy for public health nurses and other health professionals in the public health field. By including the voices of public health nursing staff and management, this research will provide nurses with a practical understanding of place-based policy within the context of public health nursing. Secondly, findings from this study provide important insights for public health managers

and policy-makers on how place shapes and influences policy implementation and that could lead to the improvement of place-based public health policies. Lastly, this research will advance knowledge on policy, contributing to the limited amount of Canadian place-based health policy research that is presently available. Nurses have acknowledged the need for more policy content in both education and research in order to become more effectively involved in the development and implementation of health policy (Gebbie, Wakefield, & Kerfoot, 2000).

### **Literature Review**

Minimal scholarly research has been conducted on place-based policy specifically, as it is a fairly new area of study. Much of the literature available to the topic of place-based policy is in the form of commentaries, review articles, and conceptual papers. Many researchers have studied the relationship between place and health (Cummins et al., 2007; Curtis & Jones, 1998; Davidson et al., 2008; Frumkin, 2003; Macintyre, Ellaway, & Cummins, 2002) with a focus on the effects rural living can have on one's health (Bryant & Joseph, 2001; Hartley, 2004; Leipert, 2005; Leipert & George, 2008; Sjolund, Nordberg, Wimo, & Strauss, 2010; Wanless, Mitchell, & Wister, 2010). The researchers were unable to find any research studies on place-based policy, specifically within the context of rural public health. However, there is a vast body of research on place and health, specifically rural places and health. This research highlights the significance place of residence can have on the health and well-being of a population. Place is recognized as an important determinant of health, effecting individuals access to health services as well as education and employment opportunities (Cummins et al., 2007; Curtis & Jones, 1998; Ryan-Nicholls, 2004). Place of residence also influence the

health concerns people face as well as the way individuals experience and construct health (Curtis & Jones, 1998; Davidson et al., 2008). Both individual factors (smoking, cardiovascular risk factors, baseline health status) and contextual factors (material infrastructure, social class, unemployment rates) contribute to spatial variations in health making it difficult to determine what effect place has on health (Cummins et al., 2007; Curtis & Jones, 1998; Macintyre et al., 2002). Yet many of the studies on place and health assert that “place” be considered in the development and implementation of health policy at the local level (Cummins et al., 2007; Curtis & Jones, 1998; Davidson et al., 2008; Frumkin, 2003; Macintyre et al., 2002). Place-based policy may be an effective policy solution to address “place” related health policy challenges (Bradford, 2008; Cummins et al., 2007, Mueller & Mackinney, 2011).

### **Relevance to the Nursing Profession**

In order to promote evidence-based practice, it is imperative that nurses conduct and utilize research. In addition, it is crucial for nurses to develop and possess a strong understanding of policy in order to become more politically astute and active. Nurses possess a deep understanding of the reality of health care, making them key players in the policy arena (Deschaine & Shaffer, 2003). Nurses realize that health care extends over a variety of settings, involves people at their most vulnerable, and offers a view of health from multiple perspectives (Gebbie et al., 2000). Effective involvement in public health policy development is essential for nurses in a health care environment that is quickly changing and affected by health care reform, limited resources, and decreased access to health care services for vulnerable populations such as the rural population (Deschaine & Schaffer, 2003; Leipert, 2005).

### **Statement of the Problem**

Place-based policy is a new approach to policy development and implementation in Canada and around the world (Bradford, 2005; 2008) and, to date, there has been little research focused on the area of place-based policy. Rural Ontario is currently faced with numerous political, environmental, social, health, and economic challenges that are worsening as the population in rural communities continues to decline and age (CIHI, 2006). The Ontario government has identified the importance of rural health as a priority for policy development and implementation (MOHLTC, 2011). Place-based policy is argued to be an effective solution to ambiguous public policy issues (Bradford, 2005), especially those within the context of rural health. Rural health policy by its nature must include a focus on place and a place-based approach may offer an opportunity to examine rural health from a different perspective than has traditionally been applied. Examining current rural public health policies for the extent to which they align with the characteristics of place-based policy will provide insight on the utility of this approach for policy development and implementation.

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## CHAPTER TWO

The effect of geographical location on health is an important area of inquiry in the fields of sociology, geography, and nursing (Andrews, 2002; Cummins, Curtis, Diez-Roux, & Macintyre, 2007; Curtis & Jones, 1998; Davidson, Mitchell, & Hunt, 2008; Leipert, 2005). However, the incorporation of context and geography into health policies, particularly in how they are implemented, is not well understood. An emerging area of policy theory examines how place is incorporated into health policy.

Place-based policy, as this is known, is still an emerging area of investigation in Canada and the United States (Bradford, 2005; 2008; Castle & Weber, 2006; Mueller & MacKinney, 2011). Canada's substantial land mass and widespread rural population make it challenging for policy makers to effectively implement federal or provincial healthcare policies that are relevant at the local or community level (Adams & Hess, 2001; McKenzie & Wharf, 2010; Moscovice & Rosenblatt, 2000). Place-based policies are specific, appropriate, and valuable to the communities they are designed to affect, making them particularly relevant to rural places that often struggle to implement and manage policies that were created with an urban lens (Berkowitz, Ivory, & Morris, 2002). Effective place-based policies can influence the development and advancement of rural communities and ensure that policy implementation considers their unique contexts (Mueller & MacKinney, 2011).

### **Background and Significance**

There has been an increasing awareness of the importance of place in public policy development and implementation (Bradford, 2005; Cummins et al., 2007; Mueller & MacKinney, 2011). Many researchers have published conceptual papers on the topic of

place and health, arguing that: 1) place is a better focus for public policy interventions than individual behaviour change (Curtis & Jones, 1998); 2) policy processes that include individuals whom they will impact are more likely to result in outcomes that correspond to the needs they intend to address (Adams & Hess, 2001); and 3) an understanding of the roles of each level of government is necessary in order to deliver effective policy interventions targeted at people and places (Cummins et al., 2007).

The incorporation of “place” into public policy implementation is referred to as place-based policy. Mueller and MacKinney (2011) define place-based policies as policies intended and designed for places rather than programs. Place-based policies are neighbourhood- and community-specific with interventions that respond to the unique needs of places, utilizing a bottom-up (e.g. local lead) rather than a traditional top-down (e.g. government directed) approach to policy implementation (Bradford, 2005). The aim of place-based policy is “both better government policy and more community capacity” (Bradford, 2005, p. 19). A place-based approach to policy aligns with principles of collaboration, negotiation, social dialogue, and community capacity associated with bottom-up approaches to policy development and implementation (Bradford, 2008; Castle & Weber, 2006; Locke, Powers, Felt, & Close, 2006).

### **Rural Health and Policy**

Rural communities, particularly those communities with limited financial resources and significant workforce shortages, may not be well served by provincial initiatives, which fail to recognize how health policies are implemented and managed locally (Berkowitz et al., 2002; Mueller & MacKinney, 2011). Rural places face unique challenges related to decreased or declining populations and greater distances to health

services (Canadian Institute for Health Information [CIHI], 2006; Wong & Regan, 2009). Rural people often have poorer health status with higher levels of morbidity and mortality than urban persons (CIHI, 2006; Hart, Larson, & Lishner, 2005; Romanow, 2002). In addition, rural residents have lower life expectancy and higher levels of physical impairment and chronic illness such as diabetes, arthritis, circulatory disease, and respiratory disease (Forbes & Janzen, 2004; Mainous & Kohrs, 1995), have higher proportions of people who smoke and a greater portion of individuals who are overweight and obese (CIHI, 2006). Rural communities face additional obstacles as a result of vast geography and limited community agencies (Leipert & Reutter, 2005).

Wong and Regan (2009) conducted a descriptive qualitative study across six rural communities in British Columbia to examine patients' perspectives on how health services could be delivered equitably to rural communities. Participants discussed the lack of health care professionals and services, the inability to maintain a continuous relationship with a care provider, and insufficient transportation services in their rural communities (Wong & Regan, 2009). More than three quarters of the participants in this study reported having one or more chronic illness and the mentioned barriers were identified as having a negative impact on their ability to receive adequate health care (Wong & Regan, 2009). According to Leipert and Reutter (2005), rural northern settings are more isolated and experience harsher environmental conditions than rural southern settings. As a result of these obstacles, diagnosis, treatment and care of adverse health conditions are often delayed (McConigly et al., 2010). In addition, advances in health services technology make it difficult for sparsely populated rural communities to keep



up-to-date with the latest health equipment (CIHI, 2006). The cost of new health care equipment is usually only warranted in urban communities (CIHI, 2006).

There are a number of positive factors associated with rural living, including resiliency (Hegney et al., 2007; Williams & Kulig, 2012; Leipert & Reutter, 2005), a sense of community (Davis & Magilvy, 2000), and increased self-sufficiency (Skinner et al., 2008). A qualitative study of rural women in northern British Columbia, Canada, revealed that resilience was an essential component of northern women's health (Leipert & Reutter, 2005). Resilience was developed by becoming hardy, making the best of the north, and supplementing the north (Leipert & Reutter, 2005). Resilience helped the women increase their courage, confidence, and skills to maintain their health (Leipert & Reutter, 2005). Similarly, a quantitative study of resilience discovered high levels of resilience in rural older adults, suggesting that resilience levels do not decrease as one ages (Wells, 2009). In addition, this study found a weak correlation between resilience and physical health, indicating that declining health status may not affect one's resilience level (Wells, 2009). With respect to the rural environment, Thomlinson, McDonagh, Crooks, and Lees (2004) examined the health beliefs of rural Canadians. The peaceful, calming nature of rural settings was believed have a positive effect on the health and wellbeing of rural dwellers (Thomlinson, McDonagh, Crooks, & Lees, 2004). Findings also revealed that rural Canadians enjoy the space, safety, and comfort associated with rural living (Thomlinson et al., 2004). Although self-sufficiency and social support can be viewed as positive factors associated with rural living, there is still a significant lack of local services available to meet the health and social needs of rural people (Williams & Kulig, 2012; Skinner et al., 2008). On the other hand, with limited community supports in

rural places, rural persons experience advantages related to strong social support built among a small number of community stakeholders (Davis & Magilvy, 2000; Williams & Kulig, 2012; Mueller & MacKinney, 2001). This strength may enable local engagement in the process of policy implementation (Swanson, 2001). Provincial health policies rarely have the same effect on both urban and rural communities (Berkowitz et al., 1998). The impact place of residence can have on one's health and wellbeing has significant implications for health policy implementation. Drawing attention to the challenges and benefits associated with rural living makes it easier to appreciate the complex nature of rural communities. Therefore, a place-based policy analysis framework may be an effective strategy for the development, implementation, and evaluation of rural public health policy (Castle & Weber, 2006; Hartley, 2004; Mueller & MacKinney, 2011), responding to specific community challenges while drawing from the ideas and resources of community residents (Adams & Hess, 2001; Bradford, 2005). Rural women's health researchers, Leipert and Reutter (2005), recommend that rural health policy should be a collaborative process that allows rural community members to contribute to policy development and implementation. Leipert and Reutter (2005) also note that although policy documents acknowledge the impact of rural environment on health, few policies actually address this issue.

