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Understanding Women's Health Promotion in Rural Canadian Churches

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Graduate Program in Nursing

A thesis submitted in partial fulfillment of the requirements for the degree in Doctor of Philosophy

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UNDERSTANDING WOMEN'S HEALTH PROMOTION IN RURAL
CANADIAN CHURCHES

(Thesis format: Integrated-Article)

by Robyn Plunkett

Graduate Program in Nursing

A thesis submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy

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

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ABSTRACT

Many rural health resources are linked to community churches, which are often well attended, especially by rural women. Thus, the rural church may be an effective health resource for rural Canadian women who have compromised access to health resources. Despite the significant role that the rural church plays in the life of rural communities, there is very limited research that addresses how the church acts or could act as a health resource for rural women. Furthermore, there is limited understanding of how the church as a place may influence health promotion in rural communities. This dissertation explores the relevance of the Christian church in promoting the health of rural Canadian women as both experiential and place-based phenomena.

Interpretive phenomenology and the photovoice method were used to understand how the church influenced health promotion for rural women. Twenty-two women in five rural southwestern Ontario communities took pictures, documented in logbooks, and participated in group sessions as a means of data collection and generation. Phenomenological and participatory data analysis suggested that the rural church significantly facilitated rural women's health promotion. The church supported the physical, intellectual, emotional, and spiritual health of rural women, facilitated social connectedness, and provided healthful opportunities to give and to receive. Furthermore, the church as a place was realized through three broad discourses: an intersection of physical and geographic environments, a gateway to experiential attachment and personal meaning, and as a connection to shared culture and beliefs.

Findings suggest that individual and collective health can be promoted with access to social structures and relationships stemming from the rural church. The church and rural women's health promotion, however, cannot be studied in isolation for they exist within broader

socioeconomic and political climates. As the church can be a supportive facilitator for rural capacity, exploring how intersectional categories shape or hinder relationships among individuals would help to better inform how the church might act as a resource towards promoting healthy communities. Furthermore, recognizing the personal meaning and shared cultures, including spatial and religious cultures embedded within places, may assist religious communities and health-care providers to promote access to religious spaces for health promotion purposes. In rural communities, parish, community, and public nurses have an increasingly important responsibility to examine how churches can shape experiences of health and of healing in addition to expressions of nursing care. Implications included reframing religious places as health promoting and socially inclusive places for rural women.

CO-AUTHORSHIP

Robyn Plunkett completed this dissertation under the supervision of Dr. Beverly D. Leipert, Dr. Susan L. Ray, and Dr. Joanne Olson.

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This dissertation is dedicated in memory of Susan Ray, who will be greatly missed. It was an honour and a privilege to have worked with Sue, whose legacy will carry forth in the many lives she touched, mine included.

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Chapter One -Introduction

This dissertation outlines doctoral research in nursing and rural women's health that occurred in rural churches in southwestern Ontario. It is presented in integrated article format as outlined by the Arthur Labatt Family School of Nursing at Western University (2005). The dissertation is composed of six chapters, four of which have been published or submitted for publication in peer-reviewed journals and the remaining two chapters serve as the introductory and concluding chapters. Because four articles are written as stand-alone papers, there is some necessary overlap between these chapters. This introductory chapter provides definitions for key concepts and describes the study background, purpose, design, and significance.

Study Background

Health promotion can be defined as a process that enables people to gain increased control over their health, thereby improving it (World Health Organization [WHO], 2014). The nature and availability of community health resources, however, inevitably shape an individual's ability to promote his or her health. Rural Canadian women, for example, often have compromised access to social determinants of health, such as social support, caused in part by rural contextual factors including rural depopulation and limited health resources (Canadian Institute for Health Information [CIHI], 2006; Winters, 2013).

Challenges to rural women's health promotion in Canada are numerous and include limited access to health care and illness-related stigma (Leipert, Leach, & Thurston, 2012). Furthermore, public health policy, which directs many primary health promotion and illness prevention resources at the community and populations levels, is often urban centric and thus is minimally or not effective in addressing rural health promotion needs (Sutherns, McPhedran, & Haworth-Brockman, 2004). Nor may public health policy adequately support community

development (Underwood, 2010), which is an impetus for healthy rural communities (Meagher-Stewart et al., 2009). Despite such challenges to health promotion, the rural landscape also presents unique opportunities for health promotion, which include health supports available through the rural church. Rural churches are often prominent community centres in rural communities and in many cases are deeply woven into the fabric of these communities (Clark, 2000).

Health-related resources available through the rural church include basic supports for life and livelihood (Douglas, 2003), including social support (Buijs & Olson, 2001). Often, churches have resources such as meetings rooms and established groups that facilitate health promotion programs (Campbell et al., 2007). Such church-related health resources may be particularly relevant for rural women as church attendance is higher for rural women than for rural men (Clark, 2000). This may be because rural women often have stronger social ties to their church congregation and women are more likely than men to continue attending church after becoming widowed, separated, or divorced (Clark, 2000).

In Ontario, rural residents account for approximately 22.7% of the provincial population (Glazier, Gozdyra, & Yeritsyan, 2011). Rural communities are increasingly becoming aged and feminized societies with senior women significantly outnumbering senior men in rural Ontario (Government of Ontario, 2009). For example, while there were 56,180 rural Ontarian women over the age of 85 in 2006, there were only 25,140 men of the same age (Government of Ontario, 2009). Thus, church closures may most negatively affect the health of senior rural women because it is rural senior women who might most often rely on the church as a primary source of community connection (Panazzola & Leipert, 2013). Because women are significant stakeholders in the health of their rural families and communities (Hibbard, Greenlick, Jimison,

Kunkel, & Tusler, 1999; Stoller, 1993), health promotion programs and services in rural areas will increasingly need to include care that is accessible, acceptable, and appropriate to the growing aging demographic of rural women. Despite the significant role that the rural church plays in the life of rural communities, there is very limited research that addresses how the church acts or could act as a health resource for rural women.

Defining Key Concepts

Rural

While there are many definitions of rural, population, density, and context are some of the often employed criteria used to determine whether an area is urban, rural, or somewhere in between (du Plessis, Beshiri, Bollman, & Clemenson, 2002). For the purposes of investigating issues in rural Ontario, the Ontario Ministry of Health and Long-Term Care (MOHLTC) designated the following definition of rural, “Rural communities in Ontario are those with a population of less than 30,000 that are greater than 30 minutes away in travel time from a community with a population of more than 30,000” (MOHLTC, 2010, p.8).

While rural may most accurately be defined as a socio-cultural place-based concept (Cummins, Curtis, Diez-Roux, & Macintyre, 2007), this study adopted the MOHLTC (2010) population-based definition of rural for numerous reasons. First, centres with a population less than 30,000 usually have less access to health-related services, including inpatient specialties and community-based health programs than do larger urban centres (MOHLTC, 2010). Second, for recruitment purposes, it was practical to have a clear and specific criterion of rural to determine participant inclusion. Third, the feasibility of this doctoral work required a working definition of rural from which a sufficient sample size could be drawn in southwestern Ontario.

Church

Churches have a long anecdotal history of supporting women's health in many rural and remote areas in Canada (Burrows, 2004). For many predominantly Christian communities, the concepts of health, spirituality, and religion are heavily intertwined. Spirituality, for example, fosters the development of cultural and social connections (Leipert, 2013), and influences rural Canadian women's health beliefs, behaviours, and even outcomes (Thomlinson, McDonaugh, Baird-Crooks, & Lees, 2004; Thurston & Meadows, 2004; Zupko, Shearer, & Vermeulen, 2003).

Religious affiliation in rural Ontario may provide frequent opportunities for rural women to socialise within the rural community and it might influence some of their life decisions. For example, it is estimated that over 80% of rural women in Ontario consider religious or spiritual beliefs to influence the decisions they make (Statistics Canada, 2003). Furthermore, over 86.1% of rural women in Ontario consider themselves Christian and 32.8% of rural women attend a religious service on a weekly basis (Statistics Canada, 2003). Thus, the church may play a significant role in the lives of many women in rural Ontario.

The term church means many things to many people. Its meanings are often deeply embedded within historical and socio-religious contexts, which might help to explain why there is no widely agreed upon definition of the term. The origin of the word church is Greek for "of the Lord" (Harper, n.d., n.p.). Yet, churches have been defined as physical buildings, programs of religious doctrine, acts of public worship, the clerical profession, and groups of people sharing a common belief in a Higher Power ("Church", 2011). Willmer (1984) further describes church as an inclusive term that includes "local congregations, centralized administrative ... institutions, ... and prophetic operations..." (p.20). Perhaps the only unattested definition of church is that it

falls somewhere between “chocolate” and “cider” in the dictionary (Knox, 2011). The definition of church extends to all Christian denominations.

To accommodate and recognize varying definitions of church, its meaning might best be individually conceptualized and often includes physical structures (buildings), organizational structures (including church leadership and membership), and social structures (congregations). A working definition of the term, however, was used to identify churches for the purposes of this study. Churches were broadly interpreted as physical spaces for Christian worship to which an affiliated group of individuals considered themselves members or adherents.

Relevant Literature

Chapter Two in this dissertation, “Women’s Health Promotion in the Rural Church: A Canadian Perspective” (Plunkett & Leipert, 2013) discusses relevant literature related to rural women’s health issues and health promotion as it has been studied in various Christian faith communities. It suggests that faith-based health promotion is most often studied from a post-positivist perspective, focussing on pre-determined variables such as cholesterol or physical activity levels (Plunkett & Leipert, 2013). Furthermore, much of the literature stems from urban areas, with little Canadian data and even less from rural settings. While there is some significant research that examines women’s health in predominantly religious communities in Canada, including High and Low German-speaking Mennonite communities (Dabrowska & Bates, 2010; Kulig, Wall, Hill, & Babcock, 2008), how the health of rural women is promoted in the rural Canadian church remains relatively unknown.

Purpose

The purpose of this study was to enhance understanding of rural women’s experience of health promotion in the rural church. Thus, this study was conceptualized to examine the

following research question: “What is the experience of health promotion in rural churches as it occurs in the lives of rural women in Ontario?” A secondary purpose of the study emerged during the research process, partly in appreciation that to truly illuminate women’s experience of health promotion in the rural church, women’s conceptualization of the rural church as a place must also be elicited. Thus, a second research question, “What is the meaning of church as place in rural women’s experience of health promotion?” was created.

Setting and Sample

This study is specific to southwestern Ontario for several purposes. First, the research was based out of a southwestern Ontario university. Thus, there was some likelihood that participants would be familiar with the university, which might ease some hesitancy for study participation. Second, because rural southwestern Ontario communities are closer in proximity to the university, multiple visits to each site were possible, which yielded a greater breadth and depth of data. Third, at the time of the study, rural southwestern Ontario was undergoing a radical change in social structure and culture, thus a unique perspective on rapidly rural changing communities was available.

Job opportunities, for example, in many southwestern Ontario rural communities were becoming increasingly difficult to find due in part to automated agriculture practices and factory closures (Van Brenck, 2013). As a result, many rural areas were undergoing significant depopulation and the closure of community institutions such as schools and churches. One rural southwestern Ontario township for example, experienced a 17% decrease in population over the last decade (Van Brenck, 2013). An article in a community newspaper that showcased this trend from the perspectives of rural residents and local government officials concluded that rural emigration largely occurred in their communities because, “Teens leave for college and don’t

come back. Couples lose jobs and pack out. Older people move to where the health care is" (Van Brenk, 2013, para. 17).

This study is specific to women because they are often the backbone of rural societies. Furthermore, women form the majority of rural church congregations (Clark, 2000) and are therefore more exposed to health influences of the church, both benefits and drawbacks, than their male counterparts. In many rural cultures, women are the primary seekers of health information (Wathen & Harris, 2007), thus their understanding of health resources may have implications that extend to their families and communities.

Methodology

"And the end of all our exploring

Will be to arrive where we started

And to know the place for the first time"

(Eliot, 1943, p. 59)

To understand rural women's lived experience of health promotion in the rural church, rural women's unique interpretation of the experience must be elicited. Thus, this research fits within the philosophical underpinnings of interpretive phenomenology, in which meaning and knowledge are constructed by individuals as they interact with the world in which they are living (Crotty, 1998). Furthermore, because health promotion is conceptualized as a phenomenon that enables individuals to exert control over their own health (WHO, 2014), it is fitting to use an interpretive phenomenological methodology that allows rural women to express their unique interpretation of the experience.

To understand the complex nature of this phenomenon, it is necessary to understand the multiple interactions, such as rural community culture, that intersect at or affect the experience.

While these interactions may not be known at the outset, they can emerge through interpretation as the unfamiliar or unarticulated intersections are exposed. This discussion and dialogue is often referred to as the hermeneutical circle (Gadamer, 1976). The research approach is one of inter-subjectivity; both the researcher and the participants begin the process with the intention of advancing understanding. “The hermeneutical circle of interpretation moves forward and backward....Through rigorous interaction and understanding, the phenomenon is uncovered” (Allen & Jensen, 1990, p.245). In interpretive phenomenology, the discovery of practical wisdoms becomes a reality (Dreyfus, 1994). In this study, such practical discoveries might help to inform how the rural church could be better utilized to promote the health of rural women.

Given that women’s experiences of health promotion in the rural church exist within a complex environment of intricacies of rural life and culture, there was an opportunity to expand upon understanding of the experience by eliciting additional data, beyond what is traditionally gathered from phenomenological in-depth interviews. To better understand the experience within its context, the photovoice method (Wang & Burris, 1997) was used alongside interpretive phenomenological inquiry (van Manen, 1997). The inclusion of the photovoice method within interpretive phenomenology filled an experiential gap of understanding furnished by limitations of the spoken language, “Epistemological silence” (van Manen, 1994, p.113).

Rooted in the theoretical assumptions of critical consciousness, feminist theory, and documentary photography (Wang & Burris, 1997), photovoice is a participatory research approach that creates spaces and opportunities for marginalized voices, such as those of rural women who are rarely included in research, to be heard. van Manen (1997) and Gadamer (1996) both discussed the importance of non-discursive artistic material for hermeneutic phenomenological inquiry as a way to help illuminate experiences by presenting and clarifying

meaning. Because both visual and linguistic forms of data contribute to a heightened understanding of the narrative and experiential phenomenon (Brunsden & Goatcher, 2007), the use of both interpretive phenomenology and the photovoice method allows for rich access to and interpretation of women's experience of health promotion in the rural church.

The combined use of interpretive phenomenology and photovoice necessitated an innovative and expansive approach to data collection. Data were collected via four primary methods: 1) individual interviews which were guided by a semi-structured interview guide (Appendix A), 2) group interview sessions, which included camera orientation sessions (Appendix B; C) and photo-sharing sessions (Appendix D) 3) logbooks for data written by study participants, and 4) photographs taken by study participants. All interviews, individual and group, were audio-recorded and transcribed verbatim.

All steps required to fulfill ethical obligations including the protection of human participants and confidentiality were taken. Ethical approval was obtained from Western University's Office of Research Ethics (Appendix E). A Letter of Information (Appendix F) was given to each participant at the camera orientation session and written informed consent (Appendix G) was obtained from each participant. Women were provided with Letters of Information for participants having their picture taken (Appendix H) and obtained written informed consent from individuals whose pictures they took.

Chapter Three, "Unspoken phenomena: Using the photovoice method to enrich phenomenological inquiry" (Plunkett, Leipert, & Ray, 2013) outlines the methodology used in this study. The philosophical underpinnings of the methodology (Heidegger, 1962) and methods (Wang & Burris, 1997) are discussed in addition to data collection and analysis approaches that were used (Oliffe, Bottorff, Kelly, & Halpin, 2008; van Manen, 1997). Furthermore, because the



photovoice method originated in the critical paradigm, close attention was given to its use within interpretive phenomenology, a methodology strongly positioned in the interpretive paradigm, to promote methodological congruency. This criterion, along with other rigor and ethical considerations of the methodology, are discussed further in Chapter Three.

Embodied Understanding

The human science researcher who explores the lived experience of others does so amidst their own lived experience. Knowledge, ways of understanding, and past experiences of the researcher become integrated into the methodology as they cannot be dissociated from the researcher as a human being. Experience can only be understood by the researcher within the context of their own presuppositions (Gadamer, 1989; Heidegger, 1962). As meaning attributed to a phenomenon is shaped by interpretation, it becomes important for the researcher to recognize how her historicity and situatedness may influence interpretation.

Thus, how I came to understand the experience of health promotion in rural churches as it occurs in the lives of rural women will be a function of my background and ways of understanding. As I reflected upon personal presuppositions related to the question at hand, I recognized that my interest in health and rural churches has been with me since a child. Spending significant amounts of my childhood in the rural farmlands of eastern Ontario, I remember thinking that the church was an integral part of the rural community which I frequented. I remember going to the church for Sunday service - the one time each week that I was guaranteed to see the people who lived nearby whose farming obligations prevented more frequent social interactions. I remember grandparents and neighbours discussing church events and clergy vacancies in neighbouring small towns. I remember reading the church bulletins that disseminated community information and acted somewhat in lieu of a non-existent community

newspaper. I remember people quoting the pastor's words and verbalizing their adherence to his teachings. And, I remember my grandfather eagerly waking us up every Sunday morning with two hours to spare so that we weren't late for church.

Quite some years later, my academic path led me to the field of nursing. It was here that I learned about health promotion and the influence of place on the health of individuals and communities. I began thinking about rural communities and the churches therein. I began wondering how the rural church, which I remembered from my childhood as being so important in the lives of many rural dwellers, influenced health both positively and negatively. In particular, I came to wonder how the church influenced the health of rural women, who I remember being much less verbal in church-related discussion than their male counterparts, but who were often found behind the scenes organizing, running, and seemingly taking responsibility for many community and church functions.

Throughout this study, I continually reflected on my experiences and pre-understandings of the phenomenon to understand how my interpretation of meaning embodied my historicity and ways of knowing. After each data collection session, including interviews and group sessions, I made field notes to document self-reflections and insights (Patton, 2002; van Manen, 1997). The field notes also documented facts such as church membership statistics and the operating hours of the local grocer that were provided by the study participants or personally observed on my visits to the rural communities. These supplementary sources provided additional context for the rural communities and allowed for a richer description of the rural environment.

In some cases, conversations were not audio-taped, such as those spontaneously occurring immediately before or after interview sessions. Additional notes were made on these

conversations to preserve their meaning as much as possible. In one case, for example, a participant provided an impromptu in-depth tour of the church parlour, which included an explanation of many pictures hanging on the wall. This discussion in particular revealed how vividly the church's history remained in her memory. I also sketched the churches' physical layouts as a reminder of the physical infrastructure of each church. In some cases, I took photographs of community settings or other scenes of interest. On one trip to a rural community, for example, I encountered a snow squall. The picture I took reminds me of the unpredictable weather and treacherous driving conditions experienced by rural women on some rural routes in the winter months. Participants in the study also graciously provided me with additional sources of data including hard-copies of rural humour in comic form, historical church documents, personal stories and poetry, and church bulletins. I am very grateful for these additional data sources as they helped to inform how the participants view their rural world.

Illuminating Experiences of Health and Place

Data were collected in 2012 and 2013 from 22 women attending five churches in rural southwest Ontario. The fourth chapter, "Understanding women's health promotion in the rural church," outlines the recruitment process for the 22 women who participated in the study. Each participant completed a two-page socio-demographic questionnaire (Appendix I) to provide information regarding their age, health status, church involvement, etc. Although 24 participants began the study, two withdrew and their data are excluded from the sample characteristics. Chapter Four is the first of two reports that present research findings in this dissertation. It presents thematic findings of women's experience of health promotion in the rural church. Salient themes indicated that the church supported the physical, intellectual, and spiritual health

of rural women, facilitated their social connectedness, and provided healthful opportunities to give and to receive.