### **Public Health Policy**

As part of a policy framework, the organization of public health services, foundational to the delivery of health promotion and disease prevention programs at the local level, can be quite challenging given Canada's extensive geography and widespread population (Health Canada, 2003). Local public health units are accountable for the

planning and delivery of services that meet the requirements and regulations set in provincial and federal legislation (Health Canada, 2003).

In 2008, in response to the renewal of public health services in the province, the Ontario government implemented new public health standards, the Ontario Public Health Standards or OPHS (Ministry of Health and Long-Term Care [MOHLTC], 2008). These standards set out the statutory expectations of public health boards, the Medical Officer of Health, and health units. Ontario public health units have been implementing the OPHS as mandatory requirements for public health programs and services, which include assessment and surveillance, health promotion and policy development, disease and injury prevention, and health protection (MOHLTC, 2008). As set out by the OPHS, each local health unit has some flexibility in programming with respect to specific community needs, as many of the requirements set out in the OPHS are to be achieved through partnerships with local government and non-government organizations that differ from community to community (MOHLTC, 2008).

Rural communities, particularly those with inadequate financial and human resources can be limited to providing only the most basic health services; public health is often a significant aspect of service delivery in these communities (Berkowitz et al., 2002; Kitly, 2007). However, rural public health units often have limited programs and functions and health human resources issues (MOHLTC, 2008; Health Canada, 2003), that may create challenges to meet the requirements of the OPHS.

As part of a Canadian Institutes of Health Research funded study of the implementation of the public health renewal policies in BC and Ontario, investigators on the Renewal of Public Health Systems (RePHS) study are conducting a case study on the

implementation of the OPHS in six Ontario public health units. This qualitative secondary analysis study analyzed data collected from the three rural Ontario public health units in the first phase of the RePHS study (Renewal of Public Health Systems [RePHS], 2010). The purpose of this study was to examine how place is discussed in the context of rural public health policy implementation.

### **Literature Review**

A review of the literature related to place and health and place-based rural public health policy was conducted across multiple disciplines, including nursing, medicine, sociology, and geography. Literature was accessed through journal databases, including CINAHL, Proquest, Scopus, and JSTOR. The keywords selected to facilitate the search for pertinent literature were: rural, health, nursing, chronic illness, public health, place and place-based policy. No studies were found that focused specifically on place-based policy.

There were, however, many papers found discussing: 1) the relationship between place and health (Cummins et al., 2007; Curtis & Jones, 1998; Davidson et al., 2008; Frumkin, 2003; Macintyre, Ellaway, & Cummins, 2002), and 2) the effect of rural places on health (Bryant & Joseph, 2001; Hartley, 2004; Leipert, 2005; Leipert & George, 2008; Sjolund, Nordberg, Wimo, & Strauss, 2010; Wanless, Mitchell, & Wister, 2010). Common to these papers is the assertion that policies need to consider the effect of rural places on the health of rural dwellers and the role of place in health policy development and implementation.

The literature review yielded some conceptual papers on place and health. In one of the early conceptual papers on geography and health, British geographers Curtis and

Jones (1998) assert that geographic setting can influence how socially disadvantaged individuals experience health disadvantage. They suggested that policies designed to affect health concerns experienced by specific groups of individuals may not be equally effective in every geographic setting and that place is a better focus for public policy interventions than individual behaviour change (Curtis & Jones, 1998). In addition, characteristics of the collective social group and physical environments will need to be addressed in order to reduce health inequities (Curtis & Jones, 1998). Curtis and Jones (1998) define place in the context of health inequality as “a particular area or region in which various social and economic processes come together in combinations which may be specific to the place and may themselves be influenced by conditions prevailing in the locality” (p. 647).

Cummins Curtis, Diez-Roux, & Macintyre (2007) contend that there need not be a dichotomy between people and place. They suggest that a “relational” view of place encourages us to envision place in terms of the social relations and physical resources that exist in the context of particular locations, while the conventional view regards place in terms of geography alone (Cummins et al., 2007). Cummins et al. (2007) propose that places are not separated by physical distance but rather by socio-relational distance, area definitions and characteristics are dynamic and fluid as opposed to being static and rigid, and contextual factors of places are described variably rather than consistently by different individuals and groups. In order to understand how place influences health, Cummins et al. (2007) offer the following three suggestions: 1) a joint relationship exists between people and place, 2) individuals’ personal geography through places and contexts over time provides insight into how environments impact health with respect to

location and duration and how individual characteristics facilitate that relationship, and 3) an understanding of appropriate levels of government from local to global and the role of actors in each is necessary in order to deliver effective policy interventions targeted at people and places.

In their conceptual paper on the effects of place on health, Macintyre, Ellaway, and Cummins (2002) suggest that there is conflicting evidence on the local or “area” effects on health which may be a result of inconsistent conceptualizations and operationalisations of area effects. The authors note that there are many factors that contribute to how places influence health, including material infrastructure and social functioning that may not be accounted for when studying the effects of place on health. Macintyre et al. (2002) list five features of local areas that may influence health: physical environment shared by all individuals in a place (air quality, water, climate); availability of healthy environments (work, home, leisure); public and private services provided (education, transportation, policing, welfare services); socio-cultural attributes of a neighbourhood (economy, norms and values, crime levels, ethnic and religious composition); and the reputation of the area. The first three categories can be categorized as material infrastructure whereas the last two categories relate to social functioning (Macintyre et al., 2002). The authors also suggest that a starting point for conceptualizing and measuring the place effects on health is to consider Maslow’s hierarchy of human needs and what individuals need in order to live a healthy life (Macintyre et al, 2002).

Yeboah (2005) asserts that place-based health planning enhances the potential for positive community outcomes by detecting and prioritizing local health needs through

collaboration with local community groups and service providers. The author describes the following as benefits of place-based health planning: community members are motivated to contribute to the success of the plan because they are a part of the plan; higher policy implementation rates occur; involvement of local community members reduces the time taken to identify community needs; and local community support for policy exists because the community is involved (Yeboah, 2005).

Although a number of authors recommended that place be incorporated into health policies (Adams & Hess, 2001; Cummins et al., 2007; Curtis & Jones, 1998; Patychuk, 2007; Yeboah, 2005), the researcher was unable to find any scholarly research studies that have been conducted on place-based policy specifically as it is a relatively new area of study. The lack of research on the topic emphasizes the need for exploratory research on place-based policy.

### **Conceptual Framework**

The following framework (Figure 1) was developed by the researcher for this thesis research from a synthesis of the literature on place-based policy (Bradford, 2005; 2008; Castle and Weber, 2006; Cummins et al., 2007; Locke et al., 2006; Mueller & MacKinney, 2011) to serve as the conceptual framework for this investigation. There is some variation in the current literature on the key components of place-based policy. The place-based policy analysis framework has been adapted from a combination of existing place-based policy frameworks (Bradford, 2005; 2008; Castle & Weber, 2006; Cummins et al., 2007; Locke et al., 2006; Mueller & MacKinney, 2011). The developed framework depicts place-based policy as a cyclical process that is comprised of three stages: identify the wicked problem, implement place-based policy, and identify the positive community

outcome(s). Place-based policy begins with stage one, *identify the wicked problem* (Bradford, 2005; 2008). Wicked problems are viewed as ill-defined, complex, complicated, and cyclical issues (Rittel & Webber, 1973) that cross the boundaries of various government sectors, and that have solutions that require the involvement of multiple community and government agencies (Perri, Leat, Seltzer, & Stoker, 2002). According to Rittel & Webber (1973), virtually all public policy matters are considered to be wicked problems. Wicked problems are characteristic of knowledge gaps and substantial coordination malfunctions that cannot be solved with “off the shelf solutions” (Bradford, 2005, p. 15). Wicked problems are difficult to describe given their complex nature (Rittel & Webber, 1973). Rittel & Webber (1973) recommended troubleshooting possible solutions to the wicked problem in order to better describe and define the actual issue at hand. For example, rural health could also be considered a wicked problem. There are many economic, social, and environmental factors influencing the successful implementation of health policy in rural communities. Declining populations, deteriorating economies, aging communities, increasing rates of morbidity and mortality, and vast geography make it extremely difficult to implement policies aimed at improving the health of rural Canadians. This stage of the framework involves trying to define the wicked problem by troubleshooting possible causes and solutions to the problem (Rittel & Webber, 1973).

The second stage of the framework, *implement place-based policy*, involves identifying solutions to minimize or resolve the wicked problem. There are six key components to a place-based policy solution: capital, local community involvement, evidence-informed decision making, intersectoral collaboration, longevity and

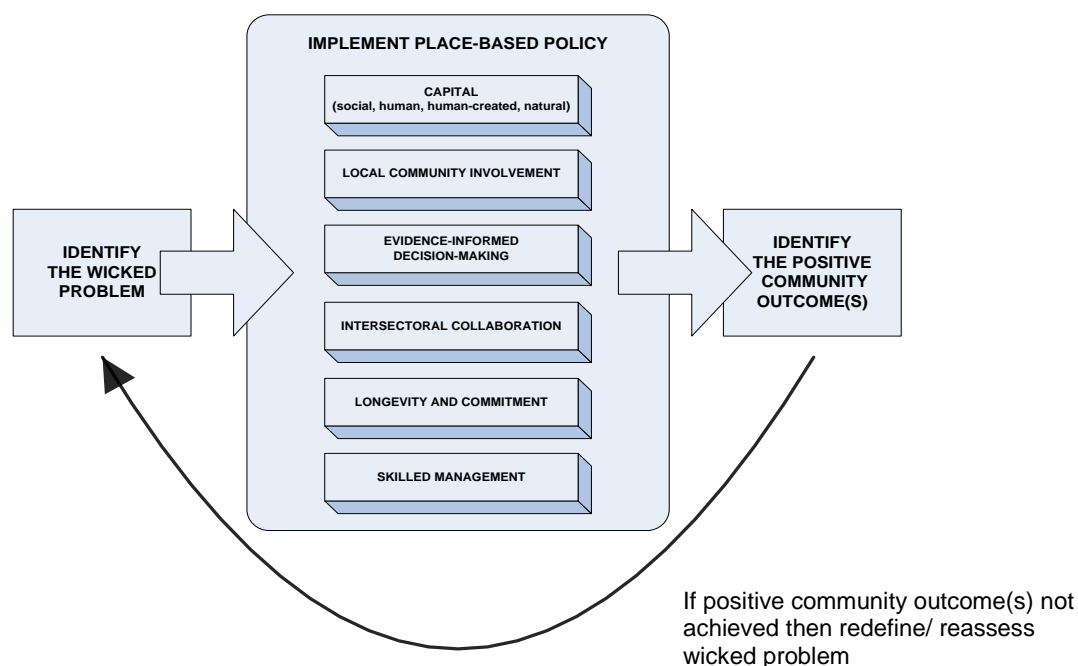


commitment, and skilled management. *Capital* is defined as the components of a society that contribute to its prosperity and wellbeing (Locke et al., 2006). Capital is further divided into social, human, human-created, and natural. Social capital refers to the norms and associations that shape the actions of people within formal and informal organizational groups (Locke et al., 2006). Human capital refers to the investments people have made in themselves to enhance their ability to meet human needs, such as education (Locke et al., 2006). A number of authors assert that human and social capital are key elements for the implementation of successful place-based policies (Castle & Weber, 2006; Locke, et al., 2006; Olfert, Berdegue, Escobal, Jara, & Modrego, 2011). Human-created capital is defined as the materials and products people have made and established to increase their productivity and enjoyment over a period of time (Locke et al., 2006). Natural capital refers to parts of the ecological environment of worth or prospective value to people, such as farmland, forestry land, and lakes (Locke et al., 2006). According to Locke, Powers, Felt, and Close (2006), social, human, human-created, and natural capital are necessary for the implementation and sustainability of place-based policy solutions.

Effective place-based policy requires *local community involvement* (Castle and Weber, 2006). Place-based policy, although grounded in the idea of community input and knowledge, also requires *evidence-informed decision-making*. This refers to the practical use of research findings from an area of study to inform policy development and implementation (Mueller & MacKinney, 2011). Though evidence is most often scientifically-generated, evidence can also be obtained through personal experience or be community-derived. *Intersectoral collaboration* across levels of government, sectors of

government, communities, community agencies, and community citizens is necessary for the development and implementation of effective place-based policies (Bradford, 2005:2008; Castle & Weber, 2006; Cummins et al., 2007). Place-based policy implementation is a long-term endeavour that requires *longevity and commitment* from all actors involved (Locke et al., 2006). Lastly, *skilled management* in the form of coaching, mediating, negotiating, team building, and strategic thinking, regarding policy implementation is required from expert decision makers, policy makers, researchers, and health care professionals (Locke et al., 2006).

The third stage of the framework is to *identify positive community outcome(s)*. A positive community outcome is the desired result of place-based policy. Outcomes are community-specific and should be determined by the community in collaboration with those responsible for policy implementation. While a positive community outcome is the desired outcome, the cyclic design of the framework recognizes that not all the outcomes will be achieved and, the next step is to re-enter into stage once again and redefine or reassess the wicked problem.



*Figure 1. Place-based Policy Analysis Framework adapted from Bradford, 2005; 2008; Castle & Weber, 2006; Cummins, Curtis, Diez-Roux, & Macintyre, 2007; Locke, Powers, Felt, & Close, 2006; and Mueller & Mackinney, 2001.*

### Problem and Research Question

Place-based policy is a new approach to understanding policy development and implementation in the context of rural health in Canada and globally (Bradford, 2005; 2008), and to date, there have been no studies identified that have focused on the area of place-based policy. Rural Canada is currently faced with numerous political, environmental, social, health, and economic challenges that are worsening as the population in rural communities continues to decline and age (CIHI, 2006; Romanow, 2002; Ryan-Nicholls, 2004). Rural health policy by its nature must include a focus on place and a place-based approach may offer an opportunity to examine rural health from a different perspective than traditionally has been applied. Policy has traditionally been developed and implemented with little consideration of the context of place. Exploring

whether and how place is discussed in the context of current Ontario rural public health policy implementation will provide insight regarding whether and how the elements of place-based policy are taken up in rural public health policy. Place-based policy is argued to be an effective approach to support public policy development and implementation (Berkowitz et al., 2002; Bradford, 2005; 2008; Castle & Weber, 2006; Locke et al., 2006; Mueller & Mackinney, 2011), particularly within the context of rural health. The aim of this study was to explore whether and how “place” was considered in the context of rural Ontario public health policy implementation for chronic disease prevention (CDP) programs. This research has been guided by the following research question: How is place considered in the context of rural public health policy implementation?

## **Methodology**

### **Study Design**

This study uses a qualitative descriptive design to conduct a secondary analysis of focus group and interview data using qualitative content analysis methods. Qualitative descriptive design is particularly relevant to answer research questions that are straightforward and relevant to practice or policy and about which little is known (Sandelowski, 2000). Unlike designs such as phenomenology or grounded theory that focus on interpretation, the aim of qualitative description is to describe the phenomenon of study. However, human perceptions are unavoidably interpretative and some interpretation is also included in a descriptive study (Sandelowski, 2000).

Secondary analysis is an efficient way to conduct research as it involves the use of data that have been collected in a previous study to answer new research questions (Polit & Beck, 2008). In many cases, qualitative researchers gather much more data than

needed to answer their research question(s) and secondary analysis is a way to maximize the use of the data (Polit & Beck, 2008; Szabo & Strang, 1997). Secondary analysis eliminates the phases of sample selection and data collection, allowing more effort to be placed on analysis of the research findings (Szabo & Strang, 1997). An advantage associated with the use of secondary analysis is the researcher's opportunity to view the data with a detachment that may be difficult to achieve for the original researchers (Szabo & Strang, 1997).

This study is a secondary analysis of data from the RePHS study (RePHS, 2010). The RePHS study aims to examine the implementation of the BC Core Public Health Functions framework and the Ontario Public Health Standards over a five year time period from 2009 to 2014 (RePHS, 2010). The primary study is concentrated on two core public health programs: the CDP and the sexually transmitted infection prevention program (RePHS, 2010). The CDP, the focus of this thesis research, consists of activities to increase public awareness, create supportive environments, and develop services related to healthy eating, comprehensive tobacco control, and physical activity (MOHLTC, 2008). Using the complex adaptive systems theory and a case study design, the RePHS study is investigating the following research questions: (1) What are the processes of the public health standards/core functions of implementation for two core public health programs in BC and Ontario, and how do contextual variations within and between each province affect the implementation processes? (2) What are the impacts and outcomes of the two core programs and how does variation in context and process of implementation affect these? (RePHS, 2010). The RePHS study sample includes six Ontario rural and urban public health units. Public health units were selected to maximize

variation and diversity. Frontline staff and managers from each of the six health units are participating in this study. Data collected for the RePHS study include that from focus groups, key informant interviews, and policy document reviews (RePHS, 2010). This thesis focuses on data collected in Phase 1 of the study where questions related to policy implementation, evidence-based practice, collaboration, community partnerships, leadership, financial and human resources were posed in both focus group and key informant interview questions (see Appendix A for Interview Questions).

### **Sampling**

The study sample was comprised of a subsample of the primary RePHS study, specifically, data obtained from three rural Ontario public health units. The three rural locations are diverse in geography, size, and demographics and the public health units provide services to rural and remote communities. Six focus groups/interviews were conducted with 29 staff (eight managers and 21 frontline staff), including public health nurses, dietitians, health promoters, and managers in the CDP program. In addition, each public health unit was asked to provide various policy documents including annual reports, strategic plans, operations reports, planning documents, program documents, practice guidelines, and statistical reports (see Appendix B for Policy Documents List provided for RePHS and selected for this secondary analysis). Policy documents were included in this study if they met the following inclusion criteria: 1) a planning document, 2) an annual report, 3) a health status report, or 4) a “show and tell” document (descriptive baseline of the CDP program delivery developed by each public health unit). In total, 11 documents were collected and analyzed.

Relevance sampling was employed for this qualitative content analysis. Relevance sampling aims at choosing all textual or sampling units that contribute to answering particular research questions (Krippendorff, 2013). There are three kinds of units: sampling units, recording/coding units, and context units (Krippendorff, 2013). *Sampling units* or *units of analysis* are units of text chosen for analysis (Krippendorff, 2013; Schreier, 2012). In this study, the sampling units were comprised of the transcripts from participants in the six interviews and focus groups. Each policy document was also considered a sampling unit. *Recording/coding units* were categorized into *context units*, or units of text that set limits on the information to be considered in the description of recording units (Krippendorff, 2013; Schreier, 2012). In this research, the context units constituted each of the participants' statements in the focus group and interview transcripts that can be further broken down into recording units.

### **Data Collection**

In the primary RePHS study, interviews and focus groups were conducted separately with front-line staff and managers (See Appendix A for the Interview Questions). Five focus groups and one interview were conducted. Focus groups ranged in size from two to eight participants with a total of 29 participants. The focus groups and interviews were approximately 60 to 90 minutes in length and conducted by the study co-investigators. Each focus group or interview was transcribed verbatim by the study research assistants and co-investigators.

### **Data Analysis**

Qualitative content analysis as articulated by Krippendorff (2013) and Schreier (2012) was selected as the method of analysis. Historically designed for use in

communication research (Krippendorff, 2013), content analysis is used today as a research method in many nursing studies, including those in the field of public health nursing (Elo & Kyngas, 2008). Content analysis is used to describe qualitative material in an organized and methodical way (Schreier, 2012) and involves dissecting text into smaller units, coding and naming the units to fit the content with which they correspond, and clustering coded text based on common concepts (Polit & Beck, 2008). According to Krippendorff (2013), there are six epistemological features of texts used in content analysis: (1) texts are not objective, (2) texts have multiple meanings, (3) the meanings invoked by texts do not require intersubjective consensus, (4) meanings speak to something other than the given texts, (5) texts have meanings relative to particular contexts, discourses, or purposes, and (6) the researcher makes inferences from the texts to their chosen context. The conceptual components of content analysis include: (a) a body of text, (b) research questions, (c) context, (d) analytical constructs, and (e) inferences (Krippendorff, 2013). In this study, the *texts* were comprised of focus group/interview transcripts and policy documents from the primary RePHS study. *Analytic constructs* were identified by the place-based policy analysis framework to inform the interpretation of the selected texts (Elo & Kyngas, 2008). The *inferences* or descriptions derived from the texts constituted the outcome of this qualitative content analysis.

Focus group and interview transcripts and policy documents were entered into NVivo 9 (Qualitative Solutions and Research International [QRS], 2007), a qualitative software analysis program used to organize data for analysis. The researcher then read and reread each transcript and policy document. In order to prepare for analysis, the data were then



coded using a coding template (White & Marsh, 2006). The coding template was developed based on key concepts from the place-based policy analysis framework (Figure 1) and each transcript and policy document was coded according to the coding template. Krippendorff's (2013) technique of clustering was then used to analyze the data. Clustering is the combining of things that are associated, belong together, or have commonalities to create a whole, while separating them from things that do not have a connection or are irrelevant (Krippendorff, 2013). The following steps as outlined by Krippendorff (2013) and Schreier (2012) were taken to analyze the data: 1) each unit of analysis was reviewed, 2) sections of the unit of analysis that could be applied to the coding template were identified, 3) one or more categories and subcategories of the coding template to each unit of analysis were applied, 4) categories and subcategories were combined or removed based on similarities and differences, and 5) these steps were repeated until all relevant data were clustered into appropriate categories and subcategories.