In Chapter Five, “Healthy spaces in meaningful places: Women’s health promotion in the rural church,” the significance of place was illuminated through three broad themes: 1) An intersection of physical and geographic environments, 2) a gateway to experiential attachment and personal meaning, and as 3) a connection to shared culture and beliefs. Data analysis suggested that place consisted of both physical realities as well as experiential ones, in addition to being a resource of culture and meaning. The concluding chapter, Chapter Six, summarizes key findings, discusses implications for nursing, and suggests avenues for future research.

Permission to Include Previously Published Material

The following chapters have been published or accepted for publication in the following journals: Chapter Two, “Women’s health promotion in the rural church: A Canadian perspective,” has been published in the *Journal of Religion and Health* (Plunkett & Leipert, 2013), Chapter Three, “Unspoken phenomena: Using the photovoice method to enrich phenomenological inquiry,” has been published in *Nursing Inquiry* (Plunkett, Leipert, & Ray, 2013), Chapter Four, “Understanding women’s health promotion in the rural church,” has been published in *Qualitative Health Research* (Plunkett, Leipert, Olson, & Ray, 2014), and Chapter Five, “Health spaces in meaningful places: The rural church and women’s health promotion,” has been accepted for publication in the *Journal of Holistic Nursing* (Plunkett, Leipert, Ray, & Olson, In press). Permission to include these manuscripts in this dissertation has been granted by each publisher (Appendix J; K; L; M).

Conclusion

This study is the first known to rigorously explore women's experience of health promotion in the rural church. It is hoped that the subsequent chapters will be useful for scholars, rural women, nurses, government agencies, and faith-based organizations to assist with the conceptualization and implementation of health promotion programs and services for rural women. The need to understand rural women's health promotion in the church is of utmost importance because the church, which plays a central role in the lives of many rural women, may also play a significant role in how rural women understand and address health. Rural women have compromised access to social determinants of health (CIHI, 2006) and there is limited research that addresses their health promotion needs and resources (Leipert, 2013). Thus scholarship aimed at exploring how the rural church does or could promote rural women's health could significantly benefit the health of rural women, their families, and communities.

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Chapter Two -Women's Health Promotion in the Rural Church:

A Canadian Perspective

Health promotion is generally defined as a process that enables people to gain increased control over their health, thereby improving it (World Health Organization, 2009). Yet, an individual's ability to promote his or her health is inevitably shaped by the availability and nature of community health resources. Rural Canadian women, for example, often have compromised health caused in part by contextual factors such as rural depopulation, distance to health services, and limited health resources (Canadian Institute for Health Information [CIHI], 2006). Participating in church-led activities may be one way that rural women obtain or could obtain access to health resources because churches frequently provide social support and connections to the community (Buijs & Olson, 2001) and many churches have resources such as meetings rooms and established groups that could facilitate health promotion programs (Campbell et al., 2007). Scholarship aimed at exploring how the church influences health promotion for rural Canadian women is gravely needed because rural women are a significantly understudied population who may strongly associate faith and health and benefit from church-based health promotion services and programs.

Faith community nurses are registered nurses working within a faith community who address health issues for both members of the faith community and for the community at large (International Parish Nurse Resource Centre [IPNRC], 2009). They may provide another way to increase rural women's access to health promotion and health care. This paper highlights specific health promotion challenges for rural Canadian women and suggests how the rural church and faith community nurses may act as a health resource for this population.

Method

In this paper, literature exploring enablers, obstacles, and possibilities of women's health promotion in the rural Canadian church was examined. CINAHL (Cumulated Index to Nursing and Allied Health Literature) and PubMed databases were searched for articles in the English language between 1995 and 2010 using the keywords: rural women, Canada, faith-based communities, faith community nursing, parish nursing, church, church-based health promotion, religion, spirituality, and related terms. A total of 42 articles were found. Of these studies, 15 did not specifically include Canadian data, five were irrelevant to the purpose of this paper, four did not distinguish between urban and rural data, and 11 did not have a significant religious or spiritual aspect. The remaining seven articles were retained and included in this paper. Due to the scarcity of literature on rural Canadian women's health and the church, additional cited articles, book sources, and national and local government-issued reports are also included in this paper.

Rural Context in Canada

Geography and Definition of Rural

While there are many definitions of "rural," population, density, and context are some of the criteria used to determine whether an area is urban, rural, or somewhere in between (du Plessis, Beshiri, Bollman, & Clemenson, 2002). Because there is no widely accepted definition of what constitutes "rural" in Canada, comparing research findings and health policies from different rural communities becomes challenging due to the different conceptualizations of "rural" (Thomlinson, McDonaugh, Baird-Crooks, & Lees, 2004). Six definitions of "rural" have been outlined by Statistics Canada (du Plessis et al., 2002). One of these definitions, the often used Rural and Small Town (RST) definition, describes "rural" as a population living outside the commuting zone of urban centres with more than 10,000 inhabitants (du Plessis et al., 2002). The RST definition of rural is useful when considering community issues such as church usage

because individuals living in RSTs may be more likely to access rural services versus those located in larger urban centres. In using this definition, rural residents account for approximately 20% of the Canadian population (Statistics Canada, 2009).

Rural Canada contains official language minority communities (English and French), small immigrant populations, and over half of Canada's 1.4 million Aboriginals (Ministerial Advisory Council on Rural Health [MACRH], 2002). The vastness of the rural Canadian landscape contains coastal, prairie, and northern areas, all of which are environmentally diverse. Rural communities, and their economies, are often dependent on the natural resources available to them. For example, fishing is prevalent in the coastal and northern regions and agriculture in the central prairies. Some communities rely solely on a single-industry such as hunting, tourism, or mining for economic stimulus, while other communities depend on several industries (MACRH, 2002).

There is growing evidence that rural communities in Canada are undergoing depopulation and that the proportion of seniors in rural areas is higher than in urban centres (CIHI, 2006). One of the major factors causing depopulation is the economy. While rural Canada is essential for farming, fishing, and natural resources in addition to playing an increasing role in manufacturing (Standing Senate Committee on Agriculture and Forestry, 2006), the rural working-age population is migrating to urban centres for the hopes of a better life (Rennie, Baird-Crooks, Remus, & Engel, 2000) as job opportunities and incomes are significantly higher in urban areas than in rural areas (Statistics Canada, 2004). Unskilled occupations tend to be centralized in rural areas whereas managerial and professional positions are primarily located in urban centres (Statistics Canada, 2005). The relative decline in the working-age population in rural Canada

may lead to fewer individuals available to care for the growing demographic of community elders, which may have significant effects on the health of rural communities.

Health Care Issues

“If there is two-tiered medicine in Canada, it’s not rich and poor, it’s urban versus rural” (Wootton, 1999, p.132).

The Canadian health care system has been undergoing major changes over the past several decades with a primary effort of striving for cost-effectiveness (Laurent, 2002). Rural Canada has been significantly affected by many of these changes. In the early 1990’s, for example, the prairie province of Saskatchewan closed 52 acute-care rural hospitals (Liu, Hader, Brossart, White, & Lewis, 2001). Furthermore, many rural health units are having difficulty staffing rural nursing positions (CIHI, 2002). As a rural health-unit employee in southern Ontario stated, “people (registered nurses) tend to come here, get experience and get pulled away to another centre due to opportunity and salary” (Haldimand-Norfolk Health Unit [HNHU], 2008, p.18). The shortage of registered nurses in Canada is a growing problem for the health of rural communities. Nurses are significant community assets for health promotion because they are often the only health promotion professionals in rural areas.

Rural residents in the prairie province of Manitoba have described community nurses, public health nurses, and home care services as key health resources in their communities (Thomlinson et al., 2004). Yet in Canada, less than 18% of registered nurses work in small towns and rural areas (Macleod et al., 2004) and half of these nurses work part-time (CIHI, 2002). Furthermore, there are 62.3 registered nurses per 10,000 rural Canadian inhabitants while urban Canada has a ratio of 78.0 registered nurses per 10,000 people (CIHI, 2002). Because many rural women prefer to seek health care provided by females (Leipert & Reutter, 2005), the shortage of rural nurses may disproportionately affect rural women’s access to health care.

Limited access to various health care services has also been documented by rural residents. For example, residents in one rural county in Ontario have reported that they are not able to access mental health services in an urban centre due to geographical distance (Woolwich Community Health Centre, 2005). Rural adolescent females in the western province of British Columbia have reported difficulty accessing sexual health care services in their community partly due to community attitudes that do not support contraception (Shoveller, Johnson, Prkachin, & Patrick, 2007). Rural women have also reported that while there may be health and social services available in their community, the services offered are not necessarily acceptable or helpful to them (Riddell, Ford-Gilboe, & Leipert, 2009). For example, there may not be transportation to the health care centre or women simply may avoid using services due to the lack of confidentiality and anonymity often experienced in a small town (Riddell et al., 2009). Thus, the lack of services and community values can both affect rural women's access to health care.

Challenges to the development and implementation of health promotion programs in rural settings may also exist due to the presence of lower levels of education in rural Canada. The secondary-school attrition rate is nearly double in rural Canada compared to urban centres, 16.4% vs 9.2% respectively (Bowlby & McMullen, 2005). Furthermore, while 22% of urban Canadians hold a university degree, only 15% of rural Canadians do (Statistics Canada & Organisation for Economic Co-operation and Development, 2005).

Thus, the implementation of health promotion programs in rural Canada may warrant an appreciation of the varying age, educational, and other demographic characteristics of the population. Because rural women have compromised access to health care (CIHI, 2006) and there is limited research that addresses health promotion needs and resources of rural Canadian

women (Leipert, 2010; Sutherns, McPhedran, & Haworth-Brockman, 2004), scholarship aimed at exploring these needs and resources could significantly benefit the health of rural women. Furthermore, the importance of providing adequate health promotion services to rural women is highlighted because the health of rural women is often neglected by themselves and others and because women are often the primary seekers of health care and information for their entire family (Hibbard, Greenlick, Jimison, Kunkel, & Tusler, 1999; Stoller, 1993). Thus, enriching health promotion services to meet the needs of rural women is important for the health of rural women as well as their families and communities.

Rural Women's Health Issues

Physical Health Issues

Canadian women living in rural areas have lower life expectancies, demonstrate less-healthy behaviours, and are more likely to be affected by poverty and violence than their urban counterparts (CIHI, 2006; Martz & Saraurer, 2000). Canadian women aged 20-64 years are at a greater risk for mortality caused by circulatory disease if they live in remote areas and women are more likely to die from cancer before the age of 65 if they live in a rural setting (CIHI, 2006). Furthermore, a lesser proportion of rural residents report eating five portions of fruits and vegetables per day, a higher proportion of rural residents consider themselves smokers or report daily exposure to second-hand smoke, and a higher proportion of women living in remote areas report themselves as being overweight compared to their urban counterparts (57.2% vs 46.9%) (CIHI, 2006).

Certain rural factors, such as questionable road safety and inadequate housing, may have a role in limiting the physical health potential of rural Canadian women. In a recent qualitative study in two rural southwestern Ontario areas (HNHU, 2008), five focus groups were held with 59 public health staff. Specific challenges to healthy lifestyles for rural residents were noted in

the form of inadequate housing, lack of affordable and healthy foods, and limited access to physical activity. One participant noted, “(You) can’t walk to the store, can’t walk safely along country roads for exercise...(You) have to go out of town and travel to take your kids swimming” (HNHU, 2008, p.18). In many rural Canadian communities, inclement weather in the winter months increases safety concerns for highway driving. Going to a neighbouring town to participate in physical activity or in health promotion programs may not be an option for many rural women in the winter months.

Low-incomes, which stem in part from limited job opportunities, may also limit the physical health potential of rural Canadian women. Rural and remote regions contain some of the lowest annual household incomes in Canada (MACRH, 2002). Low incomes contribute to reduced purchasing power that may hinder individuals’ and families’ abilities to secure adequate nutrition, housing, and clothing which may contribute to adverse health outcomes such as malnutrition (Leipert, 2005). Low incomes may also curtail rural women’s ability to access various health care options. For example, the financial cost of travelling to a health centre may be too high for some individuals, particularly if specialized care is available only in distant urban centres. In addition, individuals may not be able to access health services simply because they cannot afford to miss work to attend appointments in distant locations.

Social and Mental Health Issues

Despair, depression, and psychological distress are among some of the mental health issues that exist for rural women (Leipert & Reutter, 2005). A survey of 717 rural women in the farming province of Saskatchewan revealed that a significant proportion of rural women experienced stress-related health symptoms including sleep disturbances (66%), inability to concentrate (53%), having trouble relaxing and feeling anxious, sad, or depressed (57%), and

irritability or short temper (48%) (Kubik & Moore, 2001). The high-stress levels of these and other rural Canadian women is particularly alarming because the economic hardship encountered in many rural communities is contributing to an ever-increasing workload for rural women (Leipert, 2005) which may further heighten their stress.

While these mental health issues are not exclusive to rural women, they are of particular concern for this population because rural women may be less likely to seek or obtain professional assistance to help them cope with their condition(s). Kubik and Moore (2001) explain that while rural women may wish to consult mental health professionals, the stigma associated with mental health in many rural areas may be a strong deterrent for women to seek professional help. Some women have reported a fear of having their car identified while parked at the mental health clinic (Kubik & Moore, 2001). Rural women may also be less able to access mental health services due to a reduced awareness of mental health issues and normalization of depressive symptoms in rural communities. In a qualitative study, 14 rural women living in the maritime province of New Brunswick described their experience of depression as a regular part of daily life (Scattolon & Stoppard, 1999). As one woman stated, “we wouldn’t be too normal if we didn’t get depressed” (Scattolon & Stoppard, 1999, p.212).

Another woman attributed her depression to financial circumstances and when asked why she hadn’t sought help from a physician, she replied, “I know I am depressed and I don’t know how (a physician) can help there. (Is the physician) going to give me some money?” (Scattolon & Stoppard, 1999, p.211). The maritime women did not seek medical help because many believed that their depression was a result of their life circumstances. This rural attitude may cause them to cope with their health experience individually, possibly leading to isolation, a deepening of the depression, and limited or no resolution to the health problem.

In rural Canada, a strong sense of belonging to the community and high social support can promote mental health and may act as a protective factor against certain mental health diagnoses such as depression (Romans, Cohen, & Forte, 2010). Yet, the positive health influence that social support can have is bound by the nature and availability of social networks, which may be fading in rural communities due to rural depopulation.

Spiritual and Religious Dimensions of Health

There is growing evidence that rural Canadian women often may associate a spiritual dimension to the promotion of their health (Thomlinson et al., 2004; Thurston & Meadows, 2004; Zupko, Shearer, & Vermeulen, 2003). Many rural Canadian communities are heavily influenced by religion or faith and associated cultural norms (Dabrowska & Bates, 2010). Such communities include the Hutterites, who live predominantly in central and western Canada, Mennonites, including a large settlement in southwestern Ontario, and Aboriginals whose diverse communities span the entire country.

For many predominantly Christian communities, the concepts of health and spirituality or religion are heavily intertwined. In one qualitative study in rural southwestern Ontario, 70 focus groups were held with informants of differing ages, religious affiliations, and cultural backgrounds, including a large Mennonite population (Zupko et al., 2003). The church was often described by individuals in this research as a health promoting resource in the community. One rural individual stated that the “single most important thing to health is church – every social connection comes from church” (Zupko et al., 2003, p.18). In another study, a rural woman in southwestern Ontario noted, “I believe that God put all the cures for every disease in the herbs...it doesn’t seem right that God would allow these diseases without giving us the cure”

(Wathen & Harris, 2007, p.646). These comments suggest that there may be an association between the church or spirituality and rural health beliefs and behaviours for some rural women.

Dabrowska and Bates (2010) conducted an ethnographic study in southern Ontario with a group of Old Order Mennonite women, a self-reliant group whose religious doctrine supports apatriarchal social order (Epp, 2008), to explore their conceptualization of health. Interviews with 15 Old Order Mennonite women revealed that the religious doctrine espoused by the community clearly influenced how the women considered their health (Dabrowska & Bates, 2010). The women discussed their belief that good health is a blessing from God and further described their health as the ability to fulfill their societal role dictated by religious doctrine, as evaluated by their husbands. One woman suggested, “My husband should answer the question how my health is” (Dabrowska & Bates, 2010, p. 101).

Patriarchal social structure, religious doctrine, and traditional gender roles and expectations clearly shaped the health beliefs and practices of these rural Canadian women. Because Old Order Mennonites are culturally unique and form but a small minority of Canada’s rural population, women’s health beliefs in this community may not be similar to those of women living in other rural communities. The Old Order Mennonite population does however, provide an example of how smaller, religious-based communities in rural Canada may influence the health beliefs and understandings of women residing within the community.

In another Canadian ethnography, individuals from western mountainous and central prairie rural communities declared that spirituality was an important aspect in their conceptualization of health and important for health promotion (Thomlinson et al., 2004). “Having faith” was a description of health used by several participants (Thomlinson et al., 2004 p. 261). Study participants also declared that the church, prayer, and bible study were health

resources for them although how these resources acted as health promoting agents was not discussed. While the study did not distinguish the health beliefs for rural women from those of rural men, the influence of spirituality and the church on the health beliefs of individuals in these communities was evident.

Interviews with 24 midlife rural Canadian women in the western province of Alberta further revealed the significant influences that religion and spirituality may have on rural women's conceptualization of health (Thurston & Meadows, 2004). Some women attributed experiences of healing to God, while others described fellowship within the church as an important aspect of health. Talking with God was also described by women as a health promoting practice, possibly by acting as a healthy coping mechanism for various life transitions by providing women with an opportunity to benefit from social support and to get "out of yourself" (Thurston & Meadows, 2004, p. 105). The findings from this study further suggested that rural women may have an embodied view of health that comprises or includes their bodies, mind, and spirits. This view of health, in which spiritual, physical, and mental dimensions of a person combine to form an integrated whole, may have important implications for rural health care.

Rural Canadian women have reported an inclination to use complementary or alternative medicines (Meadows, Thurston, & Berenson, 2001) because they may view these medicines as a more holistic approach to health that addresses to the various dimensions of a person that does not simply attend to the physical needs of the body. Thus, health care and promotion that is premised upon a holistic view of health may be more effective for many rural Canadian women compared to health resources that focus solely on the physical body.

Health and Faith Communities

Church and Health

Churches have a long history of supporting women's health in many rural and remote areas (Burrows, 2004). Buijs and Olson (2001) note that faith communities may promote health and healing in several ways. The supportive environments of many faith communities may increase an individual's motivation to pursue healthy choices. For example, many religions support taking care of one's physical body; this faith teaching may have direct health benefits to members of the community (Buijs & Olson, 2001). Due to the common values and beliefs espoused by members of a faith community, such communities may help to provide effective social support which has been shown to be a significant health promoting agent (Buijs & Olson, 2001). Furthermore, leaders within the church community may be trusted sources of health messages. For example, health promotion messages, such as supporting healthy eating habits, have been demonstrated to be effective in promoting healthy behaviour when they were given by a pastor (Kumanyika & Charleston, 1992) or the pastor's spouse (Yanek, Becker, Moy, Gittelsohn, & Koffman, 2001).

Church attendance, on its own, may have a positive influence on a wide-variety of health-related outcomes (Comstock & Partridge, 2008/1972). For example, individuals in Maryland who attended church at least once a week had lower levels of mortality caused by arteriosclerotic heart disease, pulmonary emphysema, suicide, cirrhosis, and certain types of cancer than those who attended church less frequently (Comstock & Partridge, 2008/1972). Religious activities may also promote positive mental health outcomes for older rural adults (Mitchell & Weatherly, 2000). For example, individuals who participated in church activities reported fewer depressive symptoms than individuals who did not partake in religious activities (Mitchell & Weatherly, 2000). Recent data from 22 European countries suggest that it may be the social contact

experienced through church involvement that leads to the associated health benefits (Nicholson, Rose, & Bobak, 2010). In rural Canada, social connections gained through the church may also be significant health resources for many women. The closure of rural recreation facilities (Russell, 2004), rural depopulation, and the nature and sparse populace of some remote Canadian communities may contribute to a lack of occasions for rural women to build and maintain effective social networks. The church may therefore be a primary resource of social health for rural Canadian women.