In qualitative content analysis, data saturation requires that each of the categories and subcategories in the coding template are used at least once when coding the data (Schreier, 2012).

### **Approaches for Creating Trustworthiness**

Trustworthiness is the extent to which qualitative researchers justly and truthfully show certainty in the analysis and interpretation of their data (Polit & Beck, 2008). In qualitative descriptive research, the trustworthiness of the study is highly dependent on the researcher (Patton, 2002). Therefore, to ensure trustworthiness in this study, the researcher addressed the three important criteria (validity, reliability, and objectivity) for

rigor in qualitative content analysis as outlined by Krippendorff (2013) and Schreier (2012).

With respect to qualitative content analysis, *validity* refers to the extent to which the coding frame captures what the researcher set out to capture (Krippendorff, 2013; Schreier, 2012). In order to maintain validity, prior to coding, the researcher developed the coding frame based on current literature. The coding frame was reviewed by the researcher's thesis supervisor and committee member, who are experienced nurse researchers with expertise in health policy and qualitative research methods.

*Reliability* refers to the degree to which a study with similar participants and context would yield similar results (Krippendorff, 2013; Schreier, 2012). To maintain reliability of the findings, the researcher's thesis supervisor reviewed all of the coding and was in constant contact with the researcher throughout the coding process. According to Schreier (2012) reliability in qualitative content analysis can also be promoted by conducting the research in a systematic way. The researcher attended to this by adhering to Krippendorff (2013) and Schreier's (2012) method for content analysis.

In qualitative content analysis, *objectivity* refers to the extent to which the findings would be shared by the majority of people with a similar background (Schreier, 2012). This does not suggest that findings are absolute, but that the interpretation of findings is not just based on one person's understanding of the material (Schreier, 2012). The thesis supervisor reviewed all the coding, to promote consistency in coding and to establish objectivity of the findings in the broadest sense of the term.

## **Ethics**

Ethical approval for the primary RePHS study was obtained from the Hamilton Health Sciences/McMaster Health Sciences Research Ethics Board for the Ontario locations of the study (see Appendix C for Ethics Approval Letter). Prior to beginning data analysis for this secondary study, a short proposal was submitted to the RePHS Steering Committee for approval (see Appendix D for Short Proposal); this was obtained in October, 2011. Informed consent was obtained in the primary RePHS study. At the time of the primary study, permission was granted from the participants and the ethics review board for secondary analysis of their data. The researcher signed a confidentiality agreement for the RePHS research team to ensure that all data accessed by the researcher remained confidential (see Appendix E for Confidentiality Agreement).

Confidentiality and anonymity have been addressed in this secondary analysis. The participants' and health units' actual names have not been used in the presentation of findings for this study. Participants will remain anonymous in any other published material based on this study as well. Data have been accessed through a secure web portal and any hard copies of the data have been kept in a locked location to which only the researcher had access (Polit & Beck, 2008). The data will be kept for a minimum of 5 years after the date of any related publication, and then will be destroyed by the researcher.

## **Findings**

Findings about how place is discussed in policy documents and participants' descriptions of the OPHS for the CDP program are presented within the context of the

place-based policy analysis framework. Each component of the framework is described and illustrated with quotations from policy documents and participants.

### **Identify Wicked Problem**

The term “wicked problem” did not appear explicitly in the transcripts or policy documents. However, many participants described complex and multifaceted issues faced by rural public health units and communities that were consistent with the concept of a wicked problem. These issues provide insights about the nature of rural public health as a wicked problem and the challenges associated with rural public health policy implementation. Issues related to lack of time to do the work, limited finances, health human resources challenges, and community culture were identified as subthemes that could be described within the category of “wicked problem”. Lack of time to carry out the work of the public health unit was discussed in relation to both the health human resources and the geography of rural communities. Due to the widespread and sparse population in rural communities, the catchment area for a rural public health unit is often greater in geographical size than that of urban public health units. Health unit staff often have to travel long distances to reach their clients. Travel time may therefore consume a significant portion of the day, leaving limited time for healthcare staff to provide services to clients. As one rural public health unit manager said:

*The time impact is huge ... just to get to our other satellite office ... you could spend two and a half, three hours driving across our jurisdiction ... we’ve got a size greater than small countries!* (Managers Transcript 1 [MT1])

Limited funding, understaffing, and high turnover were also noted to be of particular concern to rural public health unit staff. In addition to having limited financial

resources to fund public health positions, participants described the difficulty of filling available positions and retaining individuals in rural communities and thereby, challenges in fulfilling policy implementation. In these communities, there were fewer staff to deliver programs and share the workload. Access to education and training for staff was also more challenging as a result of increased distance, cost, and time. As one rural public health unit frontline staff noted:

*Funding ... and staffing [are major rural issues] ... It's hard to ... state the case within our board of health to get enough positions to service the area and pay for that position ... We're often under-resourced staffing-wise chronically, and there's a big turnover too. (Frontline Staff Transcript 1 [FLST1])*

Human resource challenges faced within the rural health units investigated impacted the entire CDP program, including the implementation of new policies and changes to existing programs. For example, some participants noted that place needed to be considered in the context of their rural communities, as they have low population densities and high public health staff turnover. As a result, a significant amount of time had to be dedicated to hiring and training new staff, limiting the amount of time available for research, program planning, policy development, and service delivery. A rural public health manager described the impact of the rural context, saying:

*Only two of our staff have been here long term. It has certainly ... set us back because it's a lot of training so you can't just jump them into implementation [of policy] ... depending [upon] what their background is. Some of them have more experience than others ... there's a lot of mentoring needed ... I think that it would definitely have an impact on the whole CDP program. (MT1)*

A rural health unit frontline staff member discussed the issue of staffing and staff distribution, commenting on how attributes of geographically distant areas within the health unit's catchment area must be considered in the context of rural public health policy implementation, stating:

*A lot of those communities do want [programs and services] ... I have a community that grabs and gobbles up everything. But [I visit there] one day a month. I need special permission to go more. Everything that is outlined in the OPHS Standards won't necessarily reach those areas just because ... it's so much to ask for. (FLST2)*

The “show and tell” document from each health unit provided many examples of complex, multifaceted issues related to “place” that contributed to “wicked problems” within their rural communities. In one section of the “show and tell” document, each public health unit was required to list contextual factors that impacted the delivery of rural public health services. The “show and tell” document from each health unit listed similar issues that captured the nature of a “wicked problem” in the context of rural Ontario public health policy implementation. Examples included: large rural geography, community culture and attitude towards health, lack of public transportation, limited funding, and health human resources.

### **Implement Place-based Policy**

The category ‘implement place-based policy’ consists of six subcategories: capital, local community involvement, evidence-informed decision making, intersectoral collaboration, longevity and commitment, and skilled management. When describing their experiences with the implementation of the OPHS, participants used terminology

and examples that illustrated how “place” was considered in the implementation of place-based policy.

**Capital.** Capital in the forms of social, human, human-created, and natural were discussed as important factors that participants considered as contributing to the effective implementation of policies such as the OPHS. Participants specifically described the limited number of health care professionals in their rural areas as an element of human-created capital that is integral to policy implementation. The lack of human capital was described to be a significant element of place-based policy implementation, something they suggested was unique to rural places. One participant described the link between low population density and public health staffing in their rural area:

*One would be just the rural nature of us; so if they recruit someone coming from a city, then sometimes they end up feeling suffocated out here. And probably one of the primary reasons you'll see turnover is that there's not a lot of room to grow in the organizational chain. (MT1)*

Study participants revealed that unlike their urban counterparts, rural health units struggle to attract qualified healthcare providers to fill vacant public health job positions. With limited human capital, rural public health unit staff lack the capacity to complete all of their job duties. As a result, job duties that relate directly to client care may take precedent while policy and programing duties tend to get neglected. A participant discussed how a lack of human capital in their rural community impacted rural public health policy implementation in the rural context:

*Public health, like any other organization, has limited resources and capacity ... We can't be doing presentations and developing resources and policies ... You can't do it all ... so the bigger reaching stuff, the more comprehensive stuff [takes precedent]. (FLST1)*

With respect to natural and social capital in their rural community, participants discussed how community-related dependence on single resource industries was a consideration in rural public health policies and programs. One participant described the political power the local industry has in their rural community. The industry donates a significant amount of money to local community programs and initiatives, including public health programs. The health unit depends on this funding. However, when public health initiatives aimed at improving health in the community reflect negatively on the local industry, it could impact community funding.

**Local community involvement.** The involvement of local community citizens and agencies in health unit policy implementation was identified by participants as a mandatory requirement of the OPHS. This requirement was considered to be beneficial to the implementation of health unit policies, particularly in rural places where community members tend to be a cohesive and relationship-oriented group. Participants spoke of the relationships with the community as something that is inherent in the culture of their rural community. With respect to health human resources, many participants also discussed how limited staff encourages rural public healthcare workers to collaborate with community members and organizations in order to effectively implement public health policies in that context. Rural communities are often dependent on community involvement to make up for limited financial and human resources. Participants described



how a great sense of community in rural places enables rural health units to rely on community members to aid in the implementation of public health policy. As one participant explained:

*One perspective of being rural ... we're not well sourced or staffed [at the health unit]. We've always worked together really well [with the community] because we don't have a choice ... We're able to ... count on each other to work together and move forward on things and there's less silo-building because we naturally have to do that. (FLST1)*

Other participants observed how in rural places, community involvement often leads to a community development approach to public health service delivery. When rural community members are involved in public health policy, they often become key players in generating solutions to local public health issues. With limited resources, health unit staff help to empower community members by supporting them with the skills necessary to assist with the implementation of public health policy. One participant described how the role of the community is included in rural public health policy implementation, stating:

*I am seeing how our role has changed and how we are growing into our roles ... with the new OPHS ... The work that we do on our team, specifically, which is community-focused, I am finding myself oftentimes explaining it as more of a community development role and capacity. (FLST3)*

On the other hand, local involvement was described as an obstacle to policy implementation when the culture within communities did not support necessary public health initiatives. Participants described how rural residents, although very supportive of

one another, created challenges when trying to implement public health policy with which community members did not agree. As one frontline staff member noted:

*We were going to do a [health promotion] event outside of the school and we needed permission from the principals, but there was backlash from the parents and the community that were in the [local] ... business or industry and so eventually they pulled the plug on that. (FLST1)*

**Evidence-informed decision-making.** Within the context of rural Ontario public health policy implementation, evidence and its importance for policy development and implementation was significant to participants. Regarding rural public health policy implementation, evidence was described by participants as a mix between research and reality. Evidence was defined by most participants as both empirical and experiential knowledge. Words used to describe evidence were: trustworthy, proven, research-based, factual, past knowledge, and local information. Evidence was viewed as something that “guides” public health policy and practice.