Church-Based Health Promotion

One way that the church can influence the health of individuals and groups is through organized health promotion programs. A systematic review of the literature between 1990 and 2000 (DeHaven, Hunter, Wilder, Walton, & Berry, 2004) categorized such health promotion programs into faith-based programs, faith-placed programs, and collaborative programs. Faith-based programs evolve directly from the faith community, faith-placed programs are brought to the faith community from an outside source such as public health officials or researchers, and collaborative programs emanate from partnerships between a faith group and an outside source (Campbell et al., 2007). The authors concluded from the 105 eligible articles in the systematic review that health programs in faith-based communities were effective at improving health outcomes such as lowering blood pressure and cholesterol and at promoting healthy behaviours such as increasing fruit and vegetable consumption (DeHaven et al., 2004).

Church-based health promotion programs are likely to be the most successful when they capitalize upon the existing strengths and resources of the church (Campbell et al., 2007) and on the health needs of the community. Therefore, effective health promotion programs are likely to be unique to the church and community in which they occur in addition to adhering to church values. The resources available in churches for health promotion may include various types of

social, physical, and economic capital. For example, churches may have buildings with kitchens and meeting rooms, provide access to a regular flow of people who are attending various services and programs, and serve as a stable institution with a long-term clientele (Campbell et al., 2007). Churches may be among some of the more successful venues for health promotion activities because they may be less affected by economic conditions and globalization than other venues such as workplaces, making it more feasible to recruit and retain participants (Campbell et al., 2007). Churches are also often characterised as welcoming venues. The church therefore may be a sustainable setting for rural health promotion interventions into the future.

Currently, many American churches have a significant involvement in church-based health promotion initiatives in rural communities including programs aimed at substance use and abuse prevention (Brown et al., 2006), smoking cessation (Schorling et al., 1997), and alternative mental health services (Blank, Mahmood, Fox, & Guterbock, 2002). There are some American data that suggest that church-leaders often support health promotion activities in their congregations. For example, pastors from over 80 Christian denominations reported either that their church communities provided significant health promotion, disease prevention, and support services to their congregation or that they were interested in increasing their involvement in health-related services (Catanzaro, Meador, Koenig, Kuchibhatla, & Clipp, 2007).

A small feasibility study was conducted in the western Canadian province of Alberta to determine the feasibility of parish nursing in the province (Olson, Clark, & Simington, 1999). Interviews with clergy from six denominations revealed that the clergy were involved in health-related issues and were supportive of having nurses on the pastoral team of the church to address the health needs of the community. With this notable exception, there is limited rural Canadian

data that describe the readiness of church-leaders to support health promotion activities in their church communities.

Faith Community Nursing

Although churches have emerged as a growing site for community health nursing (Chase-Ziolek & Striepe, 1999), very little is known of the role of faith community nurses (FCN) in Canada, or the influence of their work on the health of rural women. The International Parish Nurse Resource Centre (2009) defines faith community nurses as registered nurses working within a faith community who address health issues for both members of the faith community and for the community at large. The Canadian Association for Parish Nursing Ministry (CAPNM, 2010) is a leading national association that supports the work of faith community nurses across the country. A primary purpose of CAPNM is to develop faith community nursing as a health resource within Canada. CAPNM has been instrumental in articulating the work of FCNs which includes health advocacy, health counselling, health education, and resource referral (CAPNM, 2010).

In the United States, faith community nurses, or parish nurses, work in a variety of community settings, such as congregations, retirement communities, day care centers, and food banks (Patterson, 2006). They can be instrumental in providing health services that are not readily accessible within the formal health care system such as case management, advocacy, and health education (McGinnis & Zoske, 2008). One rural faith community nurse noted that her services are filling a gap found within formal health services, “we lost our town doctor to retirement [and now] several people from outside the community [come to me] for BP (blood pressure) checks” (Chase-Ziolek & Striepe, 1999, p. 275).

In a survey of faith community nurses in the District of Columbia, FCNs reported providing a wide variety of health services and health promotion programs to congregations

including various types of screenings, health information and referral, and individual health counselling (McGinnis & Zoske, 2008). FCNs in the study were predominantly volunteers (87%), over the age of 55 (67%), and approximately 40% were retired from other registered nursing employment. McGinnis and Zoske suggest that the flexible work hours and autonomous role of many FCN positions may be an incentive for nurses to engage in parish nursing after retirement. In extending their nursing careers, FCNs are increasing community access to health promotion services and care in which registered nurses excel.

In Canada, the faith community nurse could be an important health resource for rural women. Rural women often prefer to seek health care providers who are female (Leipert & Reutter, 2005). Since the majority of FCNs are women, they may be viewed as an approachable health care practitioner from the perspective of rural women. Faith community nurses may also address the spiritual dimension of health, which may be relevant for many rural women and FCNs can help to provide important health services that are typically lacking in under-served rural communities (Griffin, 1999). And, as many rural women prefer to receive health advice from individuals whom they know (Gehlert, Kovac, Song, & Hartlage, 2006), they may be quite receptive to FCN health teachings because many FCNs practice in the communities where they live (Griffin, 1999).

Discussion and Implications

Barriers to health promotion in rural Canadian settings have been linked to inadequate housing, lack of affordable and healthy foods, limited access to physical activity (HNHU, 2008), shortages of rural health care resources and professionals including registered nurses (CIHI, 2002; HNHU, 2008), isolation, patriarchal attitudes, and diminishing or ineffective formal networks (Riddell et al., 2009). These and other rural factors need to be carefully considered

when developing and implementing health promotion programs for women in rural Canadian communities because the rural context clearly presents unique challenges and opportunities for health promotion.

Several studies suggest that spirituality and religiosity may influence rural Canadian women's health beliefs, behaviours, and even outcomes (Thomlinson et al., 2004; Thurston & Meadows, 2004; Wathen & Harris, 2007; Zupko et al., 2003). Understanding the intersections between spirituality or religion and women's health may have important implications for health care policies and practitioners working in rural settings. For health promotion to be effective in rural settings, congruency with the beliefs and values of rural individuals is necessary. Because rural women's conceptualization of health may often include a significant spiritual or religious component (Thomlinson et al., 2004; Thurston & Meadows, 2004; Zupko et al., 2003), the effectiveness of health promotion initiatives may be influenced by their capacity to be compatible with these beliefs.

While it has been suggested that health promotion within the rural church may be most successful or possible when it is integrated into the healing mission and leadership of the church (Mochenhaupt & Muchow, 1994), the mandate and mission of the church may also generate obstacles to health promotion activities. Church leaders may be concerned about the origins of the resources for the project. Where is the funding coming from? What values and beliefs does the health care practitioner hold? If the resources stem from institutions that do not share congruent values with the church, there may be some barriers to the implementation of CBHP. There may also be an unwillingness on behalf of the church to discuss certain health topics, such as homosexuality or sexually transmitted illnesses, that are not aligned with church values or belief systems (Campbell et al., 2007). For these and other reasons, it becomes necessary to

explore the values, beliefs, and cultural norms of the church and of the rural community when investigating opportunities for CBHP activities (Campbell et al., 2007).

Strengthening and expanding research on rural health has been suggested as a strategy for improving the health of rural Canadians (CIHI, 2006; Laurent, 2002; Leipert, 2010). Kulig (2010) further suggests that in order to improve the health status of rural residents, opportunities for rural dwellers to actively participate in health research is needed. Increasing rural women's participation in health research may have several benefits including assisting women to reflect upon how they view and enact health promotion in their lives; this may in turn elicit health promotion advocacy and action by rural women and others.

Much of the literature on faith-based health promotion is focussed upon health outcomes, or on the perceptions and beliefs of those implementing the programs such as church leaders or faith community nurses. Dyess, Chase, and Newlin (2010) in their review of 25 articles on the work of FCNs, suggest that a shift of scholarship is needed from examining the role of FCNs to addressing the impact upon individuals involved with FCNs. Scholarship aimed at exploring how the church influences health promotion for rural Canadian women is gravely needed because rural women are a significantly understudied population who may strongly associate faith and health and benefit from church-based health promotion services and programs. While there is growing evidence to support the usefulness of the rural Canadian church in promoting the health of rural women (Thomlinson et al., 2004; Zupko et al., 2003), further research is needed to explore the nature and relevance of church-based health promotion activities and the work of faith community nurses in rural Canada.

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Chapter Three - Unspoken Phenomena: Using the Photovoice Method to Enrich Phenomenological Inquiry

The discipline of nursing is one of complexities. While heated debates surround the question of what constitutes nursing science, the need for multiple modes of inquiry is seldom critiqued. Because nursing knowledge has a history deeply rooted in causes of social justice (Boutain, 2005), the creation of space for under-represented voices is a central part of nursing's disciplinary research and practice mission. Researching the lived experience is one way that nursing is continuing to fulfill this mission because the lived experience can showcase how individuals living on the margin of society make sense of and interpret their world. A critique of the lived experience representation of marginalized individuals and groups is that it may lead to a caricature portrayal and possibly perpetuate the dominant construction of people and groups (Orbe, 2000). Nonetheless, the value of understanding lived experience is significant in its ability to advance understanding beyond the conceptualizations of social structures, in addition to and beyond the everyday world and interpretations of individuals (Orbe, 2000). Understanding experience may assist policy-makers and health care professionals to make more informed choices regarding various populations, leading to better and more equitable care for those experiencing marginalization.

Understanding individual experiences in isolation however, does not necessarily give due consideration to the historic and social intersections that shape the experience of health (Kirkham & Browne, 2006). Thus, contemplating both the individual's experience and the context in which it occurs fosters research that acknowledges both the expertise of the individual in his or her experience and the influence of social context on the experience. Nursing's vested interest in social justice has led to the creation of a gamut of research practices designed to better



understand the lived experience and its social, cultural and other associated meanings. Classic research methodologies are also being used in novel ways to explore issues of social justice. Phenomenological inquiry for example, which is perhaps one of the most widely used methodologies in nursing research to study lived experience, can be used both to study and to raise the profile of the experience of marginalized populations. More specifically, interpretive phenomenology promotes an understanding of the meaning of experience as individuals interact with others and with their environment (Lopez & Willis, 2004). In this type of inquiry, a phenomenon of interest is typically investigated through open-ended individual interviews between a researcher and study participants. Often, interviews with six to eight individuals produce sufficient information about the phenomenon to promote data saturation (Morse, 1994). While the meaning of experience in common-life practices can be uncovered through narratives that emerge from interpretive phenomenological inquiry (Lopez & Willis, 2004), there are other datum sources that can also contribute to understanding the lived experience and its associated meanings.

Photovoice is an example of a research method that may be useful for eliciting data that may deepen understanding of the lived experience. It was originally developed as a participatory health promotion practice in which individuals would take photographs to document the reality of their lives (Wang & Burris, 1997). Rooted in the theoretical assumptions of critical consciousness, feminist theory, and documentary photography (Wang & Burris, 1997), photovoice is a participatory research approach that creates spaces and opportunities for marginalized voices to be heard. Freire (1970) has described the visual image as a means to enable people to think critically about issues in their community. Building upon this idea, an original emancipatory goal of photovoice was to foster such critical thinking among community

members and to create a space for voices on the margin to influence change at both the community and policy levels (Wang & Redwood-Jones, 2001).

The basic tenets of photovoice involve asking individuals to take pictures of health resources and needs in their community (Wang & Burris, 1997). Individuals then select the photos that are the most representative of their reality and discuss them in photo-sharing sessions with other individuals who are participating in the study. Logbooks are also used in photovoice studies, in which participants may document their experiences and perspectives (Leipert et al. 2011). In addition to photovoice being an emancipatory health promotion practice, it is also useful as a research method to elicit rich data about the lived experience, which is often sought through phenomenology.

Photovoice has been used within phenomenological research to explore the empowerment change among community health advisors, (Lundy, Cuellar, & Callahan, 2009), to study the essence of play for children (Berinstein & Magalhaes, 2009), and to explore the meaning of leisure within the context of dementia (Genoe, 2009). The photovoice method may help to uncover enriched understanding of experience by eliciting additional visual and narrative data in phenomenological inquiry. This paper begins with historical accounts of the origins of interpretive phenomenology and photovoice, discusses how the photovoice method can contribute to deepened understanding of the lived experience within phenomenological inquiry, offers practical suggestions for undertaking interpretive phenomenology using photovoice as a method, and discusses how rigour and quality can be pursued within the study context.

Origins of Phenomenology

“(Phenomenology) shows what range of experiences are possible in the world that people live, how they can be described, and how language has the ability to communicate these experiences to others in their richness.”

(Mostert 2002, n.p.)

The word *phenomenon* originates from the Greek *phaenesthai*, to flare up, to show itself, to appear (Moustakas, 1994). Phenomenology, as an epistemology, was first described in the early 20th century by Edmund Husserl, a German philosopher and mathematician (Dowling, 2007). Husserl challenged deductive natures of truth, which dominated epistemology at the time, and suggested that knowledge can be objectively derived from human experience (Racher & Robinson, 2003). The philosophical contributions of Husserl greatly influenced the understanding of truth. Husserl argued that the essence of experience, in its purest sense, has no presupposition of the phenomenon as an empirical object and does not account for the mental acts concerned with the phenomenon. Thus, for Husserl, phenomenology is descriptive and occurs pre-reflexively, prior to being contextualized or attached to social, cultural, or other meanings. Essentially, “(phenomenology) is the experience as it is before we have thought about it” (Crotty, 1996, p. 95). Husserl’s strictly descriptive nature of phenomenology has long been challenged by many who claim that experience and the world in which it exists cannot be separated.

Perhaps the most notable critic of Husserl’s descriptive stance on phenomenology was Martin Heidegger, a student of Husserl. Heidegger suggested that experience is not separate from the world in which it exists (Polkinghorne, 1983). Therefore, social, cultural, and personal meanings are attached to objects in the world and cannot be removed from consciousness, nor

from the experience. Rather, through reflection and interpretation, understanding experience and its associated meanings can be achieved. This understanding of phenomenology has come to be known as interpretive phenomenology (Lopez & Willis, 2004). In interpretive phenomenology, the researcher seeks to interpret the lived experience of a phenomenon into a textual expression (van Manen, 1997). The meaning of the experience, which is both value- and fact-laden, may be exposed by inquiry, "...in what is asked about there lies also that which is to be found out by asking" (Heidegger, 1927/1962, p. 24). It is through the interpretive process and the hermeneutic cycle that the unfamiliar is exposed (Gadamer, 1976), which allows for a deepened understanding of the lived experience.

The interview is perhaps the most-widely used method to elicit data of the lived experience through phenomenological inquiry. Yet, limitations of interviews as a method of interpretive inquiry have been acknowledged in the literature, particularly by discourse and conversation analysts (Brunsden & Goatcher, 2007). A primary critique of the interview method is that it may not accurately reflect what is most meaningful to those experiencing the phenomenon. Rather, the researcher's agenda and presuppositions may influence the nature of the questions asked, which may shape the content of the responses given (Brunsden & Goatcher, 2007).

One way to promote a higher degree of authenticity for phenomenological data is to create opportunities for study participants to provide data that is most meaningful to them. This can be achieved by using research approaches that elicit data from the perspective of those experiencing the phenomenon. With photovoice, for example, participants take photographs of what is meaningful to them. They control the nature of the data. Not only does photovoice create spaces for individuals to express elements of their lived experience from their own perspectives,

but it also allows for additional data that can complement narrative interview data. Furthermore, because meaning, in the Heideggerian sense (1962), is developed in relation to others (Conroy, 2003), group dialogue of experience, as it occurs in photovoice, can deepen understanding of shared social meanings in addition to perceptions of everyday experiences.

van Manen (1998) discusses the importance of literary and artistic sources for hermeneutic phenomenological inquiry as a way to provide the phenomenologist with possible human experiences and worlds not normally experienced. In fact, the non-discursive languages or the evocative effect of story and anecdote are often required for phenomenological inquiry to achieve its goals (van Manen, 1997). Poetry and novels, for example, can play a part to show, present, and clarify meaning felt and grasped at the core of our being (Gadamer, 1996). The use of data generated from photovoice in phenomenological inquiry, may fill a void of understanding furnished by limitations of the spoken language, which can be referred to as “epistemological silence” (van Manen, 1994, p. 113).

The Roots of Photovoice

Several photo-methods are currently used in nursing research, the roots of which are deeply embedded in the social sciences, such as anthropology, which may date back as far as the late 1800's (Hurworth, 2003; El Guindi, 2004). The term photo-elicitation was first documented in the 1950's by John Collier in his work with families and mental health (Collier, 1957). In Collier's novel study, families were shown photos during interviews to sharpen memories and also to clarify misunderstandings (Harper, 2002). Photographs can be used in interviews to evoke a different type of datum than that which is elicited through conversation alone, “photographs appear to capture the impossible: a person gone; an event past. That extraordinary sense of seeming to retrieve something that has disappeared belongs alone to the photograph...” (Harper,

2002, p. 23). The photographs used in photo-elicitation can be from various sources and may include photographs taken by the researcher, photos from the press, historical photos, or photographs taken by study participants (Harper, 2002). Photo-elicitation remains widely used in social and health research this day (Hurworth, 2003).

A new wave of photo-data in nursing came perhaps with the introduction of photo novella. In photo novella, study participants are given cameras and take photographs that document the stories of their lives (Wang & Burris, 1994). Photo novella can capture reality from the individual's perspective because each individual takes photographs of what is meaningful to him or her. This active act of photographing by study participants is one aspect that differentiates photo novella from photo-elicitation. Ewald (1985) may be considered a foremother of photo novella (Wang & Burris, 1994). She was one of the first educators who taught individuals, more specifically children in the Appalachians, to use cameras to document the stories of their lives (Ewald, 1985). The Appalachian children engaged in self-portraiture, which provided an opportunity for them to share their voices through documentary photography. Wang and Burris categorize photo novella as an educational tool that allows individuals to record and reflect upon their needs, promote dialogue, encourage action, and inform policy. It has been used to explore elderly women's hospital discharge experiences (LeClerc, Wells, Craig, & Wilson, 2002) and the daily challenges faced by Bosnian children who came to Canada in the 1990's (Berman, Ford-Gilboe, Moutrey, & Cekic, 2001).

Building upon photo novella's underlay of empowerment, Wang and Burris saw the evolution of photo novella into photovoice, which is categorized as a practice whose goals are to: "(1) to enable people to record and reflect their community's strengths and concerns, (2) to promote critical dialogue and knowledge about important issues through large and small group

discussion of photographs, and (3) to reach policymakers” (Wang & Burris, 1997, p. 184). Photovoice has clear activism and political foci. Most often used with individuals and groups living in the margins, photovoice has been used with homeless individuals (Wang, 2003), people living with mental illness (Bowers, 1999), and rural women (Leipert & Smith, 2009; Wang, Burris, & Ping, 1996). The potency of photovoice lies not simply in the pictures, but in the dialogical interpretation that occurs between the researcher and those taking the pictures. It is through dialogical conversation that participants and the researcher are able to offer their interpretations of the phenomenon. This process may deepen understanding of the experience and serve as a consciousness-raising process for participants and the researcher alike.

Using Photovoice in Phenomenological Inquiry

While it has been said that in the method of phenomenology and hermeneutics there is no method (Gadamer, 1989; Rorty, 1979 as cited in van Manen, 1990), van Manen (1997) offers six interactive approaches for interpretive phenomenological inquiry. These six practical interactive approaches are signposts along the way towards understanding experience. These approaches consist of: 1) orientating oneself to the phenomenon of interest and explicating assumptions and pre-understandings, 2) investigating experiences as lived through conversational interviews rather than as we conceptualize it, 3) reflecting upon and conducting thematic analysis which characterize the phenomenon and interpreting through conversations, 4) describing the phenomenon through the art of writing and re-writing (re-thinking, re-flecting, re-cognizing) which aims at creating depthful writing, 5) maintaining a strong and oriented relation to the fundamental question about the phenomenon, and 6) balancing the research context by considering parts and wholes (van Manen, 1997, p. 30). While a systematic approach may be helpful for phenomenological inquiry, ultimately it is the “interpretive sensitivity, inventiveness,

thoughtfulness, scholarly tact, and writing talent of the human science researcher” that directs the quality of phenomenological research (van Manen, 1997, p. 34).