Evidence was viewed as something that needed to be derived from research, but also needed to be relevant to the participants’ particular communities. Participants discussed how evidence from research conducted in urban places or other rural places may not be relevant to their unique community, describing the need to take into account experiential knowledge and local expert judgement. Several participants expressed the need for rural public health policies and programs to be supported by “local evidence” with the purpose of demonstrating effectiveness in the community. One participant discussed these two perspectives of evidence utilization in rural public health policy implementation, stating:

*... you have to learn that it [evidence] is about half paper, half reality ... You have to ... develop that skill between ... what works on paper, and what works in your community... because what works here may not work in a big city. But sometimes you encounter resistance from people ... who have been doing it a certain way, and they are still dead-set that ... this is the way that works. So there is the evidence to do something, and then there is also the evidence, like the evaluation results, that show that sometimes you need to change your practice, even though you are very comfortable. (FLST3)*

Although evidence was viewed by many participants as important to the implementation of policy, in the context of the rural setting, evidence uptake was considered by some participants to be a barrier to policy implementation. One frontline staff member described how limited capacity with respect to staffing and time influenced evidence utilization in the context of policy implementation in their rural health unit, stating:

*... it's just one person per program pretty much ... so just because there's evidence, that doesn't mean that you necessarily have the capacity to follow through with all that evidence. (FLST1)*

Other participants discussed that they do not feel prepared educationally to meet the expectations of the OPHS regarding the use of evidence for policy and program development. The utilization of evidence to inform policy and program development was a new practice for many participants in these rural public health units and some said that they did not feel they possessed the knowledge or skills to incorporate evidence into implementation of their policies and programs. Participants described the challenge of

finding time to search for evidence. With large catchment areas, rural public health unit staff spend a significant portion of their time travelling to access clients. One participant described how time needed to be considered in the use of evidence in rural public health units:

*I think one of our big challenges is the geography ... The catchment area that we have to cover [is large], but ... evaluation is at the forefront [of policy implementation]. [Policies or programs] that we ... put out have to be evaluated, so ... a lot of my time is ... trying to identify if this specific program is actually beneficial or has shown positive results [in the community]. (FLST2)*

With respect to evidence utilization, participants considered the transferability of available research to their local population, as research conducted in urban settings may not be applicable to rural communities. For example, a research study that evaluated the effectiveness of an intervention aimed at improving the health of street youth may be beneficial to an urban public health unit located in an area with a high population of homeless youth, while it would have little relevance to a rural farming community where youth make up the lowest portion of their population. Participants also argued that rural areas are not homogeneous, and therefore considered that there was a need for local evidence unique to each specific rural area. Some participants identified challenges in finding evidence relevant to specific population groups in their communities. For example, a large portion of the First Nation population in Ontario resides in rural areas, yet many of the programs are not designed specific to this population. As one participant said:

*... we don't have local evidence, we are using evidence from [urban] Ontario ... Also there's the ... fact that we don't have the time to do that. And also ... we're dealing with [a specific] population in our branch office and even if they come up with some evidence-based best practice [it may not apply to us]. (FLST2)*

**Intersectoral collaboration.** Participants also considered intersectoral collaboration in relation to partnerships between the public health sector and other government and private sectors within their rural context including: education, social services, city services, and local businesses and industries. Participants described intersectoral collaboration as teamwork within and across health units and health disciplines in order to accomplish common goals. Intersectoral collaboration was considered to be an important factor in the implementation of rural public health policy. Rural health units were described as relying on other health units and community organizations to supplement limited health human resources while gaining greater insight into the needs of the community from multiple perspectives. With respect to intersectoral collaboration between health units, one frontline staff member said:

*I never had to work on anything ... alone, even though I'm the only person [in this role], because I would work with [other public health units], to pool our resources, money to save costs on printing ... Those connections, ... that's where you get a lot of your information too. (FLST1)*

Another frontline staff member described the benefits of collaborating with other local government sectors on policy implementation, stating:

*[With the OPHS] there's more working together with the other ... departments because the health unit is a department ... just like public works, roads, engineering, community services, ... and tourism ... The interdepartmental connections are happening more now ... Until two or three years ago, I had never even seen this [staff report from public works] before and now I'm being asked to weigh in on the implication sections, which is awesome ... We're lucky because we're so geographically close to one another [other health units] ... whereas our counterparts in the north, probably can't ... meet as easily as we can. (FLST1)*

One health unit's annual report clearly detailed how the unit incorporated intersectoral collaboration and local community involvement into policy implementation. The report described how challenging economic times in their rural community have created a need for government sectors to work together to better integrate their services and resources to meet the needs of the community. The report also described how the health unit had been working with various local community organizations with a vested interest in health. The report mentioned that there was still work to be done in this health unit with respect to intersectoral collaboration and community partnerships, because collaborative efforts across sectors are necessary for effective rural public health policy implementation.

**Longevity and commitment.** Longevity and commitment were not major areas considered by participants when describing how place factors into the implementation of rural public health policy. Participants described how effective policy implementation requires ongoing commitment from all individuals and organizations involved. In the rural context, this was considered to be of particular concern because rural health units

experience high rates of staff turnover, making it difficult to sustain commitment with respect to policy implementation. Furthermore, the participants described a number of complex rural issues or “wicked problems” that require sustainable solutions that would have a long-term impact on the community. Participants recognized that there are rarely quick solutions to such local issues.

**Skilled management.** Participants referred to “skilled management” as managers and leaders within their organization and community who encouraged collaboration and teamwork. Skilled management was deemed to be not only important to support policy implementation in general, but in rural communities, skilled management was seen as essential to negotiate the complexity of policy implementation in the context of socio-political issues unique to each community. Rural public health unit staff considered skilled management to be managers who supported them, offered feedback on work being done, and provided them with the necessary tools and knowledge to implement policies. Similarly, managers discussed skilled management in terms of enabling staff to take on leadership roles and become involved in the entire policy process, considering this to be a particularly relevant strategy in policy implementation within small rural health units, where human resources have to be optimized. As one participant explained:

*When we asked the staff about the [OPHS policy] changes, we hear... we don't feel we should have to spend time on logic models and program development, that's your job, we're just here to implement ... And the only reason we were involving them [staff] in the first place was because: How can you plan something for your community if you're not involved in the planning? (MT2)*

With respect to skilled management, one participant described the importance of leadership in educating and preparing staff for their roles in policy implementation, stating:

*I think there were some health units that were ready [for the OPHS] and some that were not, given geographic location and [health human resources] capacity to have done a good job with mandatory program service and guidelines ... There were some health units that were ... forward thinking, moving toward policy, and there were some other rural [health units] without leadership. (FLST1)*

Participants considered policy implementation in the context of rural places to be the use of evidence-based research to support locally relevant policies and programs developed for and with the community. One frontline staff member described the implementation of the OPHS, ascribing many of the characteristics of place-based policy, stating:

*And it [OPHS] also gives flexibility to have programs geared towards your community, not just provincial programs. So it's more community focused. What are the priority populations here?, which, I think, puts a lot of emphasis on surveillance to find out what those things are in the first place, and go from there. And of course always, they are always wanting evidence. (FLST2)*

Conversely, another participant described the challenges of policy implementation when each health unit implemented the same policy in different ways. This led to what this individual considered to be “wasted resources”, illustrating a tension in the role of “place” in local policy implementation. The participant said:



*Each of 36 health units is creating their own food safety course. We're creating our own binders, our own resources, our own website ... how do we teach the course, where do we teach it and how many hours, what will we charge ... Can we not make it the same across the province?[This is] a tremendous waste of resources ... we're all doing similar things but a little bit different. Is it really necessary? ... Some things are just not that different from region to region. (MT1)*

The majority of participants considered place to be an important component of rural public health policy implementation. Most participants described how place-based policy is necessary to address the unique challenges (widespread geography, limited financial and human resources, community culture) rural places face with respect to policy implementation. However, one participant did not consider “place” to be particularly relevant to the implementation of some rural public health policies. Rather, this participant suggested that the implementation of some policies and programs in public health should be consistent across public health units to gain efficiencies.

### **Identify Positive Community Outcome(s)**

The last category of the place-based policy analysis framework, “positive community outcome(s)”, was less evident in the transcripts and policy documents that comprised the data base for this study. Positive community outcomes specific to the rural context were not discussed by participants. However, positive community outcomes were discussed in a broad sense by participants as policies and programs that have a positive effect on their community. In the policy documents, positive community outcomes were discussed in terms of the goals public health units wished to achieve for their communities. One policy document, a health status report for the CDP program,

identified a number of indicators that were to be measured for improvements to show positive community outcomes from various policies. While these indicators are utilized by all public health units, they are also relevant to health issues faced by rural dwellers including vegetable and fruit consumption, food insecurity, poverty, smoking, body weight, physical activity, alcohol consumption, and cancer screening practices. However, these were not elaborated or considered as unique to any one “place”.

In summary, study findings indicate that “place” is considered as an essential component of rural public health policy implementation. Findings suggest that public health challenges faced by rural communities require place-based policy solutions that are unique to each rural place. Further, findings illuminate the consideration of the following place-based policy characteristics: capital, local community involvement, evidence-informed decision-making, intersectoral collaboration, longevity and commitment, and skilled management.

### **Discussion**

The findings of this study suggest that place is considered to be an important component of rural public health policy implementation. Rural public health unit staff described many challenges related to place that enter into policy implementation, including: lack of time to do the work; large geographical catchment areas; limited finances, both in the rural public health unit and in the community; public health human resources challenges; community culture; and the rural industrial/economic base. These findings are consistent with the existing research on the challenging and complex issues experienced by rural healthcare professionals (Berkowitz et al., 2002; Bollman, 1999; Buykx, Humphreys, Wakerman, & Pashen, 2010; Castle & Weber, 2006; MOHLTC,

2009; Mueller & MacKinney, 2011; Ryan-Nicholls, 2004; Strasser. 2003). Study findings also suggest that place is considered in the context of rural public health policy implementation, in particular, by the following place-based characteristics: capital, local community involvement, evidence-informed decision-making, intersectoral collaboration, longevity and commitment, and skilled management.

The complex and cyclical nature of wicked problems related to rural public health policy is apparent from the findings and enhances understanding about issues in the rural settings that may negatively impact public health policy implementation. Widespread geography and limited fiscal resources may compound challenges associated with policy and program implementation for rural public health units. A significant issue for rural policy implementation is health human resources. Participants spoke about this as both an element of a wicked problem – complex, cyclical, and difficult to resolve – and as a human capital issue. This may suggest the need for more place-based interventions targeting recruitment and retention in rural areas in order to support successful policy implementation (Buykx et al., 2010; MacLeod, Browne, & Leipert, 1998; Mahnken, 2001). Examples of rural recruitment and retention interventions include: maintaining sufficient and constant staffing; providing necessary infrastructure to support the workforce; offering adequate and competitive compensation; and maintaining a supportive work environment that is based on effective leadership and open communication (Buykx et al., 2010). Though many rural public health issues were discussed by study participants, more research is needed to explore the nature of wicked problems related to rural public health policy and place-based policy solutions to those problems.

Study findings also revealed that community culture may create both significant support and challenges for rural public health policy implementation. In a study exploring how women maintain health in geographically isolated settings, participants described rural culture as a community-focused with a sense of responsibility to helping others in the community (Leipert & George, 2008). In many rural places, personal and sustainable relationships are formed amongst rural people (Strasser, 2003). Many rural dwellers possess a great sense of loyalty to the community and their fellow community members (Strasser, 2003). Study participants described the strong sense of community some rural dwellers possess. This constitutes a potentially positive feature with respect to public health policy implementation. Participants described the willingness of rural residents to collaborate with public health unit staff on public health initiatives as a result of their vested interest in the community. The findings suggest the importance of intentional efforts to develop collaborative strategies that optimize the scarce human resources in rural communities to support policy development and implementation efforts.

However, community culture may also make it difficult to implement public health policies that are not well received by community members. For example, some participants described how policy implementation was impeded by local residents when the policy had a potentially negative impact on the products being produced by the local industry. Local industries can provide a substantial number of jobs to community members, contribute to the local economy, and contribute to local community development initiatives (Stedman, Parkins, & Beckley, 2004). Participants in our study suggested that some community members felt strongly about supporting their local industry, even if that meant not supporting policies promoting the health of the public.

This highlights the need for local industry to be identified as a key stakeholder in policy development and implementation.

Consistent with the literature on place-based policy, social, human, human-created, and natural capital were described by participants and noted in the policy documents as relevant considerations for rural public health policy implementation (Adams & Hess, 2001; Berkowitz et al., 2002; Castle & Weber, 2006; Locke et al., 2006). Although participants did not use the term “capital”, they did describe how the values and norms of the people in their communities can influence public health policy decisions (social capital), especially when the geography of their community (natural capital) lends itself to a particular industry that employs a considerable portion of their population.

Sufficient human resources are imperative to support public health policy and program implementation (Joint Task Group on Public Health Human Resources, 2005). Study findings revealed that the shortage of public health staff (human capital) and financial resources (human-created capital) can have an impact on time and therefore the ability for public health staff to implement policies that are community-specific. In rural communities, human capital and human-created capital are often limited as a result of low population densities. In addition, many rural residents do not have access to the same educational opportunities as their urban counterparts which can reduce the amount of human capital in rural areas (Curran, Fleet, & Kirby, 2006; Mahnken, 2001). These findings suggest the need for effective recruitment and retention strategies for rural public health unit staff. In addition, educational opportunities need to be made available to staff to advance knowledge and further policy development and implementation.

Local community involvement and intersectoral collaboration were considered important supports for rural public health policy. These findings align with the work of Bradford (2008) who argues that solutions to wicked problems are more effective if they are community-specific and utilize not only the knowledge of experts, but the knowledge of citizens and community agencies as well. Many rural researchers assert that a “sense of community” is an important contributing factor to the wellbeing of rural residents (FitzGerald, Pearson, & McCutcheon, 2001; Kutek, Turnbull, & Fairweather-Schmidt, 2011; Leipert & George, 2008; McManus et al., 2012; Thomlinson et al., 2004). The participants suggested that the new OPHS are flexible, allowing health units to tailor policies to the needs of their communities. These findings align with the research on place-based policy (Adams & Hess, 2001; Bradford, 2008; Castle & Weber, 2006; Locke et al., 2006; Mueller & MacKinney, 2011; Yeboah, 2005). This emphasizes the importance of community involvement in the development and implementation of rural public health policy.

Participants considered evidence to be an important guiding factor for policy, programming, and practice. The OPHS mandate that policy decisions be supported by relevant research, evidence, and best practices (MOHLTC, 2008). Many participants affirmed that evidence is a reason for action and therefore supports the need for policy. Effective place-based policies need to be informed by current research and evidence (Adams & Hess, 2001; Bradford, 2008; Mueller & MacKinney, 2011). Findings from this study suggest the importance of valuing not only empirical knowledge, but experiential and personal knowledge as well. Given the lack of available rural research and the limited populations in rural communities, experiential and personal knowledge may be

the only source of local knowledge available for policy development and implementation. Evidence based on federal or provincial information may not effectively illustrate local conditions (Lewin et al., 2009; Smith, Humphreys, & Wilson, 2008). Local evidence can be obtained from a number of sources including: routine data on the prevalence of disease, survey data on household and health demographics, and data from studies conducted locally (Lewin et al., 2009).

Study findings revealed how policy longevity and commitment from those involved in the policy process are a consideration in rural policy implementation. The policy process as described in this study was time consuming and required commitment from public health unit staff, policy makers, community members, and community agencies. Aligning with the work of Adams and Hess (2001), findings revealed that there are rarely “quick-fix solutions” to rural public health issues, particularly as they are often wicked problems. According to Locke et al. (2006), successful rural policy implementation that incorporates “place” requires considerable time and commitment and skilled management. It is important for policy makers to allot sufficient time for public health policy development and implementation, specifically in rural communities with limited staff.

The study findings enrich our knowledge and understanding of the complex multifaceted issues faced by rural public health units in Ontario, in particular, the limited time to complete daily work tasks, large geographical catchment areas, constrained health unit and community finances, public health human resources challenges, and community culture. Study findings from the policy documents and participant focus groups and interviews also help us to understand how the components of place-based policy, such as

capital, local community involvement, evidence-informed decision making, intersectoral collaboration, longevity and commitment, and skilled management impact public health policy implementation.

### **Implications for Education, Practice, and Research**

Findings from this study of place-based rural public health policy may have implications for nursing education, practice, and research. With respect to professional education, a significant emphasis has been placed on nurses' involvement in health policy (Fyffe, 2009; Hall-Long, 2009) and this is reflected in the core public health competencies (Public Health Agency of Canada [PHAC], 2007). Rural public health nurses are in both frontline nursing and management positions that are directly involved in rural policy implementation. Although knowledge of policy and politics is essential for nurses to be able to influence population health (Fyffe, 2009), it is argued that nurses are inadequately prepared in their undergraduate nursing education to impact and shape policy (Boswell, Cannon, & Miller, 2005; Fyffe, 2009; Hall-Long, 2009). The findings from this study may inform curriculum development for basic and graduate nursing education programs. For example, undergraduate and graduate nursing programs should ensure that, where relevant, content on policy development and implementation are included in courses. In addition, the framework may assist nurses to understand the role of "place" in rural public health policy implementation at the local level.

Findings from this study may help nurses to understand the importance of considering "place" in rural public health practice and policy. Study findings also offer nurses insights about place-based challenges and solutions rural health units face in Ontario.



Many researchers have identified the need for “place” to be considered when developing and implementing rural health policies (Berkowitz et al., 2002; MacLeod et al., 1998; Moscovice & Rosenflatt, 2000; Mueller & MacKinney, 2011; Castle & Weber, 2006). The findings of this study illuminate important elements of rural policy implementation that may be of use to policy-makers in the implementation of rural public health policy. Though findings contribute to the growing body of theory on rural policy development and implementation, more research is needed. “Place” is not unique to rural contexts. Future research should look at place-based policy in the urban context to understand similarities and differences with rural policy implementation. In addition, exploring place-based policy outside of the public health sector should be a consideration for future research.

### **Limitations**

This study is not without limitations. As a secondary analysis study, a limitation was the lack of control the researcher had over the selection and collection of data (Szabo & Strang, 1997). The researcher was limited to analyzing data from research questions that were not designed to elicit data that answered the specific research question in this study. The three rural health units in the study sample was selected from among Ontario rural public health units. Therefore results may not be applicable to other health units in Ontario or elsewhere. However, the findings provide a beginning understanding of place in the context of rural Ontario public health policy implementation. It is not known if study findings are unique to rural public health policy or if a sample from urban health units would yield similar findings.

## Conclusion

In conclusion, this study was undertaken to understand if and how place was considered in the context of rural public health policy implementation. Study findings suggest that place is a key consideration in the implementation of rural public health policy at the local level. The unique characteristics of each rural place with respect to: capital, community involvement, evidence-informed decision-making, intersectoral collaboration, longevity and commitment, and skilled management were considered to be important elements of effective rural public health policy implementation. These findings contribute to the limited amount of research on place-based policy, specifically in the rural context. Further, this research makes an important contribution to place-based policy as it is one of the first studies to examine how place is described in the context of rural public health policy implementation.

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## CHAPTER THREE

### Summary of Key Findings

This qualitative study is a first attempt to describe how “place” is incorporated into rural public health policy implementation. The focus of this study was to explore whether and how place is considered in the context of rural public health policy for implementation of the Ontario Public Health Standards (OPHS) (Ministry of Health and Long-Term Care [MOHLTC], 2008) within the Renewal of Public Health Systems (RePHS) study (Renewal of Public Health Systems [RePHS], 2010). Findings from this study suggest that rural communities face a number of complex, multi-layered challenges in the implementation of policy, such as lack of time to do the work; large geographical catchment areas; limited finances, both in the health unit and in the community; public health human resources challenges; and community culture. These challenges contribute to an understanding of “wicked problems” within the rural public policy context. Findings from this study also revealed that policy solutions to rural public health challenges require community involvement, evidence-informed decision making, and collaboration. While the wicked problems of place are known to rural public health staff and efforts are made to construct policy solutions locally, provincial public health policy largely does not directly consider place.

The preliminary nature of this qualitative descriptive secondary analysis study suggests the need for additional investigations of place-based rural public health policy before drawing conclusions about the usefulness of the place-based policy analysis framework and presenting detailed recommendations for future nursing research,

practice, education and policy. However, some provisional implications for nursing research, practice, education, and policy will be offered.

### **Implications for Nursing Research**

Findings from this study reveal that place is an important consideration and influence on public health policy implementation. Many of the characteristics of the place-based policy analysis framework were discussed in public health policy documents and by study participants when describing the implementation of the OPHS. This suggests the need for more extensive research on place-based rural health policy. These findings lay the foundation for future research to investigate the role a place-based policy approach can have in supporting local policy implementation. As these findings emerge from a secondary analysis of data, a primary study should include a policy analysis of current rural public health policy documents as well as directed interviews or focus groups with public health care professionals. In addition, while this study focused on rural public health policy specifically, future research should explore place-based policy in urban settings and in other health sectors such as, acute care, long-term care, and home care. Ultimately, intervention studies to test the outcome of intentional efforts to create place-based policy implementation would be desirable. Future research should also focus on testing and further refining the place-based policy analysis framework to understand its utility for supporting policy development and implementation.