In phenomenological inquiry, the sample does not simply consist of individuals participating in the study but it is likely to include an array of items such as photographs, logbooks, and interviews (Sandelowski, 1995). Thus, the combined use of interpretive phenomenological methodology and the photovoice method could employ an innovative approach to data collection via five methods: 1) individual interviews, 2) group interviews, 3) logbooks written by study participants, 4) photographs taken by study participants and the photographs’ titles as provided by each photographer, and 5) the researcher’s field notes. The six-step data collection outline summarized below provides an example of how phenomenological data may be elicited using the photovoice method:

1. Camera orientation session
2. Follow-up
3. Collection and initial review and analysis of photographs and logbooks
4. Individual in-depth interviews
5. Individual photo-sharing sessions
6. Dialogical group conversation and group photo-sharing session

In the first step of the process, the camera orientation session, the purpose, plan, and method of the study are explained. This session also serves as an introductory meeting and is intended to build rapport between the researcher and the participants. Study participants are provided with a disposable camera and a demonstration of its use, and they have an appropriate time, often two weeks, to take up to 27 photographs (the number of images available on most disposable cameras) that they deem relevant to the purpose of the study. Digital cameras may

offer several advantages over the use of disposable cameras. Digital cameras are becoming increasingly more affordable, they can be reused in subsequent studies, and photos can be sent electronically to the researcher, which eliminates the need to send delicate film by postal service in some cases. Furthermore, the use of digital cameras allows the possibility for participants to manipulate pictures, which could be considered as an advantage or disadvantage depending on the study. Disposable cameras offer a different set of benefits. Because photos cannot be deleted on a disposable camera, data are preserved as taken and may serve as a basis for a rich discussion with participants. Furthermore, knowing that there is a limit of 27 pictures that one can take may encourage deeper reflection from participants prior to taking photographs. This limit may also discourage data redundancy from an over-abundance of photographs. Yet, disposable cameras are becoming increasingly difficult to find and film processing can be quite costly.

Participants are also provided with a logbook at the camera orientation session in which they may document additional information or insights during the picture taking time. The logbook may also serve as a way for participants to communicate confidentially with the researcher, as they may not feel comfortable discussing certain issues in a group setting. In addition, the logbooks will assist participants to provide data as they occur to them and help prevent loss of data and perspectives due to time issues. Alternatives to logbooks could include participant-researcher communication that is more technologically enabled, which may be more relevant for use with certain populations who have access and inclination to use technology, such as urban individuals or youth. Alternatives to logbooks may also be considered when individuals would not be likely to use logbooks for various reasons, such as low levels of literacy. Step two often occurs approximately one week after the camera orientation session. In this step, study

participants are contacted via telephone by the researcher to discuss and encourage progress in picture taking and logbook recording.

After the two week photo-taking period has expired, the cameras and logbooks are retrieved and the photographs are developed and the logbooks transcribed (step three). Several days later, the researcher returns to each participant his or her respective set of photographs and asks each individual to provide a title for each of their photographs prior to the individual interview. This process is intended to provide a narrative interpretation by the participant of the picture in order to encourage reflection on the meaning and significance of the photo. The researcher then reviews the photographs and logbooks and documents his or her initial thoughts and interpretations. In the fourth step of the data collection process, the researcher conducts an in-depth interview with each study participant individually. During this interview, each participant is asked to share his or her experience of the phenomenon. The interview questions may delve into value, feeling, knowledge, and sensorial realms (Patton, 2002). The research process of both phenomenology and photovoice is one of inter-subjectivity; both the researcher and the participants begin the process with the intention of advancing individual understanding. “The hermeneutical circle of interpretation moves forward and backward....Through rigorous interaction and understanding, the phenomenon is uncovered” (Allen & Jensen, 1990, p. 245).

In the fifth step of the data collection process, participants are asked in a one-on-one session with the researcher to discuss each of their pictures. This session provides the researcher the opportunity to ask questions to each participant individually that may be related to his or her initial analysis of data. For example, it may provide an occasion for the researcher to discuss certain topics related to the phenomenon of interest that may be of a sensitive nature and therefore not appropriate to discuss in group sessions. To further understand how social, cultural,

or contextual factors intersect the phenomenon of interest, the SHOWeD acronym (Wang, 1999) can be used. SHOWeD consists of the following questions: What do you See here? What's really Happening here? How does this relate to *Our* lives? Why does this problem or this strength exist? What can we *Do* about this? (Wang, Yi, Tao, & Carovano, 1998). These questions, which are data collection and analysis approaches within photovoice (Wang et al., 1998), may help to promote reflection and dialogue surrounding the experience of health and may be used as a guide to elicit data pertaining to particular pictures.

Upon completion of the individual interviews, all of the study participants and the researcher meet as a group for a photo-sharing session (step six) to discuss the collective meaning of the experience of health. During this session, each participant can be asked to share his or her two most meaningful photographs and their titles with the group. The purpose of this process is to create dialogical conversations and to deepen understanding of data obtained in the individual interviews. Questions can be once again framed using the SHOWeD acronym. One of the purposes of bringing the participants together for a second group session is to promote group dialogue (Wang 1999; Wang, Cash, & Powers, 2000; Wang, Morrel-Samuels, Hutchison, Bell, & Pestronk, 2004), which may contribute to further understanding of the phenomenon and may promote both individual and group reflection. Because phenomenology seeks to understand shared social meanings in addition to perceptions of everyday experiences (Heidegger, 1962), dialogue among individuals with lived experience of the phenomenon may contribute to a deepened understanding of the social meaning of the phenomenon and the relevance and importance of the experience.

Following each of the data collection sessions, field notes (Patton, 2002) can be used by the researcher to document self-reflections and insights and to record and contemplate various



aspects of the research (van Manen, 1997). The field notes may include observations of the community, such as climate or economic viability, themes regarding health and health promotion such as health-related information posted on community bulletin boards for example, or thoughts and reflections regarding the photovoice method. Study participants may contribute to the analysis by offering their insights or interpretations of the data in individual or group interviews and in logbooks, which may provide insight into how individuals interpret and make sense of their world (Willig, 2001). By collaboratively discussing the data, themes may be refined and a common orientation to the phenomenon can be pursued (van Manen, 1997). In a combined phenomenology and photovoice study, data analysis begins at the onset of data collection and continues for the duration of the research.

An approach to phenomenological data analysis that includes the photovoice method could unite van Manen's (1997) approach to interpretive phenomenological data analysis with the Oliffe, Bottorff, Kelly, and Halpin (2008) four-step approach to photographic analysis. van Manen's phenomenological analysis can be used to analyze all of the data generated from phenomenological inquiry including logbooks, individual and group interviews, photographs, and the researcher's field notes. Textual data including interview and logbook transcripts can be read, re-read, and reflected upon to elicit themes emerging from the data. Furthermore, photographs and their associated meanings can also be described through the art of writing, which fosters re-thinking, re-flecting, and re-cognizing the phenomenon (van Manen, 1997).

Data that emerge specifically from the photovoice method can be analysed using the approach of Oliffe et al. (2008). This approach involves four steps: preview, review, cross-photo comparison, and theorizing. In the preview stage, the photographs are viewed in conjunction with their titles and narratives to elucidate participants' intended meaning and representations of

the photos, from the participants' perspectives. In the second stage of analysis, the review stage, participant photographs and narratives are reviewed a second time, but from the researcher's lens. This stage may include a comparison between the data generated and the researcher's interpretation of various contexts in which the phenomenon exists, which may include an understanding of community or health factors. For example, if a participant takes a photograph of community infrastructure in poor physical condition, the researcher may consider the economic viability of the community. In the cross-photo comparison stage, the researcher views the entire collection of photographs and develops themes that arise from collective whole. In the final theorizing stage, links are made between emergent themes and the theoretical bases of the study.

The significance and value of the experience described by participants in interpretive phenomenological studies that use the photovoice method may be translated by the researcher into textual and visual form. For example, findings and recommendations may be developed into resource material in the form of print or web-based media that can be accessed by various research, policy, practice, and educational audiences. The interpretive phenomenological methodology combined with the photovoice method of data collection and analysis may also assist study participants to reflect upon how they view and enact health in their lives, which may in turn elicit health promotion advocacy and action on their part.

Rigor and Ethical Considerations

Research that acknowledges the existence of multiple truths, as qualitative research does, cannot be assessed for its accuracy in measuring one single truth. In qualitative inquiry, methodological congruency with the philosophical assumptions of a paradigm is a criterion for research quality (Guba & Lincoln, 1994; Sandleowski, 1993), which is an important

consideration for research that uses emerging blends of methods and methodologies that have a history in different research traditions. In phenomenological inquiry that uses the photovoice method, particular attention needs to be paid to this standard of rigour as the paradigmatic lines may become blurred when incorporating the photovoice method, which arose from the critical paradigm into interpretive phenomenological inquiry which has a long-standing tradition in the interpretive paradigm.

Rigour considerations include reconciling differences in aims and claims between the overarching methodology and the underlying method. For example, interpretive phenomenology seeks to understand the lived experience, while photovoice pursues the identification of oppressing social structures. Furthermore, the photovoice method often seeks emancipatory change, yet interpretive phenomenology makes no such claim. Such foundational bases, as different as they may be, provide an opportunity to create emergent research approaches that are appropriate and fitting to certain research questions that may not be best answered by traditional approaches or by a single approach. Indeed, the use of two complementary approaches, such as phenomenology with its emphasis on individual experience and photovoice which focuses more on social and contextual issues, can serve to deepen and extend understanding. A challenge lies in reflecting upon the origins and understandings of both methodology and method and navigating the lines of methodological congruency and rigour as they present themselves.

In an interpretive phenomenological study with photovoice, authenticity, which represents the balanced presentation of various perspectives, may be pursued by consistently checking the primary transcripts and photographs with the researcher's and participants' interpretations to uphold faithfulness of the participants' constructs (Guba & Lincoln, 1994). Moreover, authenticity can be promoted in the researcher's analysis and interpretation of the

photographs by asking individuals to provide a title for each of their pictures to clarify meaning and participants can be offered the opportunity to express their refinements, intellectual or emotional, of the researcher's interpretations during the individual interviews and group sessions. The applicability of the research or the transferability of findings to other settings may only be assessed by potential knowledge users in phenomenological inquiry with the photovoice method. The provision of a clear and distinct description of culture and context, participant characteristics, and data collection and analysis methods can promote transferability in the scholarly realm (Graneheim & Lundman, 2003). Photographs, just like words and numbers, have different meanings depending upon how they are used. It is therefore important to contextualize how photographs are used for data generation and interpretation. van Manen (1997, p. 27) refers to a good phenomenological description as an "adequate elucidation of some aspect of the lifeworld." Such an elucidation may be recognized by a "phenomenological nod," which may arise as something "that we nod to, recognizing it as an experience that we have had or could have had" (van Manen, 1997, p. 27). The six interactive approaches to good phenomenological description offered by van Manen can encourage deep thinking and reflection on the part of the researcher. The phenomenological nod can be used as a criterion to ascertain the credibility of a phenomenology photovoice study.

Appropriate representation is an additional ethical consideration within the photovoice method. Issues of representation, or misrepresentation, can occur when the meaning a picture, which is only a snapshot of the story, is unclear (Wang & Redwood-Jones, 2001). By providing study participants with the opportunity to discuss each of their pictures in an individual interview, clarification of meaning and significance attributed to each picture can be revealed, thereby promoting more accurate interpretation. Participants can also be asked in their individual

interviews to discuss pictures not taken. For example, participants may not take pictures of children if the consenting adult is not present. Or, if a specific time of year is meaningful for a certain experience, photographs depicting this meaning may not be taken if the research occurs in a different season. Examples such as these indicate that research data may be limited in its representativeness of the experiences presented. Discussion surrounding pictures not taken may assist individuals to better contemplate and interpret the experience as a whole.

Conclusion

Data generated from the photovoice method can contribute to a deepened understanding of the lived experience in phenomenological inquiry. Because the lived experience exists within a lifeworld (Heidegger, 1962), understanding this lifeworld may, in some cases, be important for authenticating the interpretation of the lived experience. Understanding how multiple perspectives, as revealed through photographs, individual and group interviews, and logbook recordings, will certainly contribute to an enriched understanding of the phenomenon. While these interactions may not be known at the outset, they may emerge through the interpretive process as the unfamiliar or unarticulated intersections are exposed through discussion and dialogue (Gadamer, 1976). Yet, the benefits of integrating the photovoice method into phenomenological inquiry may be somewhat reciprocal. Not only can the photovoice method elicit data that enriches phenomenological inquiry, but phenomenological inquiry can also strengthen photovoice as a research method. The use of photovoice within phenomenological inquiry provides direction and purpose regarding the phenomenon or experience of interest. The use of phenomenological approaches to data collection and analysis, such as van Manen's (1997) six interactive approaches to phenomenological inquiry may provoke a more thoughtful and reflexive approach to the photovoice method. This in turn may elicit richer data and

interpretations that may help photovoice to further achieve its goals of fostering critical thinking and creating a space for voices on the margin to influence change.

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Chapter Four - Understanding Women's Health Promotion in the Rural Church

Religiosity, which includes church attendance and religious beliefs (Edlund et al., 2010), is a salient characteristic of many rural cultures (Chalfant & Heller, 1991) and must be accounted for to accurately evaluate rural health (Arcury, Quandt, McDonald, & Bell, 2000). Religiosity is so prominent in some rural communities that it dictates daily, weekly, and seasonal life rhythms in addition to structuring social relationships (Arcury et al., 2000) The central role of the rural church in the lives of rural women has long been known, at least from an experiential standpoint. In one community newspaper, an elderly woman in Ontario described her rural church experience as, "Church seems to be the pinpoint of my life - church and family." She jokingly added, "I wouldn't know what day of the week it was if I didn't go to church" (Miner, May 21, 2010, para. 47). This is not an uncommon expression in many rural areas, where churches are often a large part of the social and cultural fabric of a community (Clark, 2000).

Churches can be health promoting assets for rural women because they can foster the development of effective social support (Buijs & Olson, 2001). In addition, churches often have physical resources, such as meeting rooms, which can serve as gathering places for health promotion initiatives (Campbell et al., 2007). Such physical resources are quite significant in many rural areas, because the church might be the only public gathering place. In rural Ontario, one third of women frequent a church on a weekly basis (Statistics Canada, 2003).

Individuals who regularly attend religious services tend to have a stronger connection to their community (Clark, 2000). They also have access to rural church resources, many of which remain to be documented because they are often "intangible, but nevertheless important ... supports through which life and livelihood are sustained" (Douglas, 2003, p. 19). In addition to measurable health supports, such as elder care and financial assistance (Douglas, 2003), churches

also contribute on a broader level to the health of the greater community. Participating in the snow removal of local roads, removing litter from conservation areas, and fundraising activities for local schools and hospitals are but a few ways in which rural churches contribute to their catchment areas. Many of these contributions, however, remain to be acknowledged from both community health and economic standpoints.

Much of the literature related to health and the church describes health outcomes associated with various forms of religious participation from a postpositivistic perspective (Koenig, King, & Carson, 2012; Plunkett & Leipert, 2013). Often, such research contains little to no gender or place based analysis. With a few notable exceptions that peripherally discuss the church's relation to rural women's health promotion in southwestern Ontario (Haldimand-Norfolk Health Unit, 2007; Leipert & Smith, 2009; Miedema & Zupko, 2006; Woolwich Community Health Centre, 2005), the health promoting experience of rural women within the church remains relatively unknown.

Health promotion, which is defined as, "The process of enabling people to increase control over, and to improve, their health" (World Health Organization, 2014, para. 1), is a significant health asset for rural women, especially because access to health care services is limited in rural Canada (Leipert, Leach, & Thurston, 2012). Furthermore, rural communities often subscribe to a culture of self-reliance (Leipert et al., 2012), which makes accessing health promoting resources within individual communities paramount. The sustainment of community connections is gravely needed in rural communities because it supports the psychological wellbeing of rural women (Lovell & Critchley, 2010), who often experience social and relational vulnerability.

Although approximately 20% of Canadian women live in rural areas (Statistics Canada, 2011), there is limited research that addresses their health promotion needs and resources (Leipert, 2013). Given the need to better understand rural women's health promotion in the rural church, we sought to understand and illuminate the phenomenon with the following research question: What is rural women's experience of health promotion in rural churches?

Defining Church

The term "church" means many things to many people. Its meanings are often deeply embedded within historical and socioreligious contexts, which might help to explain why there is no widely agreed definition of the term. The origin of the word church is Greek for "Of the Lord" (Harper, n.d., para. 2). Churches have been defined as physical buildings, programs of religious doctrine, acts of public worship, the clerical profession, and groups of people sharing a common belief in a higher power ("Church", 2011). Willmer (1984) describes "church" as an inclusive term that includes "Local congregations, centralized administrative . . . institutions, . . . and prophetic operations. . . ." (p.20). For the purposes of this study, we broadly interpreted churches as physical spaces for Christian worship to which an affiliated group of individuals consider themselves members or adherents.

Study Design

Methodology

In this study, we embedded the interactive research approach of photovoice (Wang & Burris, 1997) within interpretive phenomenological methodology (van Manen, 1997), the study of lived experience. Our goal in using interpretive phenomenology and the photovoice method was to uncover individual and shared social meanings in the phenomenological sense

(Heidegger, 1962) and to promote consciousness raising dialogue and discussion from a participatory perspective (Wang & Burris, 1997).

In interpretive phenomenology, meaning and knowledge are constructed by individuals as they interact with the world in which they are living (Crotty, 1998). Thus, to understand women's experience of health promotion in the rural church, we sought to understand the broader context of rural life and culture. The inclusion of the photovoice method within interpretive phenomenology filled an experiential gap of understanding furnished by limitations of the spoken language (van Manen, 1990). For a full description of the methodology, please refer to Plunkett, Leipert, and Ray (2013). Approval for the study was granted from the Office of Research Ethics at Western University.

Recruitment and Data Collection

We collected data in 2012 and 2013 from 22 women attending five churches in rural southwest Ontario. Each rural community was at least a 30 minute drive from an urban center with a population greater than 30,000. We chose this rural criterion because centers with a population superior to 30,000 have a greater breadth of health related services, including inpatient specialties and community based health programs than do rural communities (Ministry of Health and Long-Term Care, 2010). Two churches in this study were located in communities with populations of 2,500, one church was in a small town of 1,000 residents, and the two remaining churches were located in agriculture farmlands at least two miles from a small town. No community had public transit.

We contacted executives of women's groups and clergy in rural churches via telephone and email to recruit participants. Study participants were welcomed to recruit additional participants via snowball sampling (Atkinson & Flint, 2001) by providing interested individuals

with information about the study and the researchers' contact information. The majority of participants were recruited by word of mouth or by notices written by participants in church newsletters. We provided clergy at each participating church with a letter of information describing the study.

Rural women aged 18 years or older who could converse in English and for whom the church had a past, present, or possible future influence on their health were invited to participate in the study. Although six to eight participants is a widely accepted sample size for phenomenological nursing studies (Morse, 1994), we sought 12 to 16 women because we intended to collect data from at least two distinct sites. However, due in part to the small population of women at rural churches, we were only able to recruit seven women at the initial two sites, a sample that was insufficient to yield data saturation. Thus, we expanded the sample to include additional churches and participants.