### **Implications for Public Health Nursing Practice**

In public health, and in other health sectors, whether in frontline, administrative, or management positions, nurses need to be able to understand and lead policy development and implementation. Findings from this study afford nurses insight into

some of the supports challenges encountered by rural Ontario public health units in implementing policy. Some examples of supports include, collaboration across health units and health sectors and other sectors, local community involvement, local evidence that is a mix between research and reality, and skilled management and leadership. Some examples of challenges include, limited funding and health human resources, vast geography and large catchment areas, and the community culture of each place. Findings from this study also provide nurses with a basic understanding of place-based policy, specifically how the characteristics of place-based policy relate to the implementation of the OPHS for the chronic disease prevention (CDP) program. Findings from this study may help to educate nurses on the importance of “place” in rural public health policy implementation. Study findings also offer insights for public health nurses working in non-rural units about the place-based challenges and solutions rural health units face in Ontario. Urban public health nurses may be able to utilize study findings to inform how they might attend to place in implementing policy.

Evidence and policy are integral to the OPHS. Study findings highlight the importance of evidence for public health policy and program development. This suggests the need for nurses to have an understanding of the research process. Public health nurses need to be able to appraise, conduct, and utilize research to inform policy development and implementation (Boswell, Cannon, & Miller, 2005). Rural research is of particular importance to public health policy as it is an area of research that is lacking as a result of limited funding, limited staff, and limited access to research facilities and experts (Beaulieu & Webb, 2002; Pennel, Carpender, & Quiram, 2008). Therefore, more rural



public health research is needed to inform development of local policies and programs (Beaulieu & Webb, 2002).

Local community involvement is a key characteristic of place-based policy and findings from this study suggest that many of the OPHS for the CDP program are centered on community involvement. Nurses need to have an understanding of how to develop relationships with communities. Nurses need to encourage community members to be active in identifying and resolving local health issues (Canadian Public Health Association [CPHA], 2010). In addition, nurses are in a position to educate community member on the policy process and how they can become politically involved (CPHA, 2010). Rural communities themselves are a valuable resource for policy development and implementation that is often overlooked (Pennel et al., 2008). Nurses and policy makers need to ensure that community members (for whom the policy is intended) are actively involved in the policy process. Findings from this study suggest that community involvement not only helps to ensure that policies are relevant to those whom they are meant to affect, but it also helps to make up for the limited resources rural communities have with respect to policy development and implementation.

### **Implications for Nursing Education**

The need for nurses to be politically active has long been discussed in the nursing literature. Yet, many frontline nurses still feel that they lack the education and skills to develop and implement health policy. Study findings demonstrate the important role rural public health nurses have in the implementation of public health policy. Public health nurses are directly involved in public health policy and program implementation

and are situated in a unique position to improve the health of communities (Hall-Long, 2009).

Undergraduate and continuing education programs in nursing need to have a focus on health policy development, implementation, and evaluation (Fyffe, 2009), particularly rural public health policy where nurses are needed to be highly involved in the policy process as a result of limited resources (Mahnken, 2001). For example, undergraduate and graduate nursing programs should ensure that, where relevant, content on policy development and implementation are included in courses. Nursing education must also continue to emphasize the importance of leadership roles in nursing, especially rural nursing, where access to research centers, policy makers, and other healthcare professionals is lacking (Mahnken, 2001). Nurses are in a pivotal role to shape public health policy and promote consideration of the role of place in policy development and implementation.

Place-based policy has not been the focus of any nursing research studies aside from this one. Yet, nursing research has been highly focused on health policy development, implementation, and evaluation in recent years. Nursing research must continue to focus on health policy. With a greater awareness and understanding of health policy, nurses will be better able to recognize the significant impact place-based policy has on the health of individuals and communities.

### **Implications for Policy**

Findings from this study suggest that the components of the place-based policy analysis framework are important in the implementation of rural public health policy at the local level. Policy makers must consider how provincial public health initiatives will

be carried out by local public health units, particularly rural public health units. According to Kamien (2009), rural policies are often general, obvious, and indisputable statements that make it difficult to transform into practice and evaluate policy implementation. Findings from this study demonstrate the importance of provincial policies to act as broad guidelines for rural public health policy implementation, thus allowing each health unit to better target programs and policy to their population. Study findings also suggest that factors such as geography, health human resources, finances, population demographics, and community culture need to be taken into consideration by the provincial government before mandating local communities to carry out particular initiatives. With limited staff and resources in rural communities, rural nurses are required to take on roles in health policy development and implementation. In addition, health policy has a significant impact on all areas of nursing practice, research, and education (Hall-Long, 2009), making it a highly relevant field for which nurses must be educated and skilled.

### **Conclusion**

Place-based policy is a new and emerging approach to policy implementation that acknowledges the uniqueness of local communities for the development, implementation, and evaluation of effective health policies (Bradford, 2005; 2008; Castle & Weber, 2006; Cummins, Curtis, Diez-Roux, & Macintyre, 2007; Mueller & MacKinney, 2011). This study is one of the first research efforts to explore place-based rural public health policy. More research is needed to develop a body of place-based policy research and utilize findings in policy development, implementation, and evaluation.

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## Appendix A

### Directors and Managers

#### Focus Group / Interview Questions

#### Background

1. Briefly describe your role within the HU and specifically your involvement with the CDP/STIP program activities/initiatives.

#### Change in activities over time

1. How has your role changed with the implementation of the OPHS?
2. What do you think about the change?
3. How do you think your colleagues think and feel about any changes to the CDP/STIP activities they are involved in?  
(Clarify: Which have resulted from the implementation of the OPHS)
4. How have the following changed since the implementation of these CDP/STIP activities:
  - a. planning,
  - b. implementation,
  - c. and evaluation of programs?

#### Evidence

1. What informs or guides your practice?  
(Prompts: evidence, theory, literature, observing/talking to peers/experts)
  - a. What has the most influence in guiding your practice?
2. What does the word evidence mean to you?  
(Prompts: policy, by-law, want to capture in this question the use of evidence regarding decision-making in program planning)
  - a. What constitutes evidence for you? (Could ask this if it isn't elicited by the first part of the question)
3. What evidence or information was used to inform the development of the CDP/STIP program activities as they relate to the OPHS?
4. What is the process for applying evidence in program development?
  - a. How are the OPHS, protocols, and guidance documents used?
  - b. At what level(s) are decisions made in terms of what evidence is used?  
(Prompt: Who decides what evidence is used?)
5. What influences how and what evidence is used?  
(Prompts: science, research, social/cultural/political environment)
6. Do you have an opinion on their use?
7. Has there been an effort to create/develop provincial evidence as a result of public health renewal?
8. Are there barriers to implementing evidence?

### Planning

1. Describe the planning process for developing any guidance documents or other relevant documents to guide programs/services.  
(Prompts: who, when, how often, silo vs. integrated).
2. What do you think about the planning process?  
(Prompts: collaborative, inclusive, effective, useful)
3. How are communities involved in decisions about, and CDP/STIP activities?

### Leadership

1. How were the OPHS communicated to staff?
2. What general processes, including those specific to decision-making, influenced the successful implementation of the new policies?
3. What other factors influence decision-making around implementation?  
(Prompts: evidence)

### Implementation

1. Describe the implementation process of/for the OPHS in the CDP/STIP program area in your Health Unit.  
(Prompts: who, what, when, how, etc.)
2. What bodies/tables/venues have been established for Health Units, Ontario Ministries, and Agencies, e.g., MOHLTC, Ministry of Health Promotion, Ontario Agency for Health Protection and Promotion, and other stakeholders to interact to support implementation?  
(Prompts: evidence, data, direction, lessons learned)
3. What, if any, do you believe would be the consequences from government of any failure to implement the OPHS?
4. Are there other provincial initiatives/strategies influencing the implementation of CDP/STIP policies?
5. Are these CDP/STIP activities aligned with other local, regional, provincial, and national initiatives?
6. How has collaboration enabled the implementation of CDP/STIP policies?  
(Prompts: with whom, with what effect)
7. How does the particular governance model for your Health Unit influence the implementation process or the outcomes of CDP/STIP policies?
8. How is your Health Unit dealing with the economic changes in relation to the implementation of the OPHS?
9. Since the OPHS are relatively new, not everyone may be aware of them. What did you know about the OPHS prior to this study and how has your knowledge changed about them?

### Evaluation

1. How is your Health Unit monitoring performance on the OPHS policies?
2. Who (what position within your Health Unit) is developing the mechanisms to monitor/evaluate performance?
3. What are the accountability mechanisms in your Health Unit related to OPHS in relation to CDP/STIP policies?
4. Are there consequences in terms of accountability?



5. How well do the performance monitoring processes work in achieving implementation?
6. How do you define successful implementation of the OPHS policies?
7. How does your Health Unit define successful implementation?

### **Partnerships external to the Health Unit**

1. What new partnerships have been formed and how have old partnerships changed since the implementation of the OPHS?
  - a. What is the purpose of these partnerships?
  - b. How do these partnerships function?
  - c. Who is involved in these partnership

## **Public Health Frontline Staff**

### **Focus Group Questions**

#### **Background**

2. Briefly describe your role within the HU and specifically your involvement with the CDP/STIP program activities/initiatives.

#### **Change in activities over time**

1. How has your role changed with the implementation of the OPHS?
2. What do you think about the change?
3. How do you think your colleagues think and feel about any changes to the CDP/STIP activities they are involved in?  
(Clarify: Which have resulted from the implementation of the OPHS)

#### **Evidence**

1. What informs or guides your practice  
(Prompts: evidence, theory, literature, observing/talking to peers/experts, professional practice guidelines)?
2. What does the word evidence mean to you?  
(Prompts: policy, by-law)
  - a. What constitutes evidence for you? (Could ask this if it isn't elicited by the first part of the question)
3. What evidence/strategies do you use to guide/inform your practice as they/it relate(s) to the OPHS?
4. What kinds of mechanisms are in place for you to foster the use of evidence if any?  
(Prompts: in-services/workshops, continuing education, looking at literature)
5. How do you think evidence is used in relation to the CDP/STIP activities?
6. Do you encounter barriers regarding implementing evidence in your practice?  
(Prompts: for what the barriers are if needed)

**Leadership**

1. Did you ever have discussions/presentations about the CDP/STIP changes from the prior Mandatory Health Programs and Services Guidelines?
  - a. If yes, please describe.
  - b. What did you think of the discussion of changes?
  - c. What supports or activities (e.g., team discussions) are ongoing to discuss these changes?
2. How does your work environment support you in terms of your responsibilities within the new program?

(Prompts: role of manager/directors, other)

3. Do you have an opportunity to provide feedback or input on the CDP/STIP implementation/planning/evaluation of programming?

## Appendix B

**Policy Documents Collected for Primary RePHS Study and Selected for Secondary Analysis**

Study	Documents	Health Unit 1	Health Unit 2	Health Unit 3
<b>Primary RePHS</b>	<b>CDP</b>	29	50	8*
<b>Secondary Analysis</b>	<b>CDP</b>	3	4	4

\*in process of collecting

**Types of Documents Received**

Evaluation documents  
 Internal policies related to programming  
 Work plans  
 Minutes of internal/external meetings, team meetings  
 Community strategies/plans  
 Operational plans, strategic plans  
 Manuals and/or policies and procedures  
 Program logic models  
 Medical directives  
 Program planning guidance documents  
 Environmental scans  
 Program reports, program profiles, program descriptions  
 Annual reports  
 Fact sheets  
 Research results

## Appendix C



## RESEARCH ETHICS BOARD



REB Office, 293 Wellington St. N., Suite 102, Hamilton, ON L8L 8E7

Telephone: 905-521-2100, Ext. 42013

Fax: 905-577-8378

Research Ethics Board  
Membership

Jack Holland MD FRCP FRCP(C)  
Chair  
Suzette Salama PhD  
Vice-Chair/Ethics Representative  
Mary Bedek CCHRA (C)  
Privacy Officer  
Morris Blajchman MD FRCP(C)  
Hematology  
Julie Carruthers MLT  
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Adriana Carvalho MD, MSc, PhD  
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Medicine  
Jean Crowe MHSC  
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Medicine  
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Radiation Oncology  
Ed Younglai PhD  
Obstetrics/Gynecology

The HHS/HSC REB operates in compliance with the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans; the Health Canada / ICH Good Clinical Practice: Consolidated Guidelines (GCP); and the applicable laws and regulations of Ontario. The membership of this REB also complies with the membership requirements for REBs as defined in Canada's Food and Drug Regulations (Division 5: Drugs for Clinical Trials Involving Humans Subjects).

March 31, 2010

PROJECT NUMBER: 10-086

PROJECT TITLE: Public Health Services Renewal in British Columbia and Ontario

PRINCIPAL INVESTIGATOR: Dr. Ruta Valaitis

This will acknowledge receipt of your letter dated March 23, 2010 which enclosed the revised Participant Information and Consent Forms for the above-named study. These issues were raised by the Research Ethics Board at their meeting held on February 16, 2010. Based on this additional information, we wish to advise your study has been given **final** approval from the full REB. The submission, study protocol version 1 dated January 26, 2010 including the Participant Information and Consent Form/For Social Network Analysis, version 2 dated March 9, 2010 was found to be acceptable on both ethical and scientific grounds. **Please note** attached you will find the Consent Form with the REB approval affixed; all consent forms and recruitment materials used in this study must be copies of the attached materials.

We are pleased to issue final approval for the above-named study for a period of 12 months from the date of the REB meeting on February 16, 2010. Continuation beyond that date will require further review and renewal of REB approval. Any changes or amendments to the protocol or information sheet must be approved by the Research Ethics Board.

The Hamilton Health Sciences/McMaster Health Sciences Research Ethics Board operates in compliance with and is constituted in accordance with the requirements of: The Tri-Council Policy Statement on Ethical Conduct of Research Involving Humans; The International Conference on Harmonization of Good Clinical Practices; Part C Division 5 of the Food and Drug Regulations of Health Canada; and the provisions of the Ontario Personal Health Information Protection Act 2004 and its applicable Regulations.

PLEASE QUOTE THE ABOVE-REFERENCE PROJECT NUMBER ON  
ALL FUTURE CORRESPONDENCESincerely, Jack Holland, MD, FRCP, FRCP (C)  
Chair, Research Ethics Board

## Appendix D

### **Thesis Proposal: Place-based Rural Public Health Policy in Ontario**

Student: Angela Jurich, RN, BScN, MScN student, University of Western Ontario School of Nursing

RePHS Ontario Team Member/Thesis Supervisor: Sandra Regan, RN, PhD, Assistant Professor University of Western Ontario School of Nursing

Timeframe: October 2011 – August 2013

### **Purpose of the Study**

This study is designed to examine how “place” is incorporated into rural public health policies, particularly how Ontario rural public health policies for the chronic disease prevention program align with the characteristics of place-based policy.

### **Research Questions**

This study will be guided by the following research question: How do Ontario rural public health unit chronic disease prevention program policies align with place-based policy characteristics?

### **Background and Significance**

There has been an increasing awareness of the importance of “place” and “space” in public policy development and implementation (Bradford, 2005; Cummins, Curtis, Diez-Roux, & Macintyre, 2007; Meuller & MacKinney, 2011). Public policy is implemented at the local level and yet national and provincial governments struggle to adapt their programs and policies to meet the specific needs of each unique community. Mueller and MacKinney (2011) define place-based policies as policies intended and designed for places rather than programs. Place-based policies are neighbourhood and community specific with interventions that respond to the unique needs of places and spaces (Bradford, 2005). They utilize a bottom-up rather than a traditional top-down approach to policy implementation. The aim of place-based policy is “both better government policy and more community capacity” (Bradford, 2005, p. 19). Place-base policy aligns with principles of collaboration, negotiation, social dialogue, and community capacity (Bradford, 2008).

Federal initiatives often fail to recognize how policies are implemented and managed in rural communities, particularly those with limited financial resources and significant workforce shortages (Berkowitz, Ivory, & Morris, 2002; Mueller & MacKinney, 2011). The role of the federal government is not to download more responsibility to the local governments but rather to create national policies that provide framework conditions and support for local initiatives (Organization for Economic Co-operation and Development [OECD], 2002).

Rural places face unique challenges related to decreased/declining populations and greater distances, but advantages related to social relationships built among a small number of community stakeholders. Rural communities face additional obstacles as a result of vast geography and limited community agencies. A place-based policy framework can be an effective strategy for the development, implementation, and evaluation of rural public health policy (Mueller & MacKinney, 2011), responding to specific community challenges while drawing from the ideas and resources of community residents (Bradford, 2005).

The organization and delivery of public health services in Canada is quite challenging given the country's vast geography and wide spread population (Health Canada, 2003). Public health activities in each province and territory are administered in accordance with each province and territory's public health act (Health Canada, 2003). Local public health agencies are then accountable for the planning and delivery of services that meet the requirements and regulations set out in the acts (Health Canada, 2003). Since 2008, Ontario public health units have been implementing the Ontario Public Health Standards (OPHS) as mandatory requirements for public health programs and services, which include assessment and surveillance, health promotion and policy development, disease and injury prevention, and health protection (Ministry of Health and Long-Term Care [MOHLTC], 2008). Each local health unit has some flexibility in programming with respect to specific community needs, as many of the requirements set out in the act are to be achieved through partnerships with local government and non-government organizations that differ from community to community (MOHLTC, 2008). Rural communities, particularly those with inadequate or limited financial and human resources are limited to providing only the most basic health services (Kitley, 2007). Community public health services do not take precedent over other service areas (such as emergency care and tertiary care) that need funding (Kitley, 2007). Rural public health units often have limited programs and functions and unfilled job positions (MOHLTC, 2008), making it a struggle to meet the requirements of the public health standards.

As part of a Canadian Institutes of Health Research funded study of the implementation of the OPHS, Renewal of Public Health Systems (RePHS) is conducting a case study of implementation of the OPHS in six Ontario public health units. This proposed thesis-based study will analyze data collected from the three rural Ontario public health units in the first phase of the RePHS study.

## Methods

A secondary analysis of focus group and interview data along with the policy documents from three rural Ontario public health unit sites for the RePHS study will be conducted. The aim of the proposed study is to understand how characteristics of place-based policy are discussed or addressed in relation to the development and implementation of OPHS related to chronic disease prevention (CDP) policies.

Qualitative content analysis as articulated by Krippendorff (1980) will be the methodological framework used to guide this study. Content analysis is a method of analyzing communication messages (Cole, 1998). Historically designed for use in

communication research (Krippendorff, 1980), content analysis is today being used as a research method in many nursing studies, specifically those in the field of public health nursing (Elo & Kyngas, 2008). Content analysis is a method used for making reliable and valid inferences from data to their context, with the goal of providing knowledge, new understanding, and a description of facts (Krippendorff, 1980). Based on a review of the literature on rural health policy and place-based policy, a framework of characteristics will be developed and used to analyze the focus group/interview transcripts and policy documents. For example, analysis will include understanding social determinants of health, community health measures, and socio-economic factors unique to each of the three communities served by the rural public health units and then examine how these are discussed in relation to OPHS CDP policy implementation.

Data will be accessed through a secure web portal. Because this is a secondary analysis of existing data, ethical approval is not required by the student's home university. However, should the RePHS Steering Committee require ethical approval, this can be obtained.

### **Deliverables**

A manuscript-based thesis will be developed. A deliverable from the thesis is a manuscript for submission to a peer-reviewed journal. In addition, a summary of the thesis findings will be provided to the RePHS research coordinator for the newsletter. Findings will also be disseminated at a relevant conference either as a poster or oral presentation.



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## Appendix E



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## PLEDGE OF CONFIDENTIALITY

In order to ensure that all members of the research team involved in **Renewal of Public Health Systems (RePHS)** fulfill their obligations to the Study Participants, anyone with access to confidential information of third parties must make this Pledge of Confidentiality.

1. I recognize and acknowledge that in the course of my involvement in the research study **Renewal of Public Health Systems (RePHS)**; I may gain access to certain "Confidential Information" (as defined below). I shall not use any Confidential Information at any time except for purposes of performing my duties with respect to the Research Study. I shall not disclose any Confidential Information in any manner, at any time, to any individual or entity that is not bound to confidentiality provisions with McMaster University, School of Nursing and/or any Research Partners similar to the ones imposed by this Agreement. I shall continue to observe strict confidentiality of this information when I cease to be involved with the Research Study.
2. "Confidential Information" means information you gain access to in the course of your participation in the Research Study, that is, private information pertaining to an individual or organization or information that is of a confidential or secret nature and that may be related to the Research Study including, without limitation, the protocol, methods, processes, procedures, strategies developments, results, and outcomes.
3. I acknowledge that I have had sufficient time to review this Agreement and fully understand its contents and its effect on me.

RESEARCH TEAM MEMBER/STUDENT

WITNESS

Angela Jurich  
Printed name of Team Member/Student

\_\_\_\_\_  
Printed name of Witness

\_\_\_\_\_  
Signature of Team Member/Student

\_\_\_\_\_  
Signature of Witness

Masters Student  
Role on Research Team

September 26 2011  
Date

\_\_\_\_\_  
Date



School of Nursing

## Curriculum Vitae

**Name:** Angela Jurich

**Post-secondary Education and Degrees:** Sault College  
Sault Ste. Marie, Ontario, Canada  
2006-2010 BScN

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2010-2013 MScN

**Related Work Experience** Teaching Assistant  
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**Presentations:**

Jurich, A., Regan, S., McWilliam, C. (2012, May). *Place and Space-based Rural Public Health Policy*. Poster presented at the Iota Omicron Conference, London, Ontario,