We held a one hour initial orientation session at each church, during which we described the study, provided the study equipment including cameras and logbooks, and led a discussion on ethical picture taking. Participants then had several weeks to take pictures and to document in logbooks of ways that the church influenced their health. We then developed each participant's photographs, which we discussed in an individual interview. During the individual interview, we asked participants open ended questions such as, "What are some health benefits to living in your rural community?" and "How does the church help you stay healthy?" to elicit their experience of health promotion in the rural church. We also asked participants to title each photograph and to describe its relevance to health promotion. After the individual interviews were completed, we held a group photo sharing session at each church. Participants selected their two most meaningful photographs and presented them to their peers. In this session, we asked

participants questions such as, “Why did you choose this picture to share with the group?” and “Would anyone title this picture differently?” A semistructured interview guide was used for individual interviews and group sessions. Interviews and group sessions were audio taped and transcribed verbatim.

The location of the interviews was selected by each participant and occurred either at her residence or at a church. The length of individual interviews and group sessions ranged from under an hour to more than two hours. Each participant received a set of her photographs and 40 dollars compensation for travel costs as well as for sharing her time and insights. We retained copies of the photographs and the logbooks.

Data Analysis

To analyze the data, we used interpretive phenomenological data analysis (van Manen, 1997) and photographic analysis (Oliffe, Bottorff, Kelly, & Halpin, 2008). Data analysis began at the onset of data collection and continued for the duration of the research. We used van Manen’s (1997, p.30) practical approaches of phenomenological inquiry to understand the experience. We orientated ourselves to women’s health promotion experience in the rural church and explicated our preunderstandings of the phenomenon. We read, reread, and reflected on transcripts and logbooks to elicit themes emerging from the data using a combination of van Manen’s (1990) wholistic, selective, and detailed analytic approaches. Thus, we read the text as a whole to elucidate overall meaning, reflected on particularly striking areas of the text, and used line-by-line analysis to closely analyze each statement. We described the phenomenon through the art of writing and rewriting. Throughout this process, we remained orientated to our research question and balanced the research context by considering parts and wholes.

We analyzed the photographic data using Oliffe et al.'s (2008) approaches to photographic analysis. We elucidated individual participants' intended meaning and representations of the photos and then we reviewed the photographs from our perspectives as nursing scientists. We developed themes from the collective whole of photographs and narratives and reconnected these themes with the theoretical bases of the study including rural (Leipert, 2013) and feminist perspectives (Olesen, 2011). On analysis of data from 22 women at five churches, additional data did not contribute in a meaningful way to addressing the research question, at which point informational redundancy occurred (Sandelowski, 1996).

Findings and Discussion

“The church is not in the business of health but . . . it's part of . . . an overall health network somehow.”

We found three salient themes in the data that illuminated women's experience of health promotion in the rural church. Namely, the church (a) supported rural women's physical, intellectual, emotional, and spiritual health, (b) facilitated healthy mentorships and social belonging, and (c) provided healthful opportunities to give and to receive. The church was very much woven into the lives of the rural women who participated in the study. Much like a quilt comes together with many different pieces, each carrying their own history, so the rural church was made up of many different women and their stories. A total of 333 pictures were taken by study participants. Participants took pictures of church events, artefacts, and groups. They also took pictures of the church building, nature, and their rural surroundings.

Participants ranged in age from 32 to 86 years, with the majority being greater than 65 years of age. Most participants described their health as “Very good” or “Excellent.” At least six women had self-reported annual household incomes greater than \$75,000, whereas at least six

women had family incomes under \$35,000 per year. Nine women were primary caregivers for spouses, parents, or children, including dependent children who were 18 years of age or older. Although we did not ask participants to identify their race, ethnicity, or Aboriginal status, we observed that all women were White.

Marital statuses were diverse and included single, common-law, divorced, and widowed, although the majority of participants were married. Education ranged from having some secondary school to holding a graduate degree. More than half of the participants had at least some postsecondary education. Most women reported that they were “Very involved” in church activities, although the amount of participation ranged from once a month to 20 times per month. Participants were involved in various church activities including running youth programs, choir activities, greeting, hosting, cleaning, participating in Sunday services, bookkeeping, and archiving.

Supporting Rural Women’s Physical, Intellectual, Emotional, and Spiritual Health

The church supported the physical health of rural women by providing a physical space for exercise as well as opportunities to participate in physical activity. Exercise classes, for example, were frequently offered in one of the rural churches. These classes were often well attended by senior women who paid two dollars per class. An 85 year old participant stated that her church, “. . . is extremely important [for my health and the] exercise classes [have] . . . been very good for my hip which has had four operations.” The church facilitated the exercise classes by providing the space free of charge, as well as a network to advertise the opportunity.

Church based opportunities to improve physical health were not limited to senior women, however. One participant in her thirties also shared that her experience working with children and young adults in the youth programs kept up her physical health, “We play active games in

which we move around and get exercise.” Participants reported several activities within the church, such as cleaning and gardening, which also provided mild to moderate levels of physical activity.

Some participants, however, reported that they perceived little opportunity to enhance their physical health at the church. One woman explained that there was no room in her small two room church to hold exercise classes. When we asked her if there were perhaps other ways that the church could support the physical health of women, she responded with, “Well, we’re mostly farmers. We get enough physical activity in our daily lives – we don’t need to do more at the church!” Another individual seconded this opinion, “We [don’t really] have to worry about exercise because . . . we had a thousand pigs in . . . the one barn [that] was [quite] long. You walk down there and back and you’ve gone a half mile. Did it many times a day, never thought anything of it.”

A participant shared how her involvement in the church helped to maintain her intellectual health, “Being involved in the church [leadership] kept me reading up on [various] issues. . . . So I guess what I’m saying is that over the years, the church kept my interest in reading alive.” She benefitted from intellectually stimulating opportunities within her women’s church group which she said, “[Filled] my need for knowledge . . . my need to learn something new.” Such activities included chairing meetings and even publishing her writing in church literature. She was also able to share some of her life learnings and experiences in her church’s women’s group, “I’ve showed them some stuff I’ve learned . . . [of places I’ve travelled to]. So that feeds the intellectual knowledge side of my needs.”

In rural communities, library closures, minimal programming, and few library operational hours, limit rural women’s access to reading resources and intellectual stimulation. In one of the

small towns in this study, the library was open only two mornings a week and was thus inaccessible for many women who worked fulltime or who had limited access to transportation. Although many rural women have access to reading material from the internet, spaces and opportunities to discuss literature, which can encourage deepened thought and reflection, might be quite limited. As such, the ability of the church to cater to the intellectual needs of rural women might be quite significant.

Another opportunity to remain engaged intellectually was through quilting groups. These groups, which were attended by both church members and members of the community at large, served as a creative outlet and provided an opportunity to learn a new skill, practice a current skill, or even teach others a skill. Participants spoke very proudly of the quilts made by women at their churches (Figure 1). At two of the churches in the study, quilts were donated to various community causes such as victims of house fires or hospitalized individuals. Giving their work to members in their community fostered a sense of accomplishment and wellbeing for some participants. One participant explained, “In small rural churches, women get together to make a difference in their own communities. . . . This picture is a lap quilt for a local child that is in a wheel chair. We [also make] quilts [for] the local volunteer firemen for the trucks.”



Figure 1. Quilt Making.

Participation in the choir and church musical activities was described as being “Physically and spiritually uplifting.” One participant, who was very active in the music programs of the church, wrote in her logbook that she experienced several emotional health benefits by singing in the church choir. Another participant wrote in her logbook that, “Worshipping God through music directly impacts all three parts of my health because it is something that you do with all that you are made of; our body, our soul and our spirit.” Some women felt the presence of God through church music, which was a significant component of their spiritual health.

Hymns and instrumental music during church services offered the opportunity for deepened reflection, contemplation, and a chance to connect with hidden or obscure emotions. The influence of church music on emotional and physical health was described as, “Music captures feelings and often brings them to the surface. . . . The songs [lift] you to a different place, a place to be still . . . healing feelings of uselessness, mild depression, sadness . . . and going beyond these feelings to heal pain and physical tiredness.” One participant summed up her

interpretation of the relationship between health and her involvement with music in the church as, “ . . . physical, mental, spiritual health; I think all three are in the music.”

Women also spoke of how the church provided them with a place to share their burdens with others. One participant explained, “The sharing of burdens and . . . unloading that mental oppression. Being able to . . . share it . . . in a supportive, loving environment and then having the other people support and pray with you . . . to really lift that . . . heaviness off [of] you.” Many participants in the study experienced significant losses and tragedies in their lives such as the unexpected death of a spouse or a child. In these times of tragedy and transition, the church was a primary support for women, particularly for their emotional health, “ . . . knowing that there's somebody else out there that is caring for you...shares [your] difficulties . . . somebody to pray with which helps lift the weight off [of] your shoulders.” Another participant added, “Grieving is an exhausting process . . . and the church has certainly provided me with lots of ways to stay healthier emotionally . . . so much support.”

Facilitating Healthy Mentorships and Social Belonging

Participants discussed at length how the rural church has connected them to society and bestowed within them a true sense of belonging, which several women mentioned was extremely important for their social health. One participant spoke directly to how the church promoted her health, “It's a social outlet and it's a connection with people.” This sense of belonging was strongly evidenced in the affective support and mutual respect inherent in the rural church community. Women were extremely appreciative of the support they received from their church community in times of need. One participant, for example, took a couple of pictures of her minister visiting at her home and titled the pictures, “Grief.” She explained, “I would call them grief, grief; because it wasn't a social call she was making . . . I mean it doesn't look like grief,

like the smile on her face, but that's what it was about." The provision of affective support both formally, with the minister, but also informally with members of the congregation, was a significant comfort for some participants.

Knowing that someone would be available when tragedy or trauma were to strike was extremely meaningful. Furthermore, in the absence of trauma and tragedy, it was comforting for women to know that others were simply thinking of them and praying for them. Several participants reported for example, that when they missed a Sunday service, they would receive several phone calls from concerned church friends checking in to make sure that all was well. A significant aspect of women's social health resided in the regular contact and vitality of their relationships with others. One participant stated, "I so look forward to meeting with my small [church] group [every other week] . . . [it has] been an indispensable part of my life" (Figure 2). Another woman wrote of her church community, "They've been so supportive in our cancer journey - listening to me release worries and share good news."



Figure 2. Support and growth system.

Providing parental support for new mothers was another way that the church facilitated social connections for rural women. Many mothers remembered the long, isolating days spent on the farm raising children. They demonstrated much gratitude toward the church for providing them with a space to connect with other child-rearing mothers. A mother of two school-aged children spoke of a government program she attended, which allowed her to become, “Familiar with the [church] building and [to meet] other moms in the community.” A few years later, she joined this church, in part because she was familiar with the building from her participation in the mother programs. Some participants also remarked at how the church was a nurturing environment for them as children. One participant recalled the social role that the church played in her early life, “So we went to a little country church . . . that was very much a part of our rural life and I’m an only child so that was a big social aspect for me.”

When one participant and her husband decided to retire in a small Ontario town, she described how the church was instrumental in connecting her with others:

When we moved here, I was asked by friends in [my home province], how will you make new friends? My first answer was the church. And that has been so true . . . some of whom greeted us that first day we attended. From that time, I was welcomed.

The church was also a place where many elderly women gathered, made social connections, and felt a sense of belonging. One senior participant listed some of the women’s group activities that she has participated in at her rural church, “We gathered at the church to makes pies. . . . We made quilts. . . . There is socializing that often leads to friendships.” One participant looked forward to having lunch at a local restaurant every Sunday after church with three close friends,

all of whom were widows. Each of the four women still drove and lived independently in their own homes. At 86, she was the youngest of the group.

Participants also discussed with emotion the importance of strong woman mentors within the church community. Participants shared how woman mentors shaped their behaviors and encouraged them to live healthy lives, both by words, but also by role modeling. Nurturing leadership, for example, shaped the beliefs and behaviors of several participants toward the creation of healthy relationships. One leader was described as, “Our mentor and she was actually like a cominister, except that she never got paid for the job!” Participants shared how they were nurtured and now in turn, they nurture. They learned how to care and be compassionate from others, and they have tried to emulate these positive characteristics in their lives.

Participants discussed how woman to woman mentorship within the church positively contributed to the health of young mothers and their children. A middle-aged woman gave an example of how one young, newly married mother at her church might have benefitted health wise from such mentorship:

I think that the church is really going to contribute to her health by mentoring her . . . by teaching her, by . . . [giving] her some tips and help and I think that that's really going to really contribute to her health and her baby's health. Not only her mental health, but also the physical needs of her baby and herself as well.

The presence of strong woman leaders in the rural church was instrumental for the creation of long-term social networks. Women’s engagement and belonging in the church, for example, was described by one participant as being spawned by one mentor from 30 years prior, “She . . . pulled that group of women together and nurtured us so that today in [our] church we

probably have more women in their fifties and sixties involved than any other church in the rural area. . . ." In this case, the presence of one strong woman leader spawned significant social networks that outlasted her lifetime.

Woman mentors might be pivotal actors in the creation and maintenance of social capital within rural churches. Fostering opportunities that afford the development of such mentorship might assist in ensuring the perpetuation of women's social capital in rural areas. Particularly in rural environments that experience depopulation, closure of facilities, and fewer opportunities to socialize, the importance of strengthening social capital through the rural church is critical to curtailing the erosion of social connections. The church was described as a place of belonging for individuals who might at times experience marginalization from society at large. We were told of one situation where a church supported the inclusion of individuals with mental health and behavioral issues, "A lot of the people that live in [the] group home actually go to the church and some of them do have some episodes during the service. [The church] has a few deacons that are aware of that and will . . . go alongside the person and maybe take them out for a moment and just have them calm down a bit. But they're welcome [to attend], they're welcome."

Several women believed that their churches were accessible for homosexual individuals and couples, "There are two women who started coming about a year, maybe two years ago now who are openly, openly lesbian." More broadly speaking, this participant suggested that, "I can't think of any group that would feel like they wouldn't be welcome [at our church]." Another participant noted, "We've had several people that have attended here . . . [who] have had . . . issues in their past, where they've . . . been arrested and done their time . . . and whatever [but] nobody needs to know [about their past]. . . ."

Even though access to worship participation was generally an inclusive process, in some cases, access to certain church roles, such as leadership positions, was a gendered process and less available to rural women than to rural men. One participant shared a perspective held by a church that she attended a few years ago, “There was no woman allowed in any type of leadership position.” She noted that such a perspective could be positive for women’s health because it can bring women together by getting them “To a place where they fight for those rights.” But on the other hand she commented that:

For the most part it's not [positive for women's health], it's kind of squelching their . . . true leadership potential . . . and [if] they're not allowed to utilize that, then that's really oppressive. So I would say that that's negative to them, to their health.

In one of the churches, women participated in church related organizational decisions, which allowed them to voice their perspectives regarding resource and capital distribution within the church. For example, women were a part of the decision to donate the church’s space to allow seniors’ exercise classes to run with very low overhead. Women were also a part of the selection committee for the minister, which enabled them to voice their desire for a leader who possessed counseling abilities. Furthermore, through individual financial offerings, women could decide how to direct their funds locally and globally, giving them an opportunity to contribute financially to various health promoting causes. In each of these ways, enabling women to actively participate in these decisions allowed them the opportunity to have increased agency on their health in several ways including individually, as a collective of church going women, and as members of a global community.

Although many women in this study had influence on organizational decisions that directly shaped the church's capacity for women's health promotion, women's inclusion in influential decisions varies from church to church and from denomination to denomination. In some churches, for example, certain roles such as ministerial positions are inaccessible to women and they may not have a voice in certain church related decisions. This might reduce women's agency in optimizing the rural church's potential to be a health promoting space for rural women and for other rural dwellers. Even in exclusively male led church environments, however, there might be an informal exertion of women's voices. Therefore, the extent to which rural women exert agency on the health promoting aspects of their church remains to be understood and is likely highly variable among church communities.

In addition to sex-based exclusion, individuals may also have limited access to decision making power if it is held by a tightly knit group of church members. One participant shared that she left her previous rural church several years ago because of "Old politics", a circumstance in which she felt relatively powerless in shaping the direction of the church. She added, "Some of the elders . . . don't want to try anything new and [do not] invite new blood in." Her inaccessibility to the decision making process hindered her ability to exert agency and to feel a sense of belonging in her church community.

The churches in this study were strongly identified as health promoting spaces by participants. Several participants commented, however, that internal tensions can surface within church communities. Such occurrences might reduce a church's potential to be health promoting because they can increase stress and relational vulnerability. No community institution or organization is immune to internal conflict, but such struggles might have a more consequential

impact in rural church communities where church closures are leaving fewer and fewer church options. This might have significant implications for church going rural women.

Amidst unhealthy situations, women might choose to remain in their church despite the unwanted challenges or they might leave church altogether for a lack of viable alternatives. Both of these choices can reduce their health potential by limiting access to church based health promoting resources. One participant, who described her church as a health promoting resource, cautioned that for variety of reasons, “I think that [the church can] contribute positively to a woman's health as much as it potentially can contribute negatively and I think women have to be careful of that and to choose a place to worship that fits them.”

Providing Healthful Opportunities to Give and to Receive

Women valued the opportunity to contribute to the church and to contribute to the community on behalf of the church. When asked to take photographs of how the rural church was important for their health, participants actually took numerous photographs of hospitals, nursing homes, and other community institutions where they volunteered on behalf of the church. One participant noted, “[Our church is] right next door to the school and we have . . . volunteers going and helping with the snack program. . . . The school actually sends over a letter saying, ‘Do you have more people that you could send?’” She wrote in her logbook that working with youth in her community:

Is a very rewarding experience. It is so exciting to see the amount of community kids that come out each week. I see [how] building relationships with the kids . . . is impacting their lives and it's wonderful to be a part of that. . . . this impacts all areas of my health . . . because my emotions feel very good when I see the impact this program has on the kids and their families.



Participants described opportunities to give their time and other personal resources as being not only beneficial to the recipient, but also to them. A young mother, for example, took a picture of the offering plates (Figure 3). She described her weekly offering as a chance, “To give back, to give back to our church, to give back to our community, to give back globally.”



Figure 3. Offering.

At her church, she could direct her donation to a specific church account such as the global missions fund. A participant suggested, for example, that giving to the building fund contributed to the church’s ability to offer their facilities for health and social services such as counselling, food banks, and exercise classes for the greater community.

One 79 year old woman shared how a woman’s simple donation of garden flowers to the rural church is a significant offering. She wrote in her logbook that:

A woman who grows flowers that are cut to place in church is, although making a humble offering, proud that she can do this little act, an act that is part of the offering in worship.

. . . Even when the blooms are not perfect, as they are expected to be in bouquets from a shop, just the fact that they are given to God makes them look perhaps more beautiful than they are.

Opportunities to actively participate in various church activities were truly valued by participants. By engaging in various groups and activities, women strengthened their connections to the church and to other women. One participant noted that her most satisfying experience with the church has been holding leadership roles. She added, “I like doing the leadership and I like the church involvement but I don’t want to do it every week of the year or every day of my life sort of thing.”

Churches with decreasing congregational sizes have fewer hands to complete all of the necessary work. A participant explained that her church volunteerism has been a bit much at times, especially when there was no lead minister, “It can drain you, there’s no doubt about it.” Many participants acknowledged that having a defined work term was important to maintain a healthy workload. One participant shared that, “It’s kind of nice to have the break . . . because you work hard all year.” For example, running certain programs over ten months of the year gave a two month break to regenerate for the next year. Study participants also endorsed definite terms, such as a two year period, for certain roles.

Belonging to the church also created a sense of service obligation for many study participants. Rural aging and the emigration of the young working class from rural areas (McCracken et al., 2005) is surely contributing to the decline in rural church membership. With fewer and fewer church members to support the work of the church, both financially and also through service hours, the sustainment of the church depends on a few volunteers. In this study,

this responsibility was shared by as few as a dozen individuals, who were mostly women. Thus, there was a need for service breaks, which in some cases included seasonally closing the church in the summer months. This break from heavy service allowed women some rest to regenerate for the following year. The seasonal church closure, however, also removed a significant health promoting environment and spiritual resource for rural women within those summer months.

For many of the participants, the church was an integral part of their lives and they expressed some sadness that the church might be having a reduced role in rural life in future years because of declining congregational sizes. Although the church and its related health resources benefitted women who attended the church, many women were eager to extend their resources to the greater community. Not only did churches in this study welcome individuals from the community, but participants in this study appeared to have an increased sense of citizenship to their community as a result of belonging to the church.

Opportunities to receive health related resources from the rural church were also very valuable for women's health. One mother of two small children shared that her church provided basic financial resources to her during a difficult financial period. She recalled that the church gave approximately 1,200 dollars to her family over a period of a few months when they had difficulty paying their mortgage because of unexpected property damages:

The one time we got four one hundred dollar grocery vouchers. . . . We didn't ask for it . . . just one of the deacons . . . in our small group . . . knew of our situation . . . that was God was taking care of us through the people in . . . our small [church] group.

Participants at one church stated that their church regularly purchased diapers and food vouchers for families experiencing financial hardship in their communities. Some of the rural

church going women participated in community service by driving elderly individuals, often women, to the local grocery store. This illustrated how the church assisted individuals and families obtain the basic necessities of life, including shelter and food, without which health cannot be easily maintained.

The capacity of the church to support individuals and families monetarily with unanticipated financial burdens, such as unexpected housing costs, is a valuable church based rural resource. In urban centers, for example, an individual might have the opportunity to increase his or her take home pay by taking on more hours at work or by obtaining additional employment. But in rural areas, labor market participation rates can be lower than in urban centers (Federal Economic Development Agency for Southern Ontario, 2013), thus the ability to rebound from financial hardship by increasing income might be less available.

Often, food was a centerpiece of the healthful giving and receiving by the women in rural churches. One participant wrote in her logbook of her rural church food sharing experiences:

Pot luck dinners are everywhere and, again, we are offering out best. In rural churches, the dishes brought are often indicative of the local harvest. One woman brings a “Carrot from the garden” salad. Another has real farm fresh corn on the cob or baked beans in a pot. . .

The sharing of food, whether it was participating in church pot lucks, providing free monthly suppers to members of the rural community, or sharing the bread and wine in communion, was a health promoting activity for many study participants. Perhaps, such events can be thought of as a relational and equitable distribution of resources. Or

more simply put, in the words of one participant, “Those who can afford it, bring much. Those who are hungry, eat much.”

Even in what might appear to be the simple act of providing food vouchers or the more organizationally intensive acts of operating food banks or providing free community meals, the rural churches in this study were contributing to the food security for individuals and families in their communities. Many rural grocery stores remain closed on Sundays and have limited Saturday and evening hours, which limits food purchasing options for fulltime workers. Also, rural depopulation (Statistics Canada, 2011) contributes to reduced market sizes from which retail grocers can attract customers.

The local grocer in a rural community neighboring one of the church communities in this study recently retired and the store closed because there was no purchaser for the business. Participants discussed how residents of this community had to secure transportation out of town to obtain groceries because grocery delivery services were quite costly, especially for those on a fixed income. With fewer and fewer rural grocers, the cost of grocery items is likely to continue to increase because of limited business viability within a depopulating market. Decreased access to affordable food further incapacitates rural populations who already experience greater levels of poverty than their urban counterparts (Canadian Institute for Health Information, 2006). Therefore, the rural church’s role in promoting food security might be somewhat underestimated and quite significant in many rural communities.

Conclusion

Although there is a wealth of diversity in rural communities across the country, there are likely many similarities in women’s experience of health promotion in the rural church. Thus, our findings from these five rural churches might very well be paralleled in rural churches

elsewhere. It is worth noting that this group of participants was generally well educated, had above average incomes, and had very good or excellent self-declared health statuses. This might be an unlikely presentation for a rural community, as such communities tend to have higher incidences of poverty and lower levels of education than urban centers (Gilmore, 2010; Standing Senate Committee on Agriculture and Forestry, 2006). How these demographic factors shaped their experience of health promotion in the rural church warrants some consideration.

Study participants might have more actual or perceived access to the church and its resources because of their societal placement and influences of class, which must not be underestimated. Furthermore, somewhat representative of rural church communities, our sample consisted primarily of older women. Thus, our understanding women's experience of health promotion would benefit from additional research with a broader sample of generational perspectives.

Health professionals who are currently using rural churches for health promotion purposes, including parish nurses, might want to seek out rural women who do not use health services in the church and explore possible barriers and facilitators to their accession. It might be that the church carries negative meaning for some women, whereas to others, perhaps it is largely a place of unfamiliarity. Whatever the reasons might be, it is important for rural health professionals to enter into dialogue with these women to promote and provide services to those who require care in their communities, regardless of their belonging to a church. In rural communities, parish, community, and public nurses have an increasingly important responsibility to examine how churches can shape experiences of health and of healing in addition to expressions of nursing care.

Findings from this study support the church as a health promoting resource for rural women. Individual and collective health can be promoted with access to social structures and relationships stemming from the rural church. The church and rural women's health promotion, however, cannot be studied in isolation for they exist within broader socioeconomic and political climates. Directions for future research include examining how intersections of class, religion, gender, age, and place, for example, influence health promotion and shape social structures arising from the rural church. As the church can be a supportive facilitator for rural capacity, exploring how intersectional categories shape or hinder relationships among individuals would help to better inform how the church might act as a resource towards promoting healthy communities.

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Chapter Five - Healthy spaces in meaningful places: Women's health promotion in the rural church.

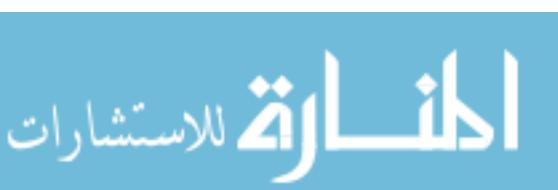
In health research, place has largely been conceptualised as an objective term with defined boundaries. Rural places, for example, are often defined by postal or zip code areas, geographic co-ordinates, population density, or distance from urban centres (du Plessis, Beshiri, Bollman, & Clemenson, 2002). Such interpretations of place may be useful, particularly from an epidemiological standpoint, for defining under-serviced areas or morbidity patterns that have spatial clustering. Such definitions, however, generally regard place as an inert variable, ignoring its spatial meaning and do not consider spaces as lived places. It has been suggested that as places are experienced, they become spaces (Williams & Kulig, 2012). Therefore, studying place warrants an appreciation of spatial dimensions, which include cultural and social conventions (van Manen, 1997).

Critiques of the definitive or conventional interpretation of place note that studying place as a discrete variable may discount influences of places being interconnected with one another (Chaix, Merlo, & Chauvin, 2005). They may also assume that geographically present health resources are analogous to accessible health resources, an assumption which may not always be accurate. For example, Kubik and Moore (2001) report that some rural women do not access mental health services in their community for fear of their car being identified in the parking lot. Thus, there can be a disconnect between health resource access and place based on social situations. Measuring place as a defined variable, such as by zip code boundaries, may de-contextualize, ignore, or minimize the spatial influence of social meaning and relationships, which are known to significantly shape health experiences as well as access to health resources

(Cohen, 2004). This might be especially relevant in rural places where people often know each other well.

A relational understanding of place is beginning to surface in health research (Cummins, Curtis, Diez-Roux, & Macintyre, 2007). This conceptualisation shifts understanding of place from a rather static, physically defined area to an area that is less defined by traditional geographic boundaries and more defined by social interfaces. This relational conceptualisation of place suggests that places may be separated or connected by socio-relational distance, in addition to physical distance, and reflect social power relations and cultural meaning as opposed to displaying social and cultural neutrality (Cummins et al., 2007). Place can further serve as an epistemological tool that is rooted within our understanding of experience (Casey, 1993). That is, we know what we know based in part on where we are and where we have been. van Manen (1990) describes space phenomenologically as an experiential concept, one which is both lived and felt, “lived space is felt space.... It is largely pre-verbal; we do not ordinarily reflect on it. And yet we know that the space in which we find ourselves affects the way we feel” (p. 102). Merleau-Ponty further notes that individuals exist “not in space, but...rather of space” (2012, p. 149).

In Canada, rurality is a determinant of health because it significantly shapes the health and health experiences of rural Canadians (Leipert, Leach, & Thurston, 2012; Williams & Kulig, 2012). Rates of morbidity and mortality, for example, are often higher in rural than in urban centres (Canadian Institute for Health Information, 2006) and rural access to health resources is often limited compared to urban contexts (Leipert et al., 2012). Thus, rural health is a place-based concept that warrants an appreciation of rural characteristics, which include rural social structures and culture. Furthermore, because health promotion is defined as a social process that



enables people to gain increased control over their health (World Health Organization, 2014), it is fitting to use a relational conceptualisation of place to understand rural health promotion.

Critical discourses of place suggest that examining how social processes and relationships shape and perpetuate health inequalities may lead to a more accurate understanding of health disparities because the relationship between agency, practices, and social structure may be embedded within the construct of place (Frohlich, Corin, & Potvin, 2001). It has also been suggested that space is reciprocally constructed because while people create spaces, spaces also shape people (Halford & Leonard, 2003). Thus, spaces and places can be essentially integrated into health experiences by informing emotions or shaping the contexts in which health experiences exist.

The Church as a Place

Critical discourse of the church as a place has received minimal attention, especially in health research. Yet, for rural residents, women in particular, churches can be a very significant health and social resource (Arcury, Quandt, McDonald, & Bell, 2000; Clark, 2000; Douglas, 2003). The church has been discussed at length as a static environment in which to implement church-based health promotion (Campbell et al., 2007). And, church attendance has often been discussed as a health behavior that reduces the incidence or severity of illness and disease such as depression or hypertension (Koenig, King, & Carson, 2012), a discourse, which largely recognizes the church as an inert variable. Many studies (Koenig et al., 2012) suggest that the church can be a place for health promotion, but how the church as a place specifically influences health promotion remains unclear. This may be partly because traditional interpretations of church tend to de-contextualize it from its greater environments, which include spatial, cultural,

social, and institutional dimensions. Interpreting the church as a relational and dynamic form of place may yield important understanding of its influence on health not yet recognized.

Study Design

Methodology and Method

This paper explores the significance of place in rural women's experiences of health promotion in the rural church as revealed in an interpretive phenomenological study incorporating the photovoice method. The research question is: What is the meaning of place as it emerges in rural women's experience of health promotion in the rural church? The findings presented in this study are based on data collected in 2012 and 2013 at rural churches in southwestern Ontario using interpretive phenomenological inquiry (van Manen, 1997) and the photovoice method (Wang & Burris, 1997). In interpretive phenomenology, which is the study of lived experience, meaning and knowledge are constructed by individuals as they interact with the world in which they are living (Crotty, 1998). The phenomenologist seeks to interpret the lived experience of a phenomenon into a textual expression "in such a way that the effect of the text is at once a reflexive re-living and a reflective appropriation of something meaningful" (van Manen, 1997, p. 36). Rooted in the theoretical assumptions of critical consciousness, feminist theory, and documentary photography (Wang & Burris, 1997), photovoice is a participatory research approach, originally used with rural women, that creates spaces and opportunities for individual and collective voices, to be heard. Using both interpretive phenomenological methodology and the photovoice method allows for a rich interpretation of experience because the visual and linguistic forms of data can contribute to a heightened understanding of the narrative and experiential phenomenon (Brunsden & Goatcher, 2007; Plunkett, Leipert, & Ray, 2013).

Participant Recruitment

Women's group executives and clergy in rural churches were contacted via telephone and email to discuss their church's possible participation in the study. A contact was established at each church, who invited women over the age of 18 who could converse in English and for whom the church had a past, present, or possible future influence on their health to participate in the study. Snowball sampling (Atkinson & Flint, 2001) was used as study participants were welcomed to provide potential participants with information about the study and the researchers' contact information. Most participants were recruited by word of mouth or by notices in church bulletins written by participants. Six to eight participants is often a sufficient sample size for phenomenological nursing studies (Morse, 1994). The initial recruitment goal for this research, however, was 12 to 16 participants because data was to be collected from at least two distinct sites to generate additional perspectives from different churches. Recruitment continued until data saturation occurred, which occurred with a sample of 22 women at five churches.

Data Collection

Over the course of the study, 22 rural women in southwestern Ontario took pictures, documented in logbooks, and participated in individual interviews and group sessions to reveal what they perceived to be health resources and needs in their churches and communities. Participants at each church initially met in a group setting, during which the author described the study, distributed disposable cameras and logbooks, and led a discussion on ethical picture taking. This session also served to build rapport between the author and participants and offered a space in which participants could ask questions about the research process. Participants were then given several weeks to take photographs and to document in logbooks of ways that the church mattered to their health before meeting with the author for an individual interview.

The length of the individual interviews and group sessions ranged from under an hour to over two hours and were audio-recorded and transcribed verbatim. Interviews were conducted by one author and occurred in rural communities at either the participant's residence or at a church. A semi-structured interview guide was used to guide the interview and included open-ended questions such as, "How do you feel after worship?" and "How would your experience of health in the church be different in an urban setting?" Participants were also asked to title each of their photographs, to share why they took each photograph, and to describe what they saw in each photo. In addition, participants were asked if there were any photographs that they would have liked to have taken, but were unable to. This question served as a means to elicit greater understanding of the phenomenon as a whole and to promote appropriate representation of the photographs (Wang & Redwood-Jones, 2001).

Participants then shared their two most meaningful photographs with peers in a photo sharing session. In this session, additional perspectives and context for the photographs were elicited. Questions such as, "Would anyone title this photo differently?" and "What types of pictures would women from other churches take?" were asked. Questions were created to promote reflection and dialogue as well as to understand the roots of participants' health promotion needs and assets (Wang, Yi, Tao, & Carovano, 1998). Approval for the study was granted from the Office of Research Ethics at Western University. Each participant received a set of her photographs and \$40 compensation for travel costs and for sharing her time and insights.

Data Analysis

Data analysis began at the onset of data collection and continued for the duration of the research. van Manen's (1997) interpretive phenomenological approach to data analysis was used to analyze the textual data generated from logbooks, individual interviews, and group sessions.

Transcripts were read, re-read, and reflected upon to reveal new understandings emerging from the text (van Manen, 1997). A combination of van Manen's (1990) wholistic, selective, and detailed approaches was used to initialize thematic trends. Thus, the text was read as a whole to elucidate overall meaning, particularly meaningful areas of the text were further reflected upon, and line-by-line analysis was used to carefully understand each statement.

Oliffe, Bottorff, Kelly, & Halpin's (2008) four-step approach to photographic analysis was used to analyze photographs in addition to interview and logbook data. This approach to photographic analysis involved 1) elucidating individual participants' intended meaning and representations of the photos, 2) reviewing the photographs several times to compare the data generated and the researcher's interpretation of the data, 3) developing themes from the collective whole of photographs and narratives, and 4) reconnecting these themes with the theoretical bases of the study including rural (Leipert, 2013) and feminist perspectives (Olesen, 2011).

Photographs were frequently revisited and were often reviewed with transcripts. Researcher field notes (Patton, 2002) were taken to document community, church, and sample characteristics. When revisited with participant data, the field notes allowed for a richer interpretation of the research context. Data were collaboratively reviewed and discussed amongst the research team, which contributed to a common orientation toward the phenomenon (van Manen, 1997). Understanding the multiple participant perspectives, as revealed through photographs, individual and group interviews, and logbook recordings, contributed to an enriched description of the phenomenon. Themes emerged through the interpretive process as the unarticulated intersections of the phenomenon were exposed through discussion and dialogue (Gadamer, 1976).

Authenticity of the research was promoted by revisiting the primary transcripts and photographs throughout the analysis to remain orientated to participants' descriptions and interpretations of the experience (Guba & Lincoln, 1994). Additionally, participants were provided with thematic descriptions of the phenomenon and offered the opportunity to express their refinements to the researchers' interpretations, a practice that further contributed to the authenticity of the findings. The credibility of the research was pursued through a phenomenological description that illuminated the experience as familiar or potentially familiar (van Manen, 1997). This approach included writing and re-writing the phenomenological description and by incorporating evolving interpretations of the data.

Setting and Sample

The 22 participants in the study attended five rural protestant churches in southwest Ontario that were at least a 30 minute drive from a populated centre with more than 30,000 people, which is a provincial definition of rural (Ministry of Health and Long-Term Care, 2010). Two churches resided in communities with populations of 2,500, one church was in a small town of 1,000 residents, and the two remaining churches were located at a distance from a town in agriculture farmlands. The churches were located in underserviced geographic areas where access to social determinants of health and health-related services was limited.

The study is specific to women because there is limited research that addresses rural women's health promotion needs and resources (Leipert, 2013). Furthermore, rural women are often the primary seekers of health information for their families and communities (Wathen & Harris, 2007) and rural Ontario, along with many other rural regions, is progressively becoming a feminized society (Government of Ontario, 2009). Thus, the health needs of rural women are of key importance for the health of rural communities.

Findings

“[The church has seen] many changes over a hundred plus years [and is] always the centre of our lives” –Rebekah’s logbook

Study participants ranged in age from 32 to 86 years, with the majority of participants being over 65 years of age (n=13). Most participants described their health as very good (n=8) or excellent (n=7). Thirteen participants had household incomes over \$35,000 per year, while six participants had family incomes under \$35,000 per year. Marital statuses included single (n=2), common-law (n=1), divorced (n=1), and widowed (n=3), although the majority of women were married (n=15). Education ranged from having some secondary education to holding a graduate degree. Most participants had at least some post-secondary education (n=17). Although 12 women were retired, several of these women continued to work on a part-time basis on their farm. Pseudonyms are used for participants and communities to promote anonymity.

The church was presented by participants in several different ways including as a place of worship, a community institution, a place of employment, and as a network of people. Each of these presentations clearly shaped the women’s social interactions in their daily lives. Churches in this study were used to hold exercise classes, food banks, counselling services, and served as social gathering places. Participants took a total of 333 pictures, which included the church building, inside and out, items within the church, people, community institutions such as long-term care facilities where congregants volunteered on behalf of their church, and pictures of their church’s rural community.

It was evident through the women’s stories and photographs that the church had a significant role in supporting their health. For example, many participants discussed the church as their primary provider of social support, especially in times of need. For example, when

Rebekah's husband died suddenly in his forties, she described her church in the following way, "That was my medication I guess, was church. And all the life that involved around it." In this study, place was revealed through three broad themes of women's experiences of health promotion in the rural church. Firstly, the church was presented as intersecting physical and rural environments, secondly it served as a gateway to experiential attachment and personal meaning, and lastly it represented a connection to shared culture and beliefs.

Intersecting Physical and Rural Environments

In the rural communities in this study, churches were prominent community centres that were used for weddings, funerals, anniversaries, and community meetings among many other activities, including the more traditional church-related activities such as worship services and bible study. While some of the communities in the study did have other community meeting places such as a fire hall, old school house, or, in two of the communities, legions, the church was described by participants as the community centre they frequented the most often.

Participants used various words to describe the church's rural and physical place including "in town", "country church", "building", "facility", and "community centre." Participants took many pictures of the natural landscape surrounding their church, which clearly displayed the ruralness of the church, and helped them connect with nature in their rural surroundings. Ashley wrote of the memorial garden at her small church (Figure 4) that displayed the names of church members who have passed on, "There is a bench in this garden and it is lovely to sit [there] and enjoy the quietness, birds and nature."



Figure 4. Memorial garden.

Kaitie proudly described her church building, “it’s a nice facility, it’s well kept up, it’s wheel chair accessible, so it’s easy for people to use...it does get used a lot.” Evangeline, who uses a wheelchair, felt comfortable getting around in church because the hallways were amply wide and there was an elevator to bring her from the main entrance up to the second floor sanctuary. Physically accessible rural churches allowed women, like Evangeline, to partake in a variety of services and programs offered in the church such as women’s groups and worship services. In Evangeline’s case, church members also provided her with transportation to and from the church. In a small rural town like hers, where there is no public or accessible transportation and few community gathering places, Evangeline relied primarily on the church for her social and mental health promotion. Catherine, whose church rarely had more than two dozen attendees at any given Sunday morning service, described how belonging to a small, rural church kept her

socially engaged, “The social aspect of smaller churches does improve women’s health – gives them lots to do, keeps women busy baking pies and stews and soups and squares. And talking with friends while we serve [and] clean the church.”

Pearl’s church was located in the centre of her small town, so she and other small-town dwelling senior women could walk to church. Because of the church’s proximity to her apartment, 85 year-old Pearl could participate in exercise classes and social events offered in the church, which were important for her physical, social, and mental health promotion, without having to consider transportation. Especially in the inclement weather of the winter months, the church enabled women to interact socially in what is sometimes a dark and snowy season that can otherwise create isolating circumstances in rural areas where treacherous driving conditions can abound.

In addition to assisting with the creation and maintenance of social connections, the church also formally increased individuals’ access to a variety of health and social services. As one of the few buildings available to the public in the small towns, the church was often at the centre of the diffusion of health information, which included advertisements for various community health services and health promotion opportunities. For example, women noticed postings on church bulletin boards or read in church bulletins about various health promoting opportunities, such as counselling services, which in one case, was actually available at the church. Participants also explained that the posting of weekly room bookings at the church was often a good source of knowledge for what types of health and social services were available within the church as well as in the greater community.

Having church members who were health or social workers facilitated health information diffusion, as one participant stated, “We were more aware of … all the work of public health

when we had a member here who was a public health nurse.” A participant from another church shared a similar perspective, “It’s a good thing [the nurse comes] here ‘cause I wouldn’t’ve known any of [these health resources in our community existed].”

In many rural areas, the lack of anonymity for health and social services is a significant barrier to resource access because individuals are often known to one another. The churches in this study, however, did not seem to be a barrier to service access despite sponsoring some services that might not normally be accessed without assured anonymity, including a food bank, alcoholics anonymous, and counselling. Laura suggested, “Thursday night [when the food bank is open] is often a very busy night in this church...The parking lot can be very full sometimes...So [people] could be going in that door ... for any number of reasons.” Laura’s church however, was a rather large rural church that housed multiple meeting rooms over three stories. In very small rural churches, including one-room churches, such anonymity may not be possible.

A Gateway to Experiential Attachment and Personal Meaning

In addition to the church being a physical and rural place, it also emerged as an experiential place that existed in the memory of rural women. Lotta described how her experience in the church building has had a significant role in her health promotion and carried many memories and much meaning, “Many ... years have been spent in the choir loft ... It is friendship and glory and praise and love and laughter and tears and free therapy all in one room.”

The church also served as a keeper of many meaningful items, including memorial artefacts with religious, familial, or community ties. Participants could recall which family donated the baptismal bowl, the communion table, and the stained glass window, for example. Various artefacts present in the church were reminders of times gone by and signified hope for

times to come. Memories were also connected to the churches' construction. Participants could recount the year that additions were added, the year that the church gained indoor plumbing, and the year of the 100th anniversary. Lotta noted,

There are so many ways to remember the people we have loved and who have died – and in church there are remembrances of them. The communion table in memory of my Grandfather. The candlestick holders in memory of my husband's niece who died in a car accident at 5 years old.

Participants noted that there was healing that occurred with some of these memories. Joy described some items that were donated in memory of her young daughter, Julie, who died tragically in a roadside accident,

Julie's candles and the doors represent the love and support we have received from our church family over the years. They have made a very difficult journey a little easier, because we know they loved her too. The candles and the doors are a gift to us because they continue to allow us to share Julie's life with all who enter into our congregation.

Hannah, at 82 years old, attended the same church since childhood. She took a picture of the baptismal bowl at her church (Figure 5) and, in her logbook, described the personal history attached to this artefact,

The Baptismal bowl was donated by an elderly lady that lived next door to us in memory of her parents that lived there too. All five of our kids and thirteen of our fourteen grandkids and two of our great grandkids plus many other children in the community were baptized using this bowl.

Thus, for women like Hannah, the contents of the church can carry significant history and may help to foster their personal, familial, and community identity.



Figure 5. Baptismal bowl. This photograph has been modified by blurring the inscription on the bowl to preserve the anonymity of the church community.

Tabitha shared how personal meaning and memory of a church building may not always be positive and can actually pose some questions of inaccessibility. She stated:

Like that barrier, just that it's a church. There [are] some people that do not want to come into any building that's a church. Like my husband's sister... she will not go into any church building... So when [my mother and father-in-law] had their fiftieth wedding anniversary, they couldn't have it here in the church, they had to have it at the community centre 'cause his sister would not come if it was here at the church.

Alternatively, personal meaning connected to a church can be a very positive and comforting characteristic of communities for many women and may assist in repopulation of some rural

communities. For example, when Evangeline was visiting prospective places to retire to, she was looking for a small town in which to settle. Upon visiting one small town, it was the church that drew her in. She noted, “And when I came here, … I knew I would eventually be on my own (widowed) And when I heard the [church] bells, I thought that ‘yes, this is where I’m supposed to be.’” There was something about the church bells for Evangeline, and the church building for others, that indicated a particular familiarity or comfort despite them never having experienced a certain church or community before. Dot, a church pianist, reported that cars often park outside the church at noon hour. She supposed it was to hear the church bells, because vehicles arrive shortly before the bells sound and depart once the chiming concludes. Thus, for some individuals, personal meaning and memory form a part of their place-based experience of the church.

Church closures in rural southwest Ontario are on the rise and such closures were real possibilities facing several of the churches in this study. Karen attended a closing service for a neighbouring rural church, listened to conversations, and described what she heard,

They talked of women who always did certain jobs, some who cleaned the church or kept the grounds neat, special visitors, funny stories and sad stories. They spoke of community events and included people who did not even go to church there...People said how happy they were to be there but then there was a certain atmosphere of sadness.

The experiential attachment and meaning between rural women and their churches may perhaps become more evident with the threat of losing a church. In one of the churches in this study, two neighboring congregations merged due to decreasing congregational sizes but they continued to sustain two church buildings and, in four-month time blocks, they alternated worship services between the two sites. There was so much personal meaning and memory

embedded at each site that the decision regarding which site to close was extremely difficult. As Hannah so poignantly revealed, “To me, the church [is] … just part of my life and who I am.”

A Connection to Shared Culture and Beliefs

The church, for many participants, was a place where shared values and beliefs were enacted. This idea of place came not so much with the geographic coordinates of the church, nor with the building in and of itself, but rather with the sense of social belonging and collective connection with a spiritual presence. For many of the participants, the church was a reminder of their connection with the unseen. For some, it was God, for others it was a web of people. Laura described, “and I guess that I look at the church as being a kind of connection to people around the world… The thought of that [the church] not being there at all would be terrible. That would be very detrimental to my health.” She continued,

Not that church has always been a huge [part of my life], but it’s always that security of knowing that it’s there. That, yes, there’s a building there, but a group of people that go with that building. Even if you were in a town visiting, and something tragic happened, you can go to a church and know that there’s a support network associated with that, anywhere in the world for that matter.

In this sense, participants felt that their church served as a connection to others and, as Lotta wrote in her logbook, “Being a … part of something much bigger than I.”

The church also served as a place imbued with shared meaning, which emerged primarily as religious significance and constancy over time. Laura described such a shared meaning as, “That kind of common belief in God and that common faith.” Lotta was reminded of the constant message in church literature, “[Bibles] come in all sizes, colours and age as years go by – but inside never changes. What served generations before us – still serves us.” She took a picture of a



stack of the various versions of bibles that her church has accumulated over the years (Figure 6). Pictures and narratives such as these suggest that the shared meaning is not only experienced in the present, but is also a connection to individuals and beliefs in the past and perhaps into the future as well.

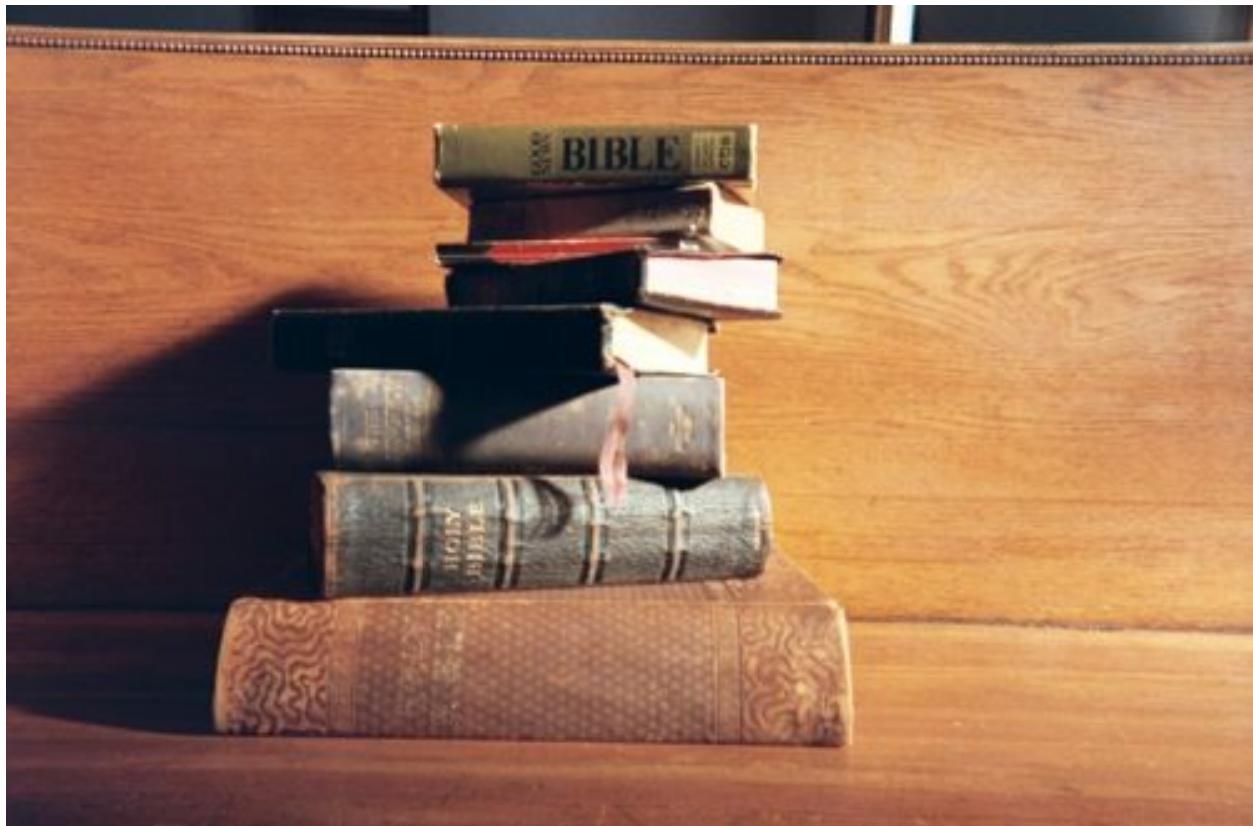


Figure 6. Stack of bibles.

Corrina took her entire roll of film of the crosses worn by the women of her church. She wrote in her logbook,

When the strength of the group is jeopardized – through a loss, sickness, loss of job, health reasons, [we are] strengthened through prayer, love, compassion. No matter what – we never lose that connection with the bigger larger cross – Jesus Christ. He is always there to comfort us and strengthen us through his power and love. We never have to bear our cross alone.

Thus for Corrina, the crosses worn by the women in her church symbolized a connection to shared religious and spiritual beliefs.

Some participants spoke about how their experiences of social connectedness in the church differed from connections in the greater community. For example, Lisa explained, “There is this security … when you have people of the church family as opposed to out in the community. I guess it’s just a different feeling…that common belief in God and … life everlasting that you share.” Lisa suggested that the spiritual element in some of her church relationships elevated her trust in these relationships. She further described certain positive, healthy behaviors that she perceived are promoted within her church, “if we’re faithful followers of God then [we’re encouraged to behave with] … patience, kindness, goodness, faithfulness, gentleness, self control …”

Discussion

In rural areas, where health promotion infrastructure is minimal or lacking, the church plays an important role in women’s health promotion. Since churches can be one of the few maintained buildings in many small towns and rural areas, they often have a central role in rural social and cultural life. By providing opportunities to socialize and to belong and by sponsoring health and social services, such as food distribution centres, the church is well positioned to facilitate women’s health promotion.

Rural women in this study associated both individual and collective meanings to their rural church. Individual meaning came from the church building as well as from its contents and artefacts, which supplemented women’s memories and supported their identity. Such a bond to a physical space, place attachment, is also known to provide psychological benefits in addition to fostering identity (Brown, Perkins, & Brown, 2003). It has been demonstrated that strong positive

bonds to a place can result from feeling secure in the environment, and that place can actually be viewed as an extension of the self (Brown, 1987). This may be the case for some women in this study, although further research is needed to support this claim. If place can indeed become an extension of the self, implications for holistic nursing practice might include reframing care to more intentionally include the socio-religious environment in which health promoting experiences exist. In other words, to wholly care for a person, care consideration must also be given to the individual's environment.

Place attachment may promote increased neighbourhood cohesion and collective efficacy because it fosters stability, familiarity, and security in addition to feelings of pride and well-being within a community (Brown et al., 2003). Yet, rural church closures and changes to the social fabric of many rural communities may alter the capacity for women to develop place attachment to the remaining church and to its rural community. Thus, a decline in place attachment, which can have detrimental social and physical effects on communities (Brown et al., 2003) may result in reduced rural community capacity. Alternatively, it may be that women develop stronger place attachment to their church as its future existence becomes uncertain.

Because the majority of participants were senior, data largely emanated from a social generational perspective reflective of birth years in the 1930s and 1940s. Thus, throughout their life course, participants were exposed to an evolving rural world, one that saw significant transformations of gender and family roles as well as religious culture. Such perspectives necessarily shaped the data by allowing not only for current experiences but also by capturing a glimpse of the essence of experiences from days gone by. Especially for participants who grew up in a single rural community, their place attachment to the rural church may be particularly

strong. Over time, the meaningfulness of the church could intensify and its evolution from a place to a space could ensue.

The rural churches in this study were described by participants as health-promoting environments. Participants discussed healthy behaviors that were encouraged in their church, including fostering gentleness and kindness in inter-personal relationships. A part of the adoption of healthful behaviors may be that the church is recognized as a sacred place, thus individuals may restrain from certain unhealthy behaviors while in the building. But it may also be that the church is a place to learn and be mentored about healthful behaviors through informal social influence, a process that has been documented with other social groups (Kawachi, Subramanian, & Kim, 2008).

Yet, rural individuals who have few or no bonds to the church may experience community, social, or resource exclusion. Newcomers to a rural community, for example, may experience more difficulty accessing health resources through the church because they have no previous connection to the church or to members of the congregation, who are often a tightly-knit group. Furthermore, because common history and shared culture can connect life-long rural dwellers together (Zanjani & Rowles, 2012), newcomers may experience some form of social exclusion simply by virtue of being new to a community and by possibly not behaving according to social norms and expectations that shape rural relationships and life (Brennan, 2005).

The church, in its current religious and societal place, is not accessible to all rural women. Women who have left the church or religion in its entirety, women who ascribe to a religion other than Christianity, to a different Christian denomination or to no religion, and women who are extremely isolated by virtue of disability or familial issues are examples of women who may not be able to access health promoting resources available through the church. The placement of

services intended for the communities-at-large within buildings with religious affiliations suggests a need to reframe religious places and spaces as environments for rural social inclusivity and health promotion. Contemplating how place might shape nursing exchanges ought to be a consideration of care.

Because churches are often value-laden places with significant ties to religious doctrine, the effectiveness of health promotion initiatives may be influenced by a church's capacity to be compatible with the health promoting values and beliefs of rural individuals and communities (Plunkett & Leipert, 2013). Congruency between values, beliefs, and cultural norms of churches and the community-at-large needs to be reflected upon prior to initiating health-promoting programs to elucidate any possible conflicting values (Campbell et al., 2007). Furthermore, a deeper recognition of individual and collective value-based health beliefs would strengthen the practice of holistic nursing. By gaining a better understanding of how health decisions are influenced by values, including religious beliefs, nurses would be better positioned to provide value-centred care.

In rural communities, religious places could be Centres of Excellence for building and sustaining social capital, both within and outside of religious values and communities. The need to explore how religion may serve as a facilitator and as a barrier to accessing health promoting resources through the church may be key to reaching those women who may most benefit from its health and social benefits.

Limitations

Findings from this study are reflective of a small sample of relatively well educated rural women with generally positive experiences of health promotion the rural church. To examine more closely how the church could be more health promoting, extending the research question to

other women, those who might have left the church or those who have never attended, would enrich the description of the phenomenon and perhaps allow for more insight into making the church a healthy space for more rural women. Data were also collected in geographically similar areas in southwestern Ontario over a relatively short period of time. Because data were also shaped by the time and place in which they were gathered, the collection of data in additional spatial-temporal dimensions would further illuminate the emergence of place as space in the rural church.

Conclusion

Place is a fundamental feature of women's experience of health promotion in the rural church. This research suggests that rural women's experience of health promotion in the rural church is complex and that place necessarily contributes to its intricacy. Further research is necessary to explore how place shapes rural health promotion for other rural residents including men and children. Recognizing the personal meaning and shared cultures, including spatial and religious cultures embedded within places, may assist religious communities and health-care providers to promote access to religious spaces for health promotion purposes.

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Chapter Six - Conclusion

This is the first known study to explore women's experience of health promotion in the rural Canadian church. As such, themes arising from the data offer a unique, albeit initial, perspective of the phenomenon. Thematic analysis supported churches as health promoting places for rural women and environments of social inclusion. Participants' experiences of health promotion in the rural church suggested that both individual as well as collective health could be promoted with access to social structures and relationships stemming from the rural church.

Because the rural church holds such a prominent place in many rural communities, access to many health promoting resources might depend on an individual's ability to access the rural church. The church in this study was described as welcoming and socially inclusive environment where social relationships could develop and deepen. This concluding chapter outlines reflections on the research including methodological, thematic, and nursing considerations. Following these reflections, areas for future research are discussed. Pseudonyms have been used to protect the identity of participants and communities.

Reflections on Methodology

This study utilized a novel combined and complementary approach of interpretive phenomenology and the photovoice method for inquiry into and analysis of the phenomenon of rural women's health promotion in the rural church. As discussed by van Manen (1997) and Gadamer (1996), the inclusion of non-discursive material, which in this study was in the form of photographs taken by study participants, for hermeneutic phenomenological inquiry illuminates experiences in ways that cannot be described by words alone.

Dialogical conversation that occurred within the photo-sharing sessions contributed not only to data elicitation and emancipatory experiences within the photovoice method (Wang &

Burris, 1997), but also served to draw out shared social meanings of the phenomenon.

Additionally, group sessions served to clarify facts and meaning, both for the participants as well as for the researcher. Participant comments included, “Laura, cut [in] if I’m, not right about this”, “I didn’t realize [we ran that program], is there still one going?”, and “[Dot], do you want to explain that [idea]?” Such excerpts suggested that group sessions offered a space for participants to offer their individual interpretation of the experience, while encouragement from peers promoted deepened contemplation of the phenomenon. Participants in this study were asked to provide a title for each of their pictures. Yet, in some cases during the photo-sharing session, peers offered additional titles for photographs, a practice that served to promote further reflection and understanding.

Several participants continued to email the researcher after the study was completed. Excerpts from emails included, “I sincerely enjoyed thinking about how our church family has enriched my life,” “I have learned more of who I am in doing this,” “driving home [I] thought of [one] more reason for a parish nurse,” and “I wonder if ‘attitude of gratitude’ has come up at all....the concept of expressing gratitude and receiving blessings because of that expression. This has always intrigued me.” Thus, the research approach elicited additional thought and dialogue from participants beyond the study time-line, which might contribute to the emancipatory effect of the research. Participants were also appreciative of having had this research experience. Emailed phrases included, “thanks again for your interest in our little church community!!” and “Thank you for sending us your paper. We could see ourselves in some of your findings. We certainly enjoyed the experience.” Such comments suggested that this experience was a positive and fruitful one for some participants, which might help to demystify research in rural communities into the future.

In many rural areas where social structures are deeply embedded within health experiences, health promotion is very much a collective endeavour. Thus, the use of the rural research methodology, interpretive phenomenology and the photovoice method, acknowledged, respected, and included rural socio-cultural characteristics. As a result, it became possible to better examine the phenomenon as a function of its context, thereby contributing to an analysis that did not isolate the experience, but rather appreciated its rural existence, provided more accurate and relevant information, and enhanced the reliability of the study.

Advantages and disadvantages of disposable camera usage for the photovoice component of this study were an area of significant methodical contemplation, particularly in a setting where digital cameras are often readily available. The use of disposable cameras over their digital counterparts is advantageous for several reasons, including that it allows study participation from individuals who might not have access to a digital camera, the number of pictures that participants can take is limited to the amount of space on the film, which may encourage deepened reflection prior to taking a picture, and disposable cameras are fairly simple to use, often with only two buttons (including the flash). Some participants also noted that the use of the disposable camera reminded them of their study participation and encouraged them to continue taking pictures. One participant, for example, stated that every time she opened her purse and saw her disposable camera, she was reminded of the study, which might not be the case if she would have used her own digital camera.

Disposable camera usage is comparatively expensive to digital options because single-use cameras need to be purchased for each participant and cannot be reused for subsequent studies as digital cameras can, photo development for disposable cameras is more costly than printing digital pictures, and the photos need to be transferred into electronic versions for analysis and

dissemination purposes. One study participant chose to use her own digital camera, while many other women supplemented their disposable camera photos with electronic photos that they emailed directly to the researcher.

While most participants used the hardcopy notebook provided to document their insights, some participants used word processing software in lieu of a hardcopy. One participant emailed the following message, “I find it a little difficult to write ‘feelings’ on paper.” So instead, she typed them. Electronic logbooks tended to be longer and more reflective in nature than their paper counterparts. Paper logbooks, for example, were often written in point form, while electronic versions were in long sentence form. Participants wrote stories and detailed accounts of their history in their church in the electronic logbooks; such reflections were much less common in paper logbooks. Participants who chose to document electronic logbooks emailed them directly to the researcher. This facilitated data management for several reasons, including eliminating the need for logbook transcription and proofing. It also allowed for increased accuracy in understanding participant written comments, which can be misread when hand-written. The paper notebook however, was in some cases more accessible for note writing. One participant for example, while in a hospital waiting room, happened to have her logbook in her purse. Thus, she spent her waiting time documenting her reflections. This data would not have been elicited if notebooks were not provided.

In future research, it is suggested that paper notebooks be provided to participants as there is little associated cost. At the same time, offering participants the option to submit electronic reflections could also be encouraged for reasons mentioned above. The choice to use either disposable cameras or digital cameras likely depends on the participant sample and research context. Some issues to be considered include the feasibility of using each type of camera, cost,

participant preference, accessibility, and data access and interpretation. For example, on digital cameras, participants can delete or manipulate photos – how might this shape the data collected in a given research study?

Thematic Reflections

Rurality had several implications for participants' access to health resources. Several participants noted that they did not have access to even basic health care services. When Catherine's adult son, for example, required day surgery at an urban hospital, the trip in from their rural community was quite challenging. In addition to her taking a day off of work to travel, she added,

We stayed [at the hotel the] night [before the surgery] cause it was blowing [snow]. We got [discharged] about 2pm and I called my husband and he said, no don't come home, it's really blowing...And I thought- what am I supposed to do? Drive around? I said no, we're going to get [another] motel.

When they did arrive back home, Catherine took responsibility for monitoring her son's post-surgical care, despite her not having education on wound care. She expressed her sentiments towards her son having no access to rural nursing care for surgical follow-up, "I was shocked ... nothing was arranged for him. I don't even know if they asked, can someone change [your] dressing? I was surprised ... but I'm a really good nurse when I have to be." Another participant wrote in an email, "I'm just going to get something checked out at emerg." Visiting the emergency department to get something "checked out" attested to the limited access to family health services in this rural community. Another participant wrote that she, "think[s] twice about calling for an appt." with her family doctor because he is always booked solid. Several participants commented that their family physician was the on-call emergency department doctor.

For many participants, the church was an integral part of their lives and they expressed some sadness that the church might be having a reduced role in rural life in future years due to declining congregational sizes and the changing nature of rural society. Participants in the study described many changes that they have seen over the years in their rural communities, many of which have altered social support systems and the sense of community that rural dwellers have so long relied on. For example, Rebekah noted, “New people don’t get involved in the community because they don’t have the ties. People that were here before … had two and three and four generations of people they knew … [but] farms are getting bigger… houses … are being disposed of … and it’s just farmland.”

Lotta also described how the social situation in her church’s rural community is no longer the tightly-knit social network it once was, “many of the residents do not know each other well.” Rebekah shared that a few members from her church went to welcome a couple who recently moved into their community. They were quite surprised to learn that the couple had, “moved to the country just for peace and quiet. They had no intention of being a part of a community.” She added, “everybody’s working so you see them go down the road but you might not even know what their name is, but that’s not the way it used to be in the country.”

The changing rural context affects the rural church because it is situated in a climate of uncertainty with declining congregational sizes and in some cases, an over-reliance on voluntary labour from its members. Some of the churches in this study were experiencing dwindling participation rates in overall as well as in small group membership. Hannah described the attendance at her church’s women’s group,

We had a [women's] meeting [but there were]... not many out that day as some of our older members have passed on or gone into nursing homes. A couple of the ladies have to stay home with sick husbands. The younger ladies are working.

There were fewer than half a dozen women who attended this meeting, which was a usual number of attendees despite this being the church's only women's group. Such social realities suggest that there may be an erosion of social networks not only in the rural communities of these women, but possibly also in their churches. Fostering opportunities to connect on a social level within the church may support the perpetuation of women's social capital in rural areas. Particularly in rural environments that experience depopulation, closure of facilities, and few opportunities to socialize, the importance of strengthening social capital might be critical to curtailing the erosion of rural social connections and the health of rural residents.

In rural communities, religious places could be centres of excellence for building and sustaining social capital, both within and outside of religious communities. The need to explore how religious social capital may serve as a facilitator and as a barrier to accessing health promoting resources through the church may be key to reaching those women who may most benefit from its health and social benefits. Furthermore, it is of primary importance to understand how the rural church can create barriers to access. The placement of services intended for communities-at-large within buildings with religious affiliations suggests a need to reframe religious places and spaces as environments for rural social inclusivity and health promotion.

Nursing Reflections

Nurses are often trusted professionals in rural areas and contribute in significant ways to the maintenance, development, and cohesion of rural healthcare systems (Lauder, Reel, Farmer, & Griggs, 2006). In many rural communities, nurses are often primary health resources

(Thomlinson, McDonaugh, Baird-Crooks, & Lees, 2004), especially for rural women, many of whom prefer to seek health care and advice from female health professionals (Leipert & Reutter, 2005). A participant in this study, stated for example, “I think it would be excellent to have a woman … a nurse [in this community].”

Often, rural nurses are well-known in the rural community where they practice (Bushy, 2000). Since rural women often prefer to seek health care and information from individuals whom they know (Gehlert, Kovac, Song, & Hartlage, 2006), nurses are often viewed as approachable health professionals whether they hold an official nursing role or not. One participant noted her preference for a known nurse,

Growing up we had a nurse as a neighbour so if we had any questions we would go to her, everyone did that...Cause people these days don't always want a stranger coming into their house checking to see if they are doing okay, people are more private.

The lack of formal nurses in many rural areas might increase the demands on off-duty nurses. It might also be that some nursing roles are falling in the hands of less qualified rural families and clergy. Participants in this study provided examples of families providing post-operative home-care and clergy providing mental health consultations, simply because there was no nurse.

Churches play a vital role in the health infrastructure of rural communities and can be significant facilitators for rural nursing. Rural nurses may be connected to rural churches in a number of ways, including offering professional services from church buildings, working predominantly out of churches, as is the case with parish nurses, or simply by being a member of a rural church. Many health promotion programs for example, such as well-baby drop-in programs, offered by rural public health nurses are held in rural churches (Grey Bruce Health Unit, 2012). Additionally, rural nurses who are socially connected to a church can use the church

as a means to disseminate health information through the church's social network. This can occur because of the intimate knowledge of community and health needs that nurses embedded in rural communities have (Bushy, 2000).

Parish nurses may be among the best placed registered nurses to capitalise on the existing strengths of rural churches to promote the health of individuals in the communities in which they serve. In Canada, rural parish nurses can be an important health resource for rural women because they provide important health services that are often lacking or absent in under-served rural communities (Griffin, 1999). Parish nurses also address the spiritual dimension of health, which many rural women have suggested is an important part of their health (Thomlinson et al., 2004; Thurston & Meadows, 2004). Participants declared a need for parish nurses in their rural communities, especially for, "education . . . people need more [health] education." It was also suggested that parish nurses would be useful for, "[taking] somebody's blood pressure [or] daily monitoring of sugars . . ." Parish nurses would be especially helpful for "the aging population." It is not uncommon for senior women to be the primary care providers for family, friends, and neighbours in rural communities, in some cases, to the neglect of their own health and well-being. Furthermore, as several participants noted, many rural seniors will not access health care services in urban centres if they have to drive on highways.

The transition from adult citizens to senior citizens was largely blurred in the rural communities studied. Numerical age aside, senior women were fulfilling expectations normally associated with younger, healthy adults. Seniors were discussed in this study as significant contributors to their families, churches, and communities well into retirement. Retirement, however, was an elusive experience for this group. While some participants in the study over the age of 65 may have been officially retired, many continued to work in some capacity on the farm

or at another part-time job. Several seniors continued to care for dependents. Others partook in physical labour to upkeep church grounds. They spent extensive amounts of time and effort contributing to the sustainment of their churches and communities in voluntary capacities. One participant in her mid-eighties noted, “The senior citizens groups shrank and shrank and shrank because younger seniors didn’t want to be seniors.” While, this may be the case, it may also be that seniors simply have less access to leisure time because of their increasing contributions to rural capital. Thus, local nurses would provide much needed health supports to aging women.

A recent report from a rural health unit in southwestern Ontario recommended that communities build upon existing physical and social capital in rural communities to promote the health of rural residents (White, 2013). Recommendations included delivering health promotion programs in rural churches as well as promoting church events to community members to promote social and community connectedness. Thus, there appears to be some local governmental support to foster relationships between health promotion initiatives and the resources of rural churches. Because rural nursing practice is and could be connected in many ways to the rural church and because the rural church has a significant role in the lives of many rural women, understanding how the church acts or could act as a health resource for rural women would significantly enable rural nurses to further promote the health of rural women.

The contribution of nurses to church-based social capital in rural communities may be quite significant and underestimated, although it remains poorly understood. Nurses are often embedded within the social fabric of communities (Lauder et al., 2006), are often the only health care professional in many rural communities, and are the largest in number (Canadian Institute for Health Information, 2002). Rural nurses also promote and strengthen mutual trust, reciprocity, and interpersonal relationships within rural communities (Lauder et al., 2006). Thus,

they may be significant stakeholders in shaping how health resources enter and circulate within rural church social networks.

Given that the church plays such a prominent role in the lives of rural women, nurses' appreciation of the various meanings attributed to churches may assist in providing place-appropriate care. For example, understanding the sacredness or shared-meaning held in certain places of worship or in artifacts therein may be one way for nurses to demonstrate respect for their clients, thereby facilitating trust in their professional relationships.

Nurses who are currently using rural churches for health promotion purposes, including parish nurses, may want to seek out rural women who do not use health services in the church and explore possible barriers and facilitators to their accession. It may be that the church carries negative meaning for some women, while to others, perhaps it is largely a place of unfamiliarity. Whatever the reasons may be, it is important for nurses to enter into dialogue with these women to promote and provide services to those who require care in their communities, regardless of their belonging to a church. In rural communities, parish, community, and public nurses have an increasingly important responsibility to examine how places can shape experiences of health and of healing in addition to expressions of nursing care. For nurses, understanding places of health and healing may promote the optimization of therapeutic relationships and nursing care.

Rural nursing is a unique practice that is most successful when nurses have an understanding of rural people, culture, and health needs and resources in the rural context (Winters, 2013). Nursing curriculums, however, are often delivered out of major urban centres, thus it is perhaps not surprising that they are somewhat urban centric. Opportunities for nursing students to engage in rural practicums remain somewhat limited, despite the richness of learning that students have experienced (Van Hofwegen, Kirkham, & Harwood, 2005). Thus, increased

exposure to rural nursing in undergraduate nursing programs could help to provide new nurses with context-dependent tools and knowledge to be successful in rural nursing. This might also help to alleviate the rural nursing shortage, which has been on the rise since 2003 (Pitblado et al., 2013).

Avenues for Future Research

Given the diversity of rural communities across the country, the findings from this study are likely to be unique. In particular, this group of participants were generally well educated, had above-average incomes, and had very good or excellent self-declared health statuses. This is an unlikely presentation for a rural community; as such communities tend to have higher incidences of poverty and lower levels of education than urban centres (Gilmore, 2010; Standing Senate Committee on Agriculture and Forestry, 2006). How these demographic factors shaped the women's experiences of health promotion in the rural church warrants some consideration. These women may have more actual or perceived access to the church and its resources due to their societal placement and influences of class, which must not be underestimated.

Within rural churches, social relationships may be shaped by occupation, familial social status, or even an informal role within the church, such as being the pastor's wife, among many other factors. Bourdieu (1986) cautions that elements of class are embedded within social relationships, thus relationships of power may ultimately shape the accessibility of resources within a social network. Accessing health resources acquired through the rural church may therefore be inequitable regardless of one's belonging to a given rural church social network. How such inequities are shaped and propagated within a social network in rural churches may foster better understanding of the nature of rural relationships and their contribution to rural women's health promotion in the church. Although, additional research is necessary to further

explore health advantages and disadvantages of social capital within the context of rural women's health and the church.

Critiques of social capital include the critique that it ignores the political struggle for justice and equity. Portes (1998), for example, cautions that social capital might not always be health promoting for reasons that include: 1) excessive demands may be placed upon members of cohesive groups to support to others; 2) expectations of social norms and culture might restrict individual freedom and limit the enactment of community diversity; 3) significant group cohesion might result in social exclusionary practices towards others; and 4) the down-leveling of norms can limit upward social mobility. Close examination of these, and possibly other, health-impeding aspects of social capital would assist in shaping a broader, more balanced view of rural women's health promotion in the rural church.

Furthermore, the church and rural women's health promotion cannot be studied in isolation for they exist within broader socio-economic and political climates. Directions for future research include examining how intersections of class, religion, gender, age, and place, for example, influence health promotion and shape social structures arising from the rural church. As the church can be a supportive facilitator for rural capacity, exploring how intersectional categories shape or hinder relationships within and amongst individuals would help to better inform how the church may act as a resource towards promoting healthy communities.

Conclusion

The rural church could be a leader in the development and sustainment of health in rural communities. This research suggested that rural women's experience of health promotion in the rural church is complex and that place necessarily contributed to its intricacy. Recognizing personal meaning and shared cultures, including spatial and religious cultures, embedded within

churches might assist religious communities and health-care providers in promoting access to religious structures and spaces for health promotion purposes.

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Appendix A

Individual Interview Guide

Would you tell me about your experience of health as it relates to your church.

What would you title this picture?

What does this picture tell us about your health and the church?

How does living in a rural community positively influence your accessibility to health resources, such as nurses, health support groups etc.

How does living in a rural community negatively influence your accessibility to health resources, such as nurses, health support groups etc.

What are some health resources that women in your community use to meet their health needs?

What are some health benefits to living in your rural community?

What are some health challenges related to your living in a rural community?

What do you see in this picture?

What's really happening here?

Are there any pictures that you would have liked to have taken but were not able to?

Individual Interviews – Probes

How could your church be better used to promote the health of individuals, families, and communities?

How would this situation be different in an urban setting?

How does this relate to your lives as rural women?

Why does this problem or this strength exist?

What pictures would women from other churches in your community take?

Is there any person, or group of people, living in your community who you do not think would benefit from church-based health promotion programs? If so, would you tell me more about that?

What type of issue or topic would benefit from church-based health promotion programs? Is there anything else that is important to your experience of health in the church that you would like to share with me?



Appendix B

Participant Information for the Camera Orientation Session

Participants will be informed that consent must be obtained from individuals prior to photographing them, and that they must only take pictures to which these individuals agree. Pictures will not be taken of individuals who can be identified without their knowledge and consent. Participants will also be informed that the anonymity of individuals in pictures should be maintained, unless the individual provides consent that allows for identification. Whether the person can or cannot be identified in the photographs, participants will be oriented to the respectful and responsible taking of photographic images. As the camera can be a source for invasion of privacy, participants will be oriented to ethically use the camera and their photography in such a way as to prevent intrusion into a person's private space, to avoid disclosure of embarrassing facts, to avoid twisting the truth, and not to publish any photographs as a way to make money (Moffitt & Vollman, 2004).

Topics that will be discussed at this Orientation Session are based on recommendations of the creator of the photovoice method and include (Wang, 1999):

1. Introduction to the photovoice concept and method
2. Discussion of the responsibility and authority conferred to the photographer yielding the camera
3. Ways to minimize any potential risks
4. Presentation of an ethic of giving photographs back to the community as a way to express appreciation, respect, and camaraderie
5. Discussion questions will include the following:

How can pictures be taken that speak to the health of rural women within the context of the church? Examples of possible pictures will be discussed.

What is an acceptable way to approach someone to take his or her picture?

When would you not want to have your picture taken?

To whom might you wish to give photographs, and what might be the implications?

Should someone take pictures of other people without their knowledge?

Appendix C

Camera Orientation Session–Interview guide

The following questions may be asked in the camera orientation session following discussion on camera use and the ethical nature of the study:

What are some of the health concerns for rural women in your community?

How has the rural church helped you stay healthy?

How does the rural church help you stay healthy?

How could the rural church help you stay healthy?

Please tell me about your experience in the rural church and how your health has been influenced positively or negatively because of this experience.

Appendix D

Interview Guide - Group Photo-sharing Session

What title did you give this picture?

Would anyone title this picture differently?

What does this picture tell us about how your church helps you stay healthy?

Why did you choose this picture to share with the group?

What do you see in this picture? What's really happening here?

How has this research project influenced how you see health promotion in the church?

Is there anything that you would change about the research process? For example, perhaps you did not feel that you had sufficient time to take photographs. Or perhaps, there would be a better time of year to do the project, etc.

Group Photo-sharing Session– Probes

How has the church influenced the health of your community?

How is the church influencing the health of your community?

How could the church be used to help meet the health needs of rural women in your community?

How would this situation be different in an urban setting?

How does this relate to your health as rural women?

Why does this problem or this strength exist?

What church groups or activities could help to alleviate this health issue?

How has being a woman influenced the types of picture that you have taken?

What activities or groups do you participate in at the church?

How is participation in these activities or groups important for your health?

What other church activities or groups would you recommend to promote health?

What did you enjoy the most of this research project?

What was the hardest part of participating in this project?

Is there anything else that you would like to tell me that we haven't discussed?

Appendix E

Ethics Approval Notice



Use of Human Participants - Ethics Approval Notice



Principal Investigator: Dr. Beverly Leipert

Review Number: 18413E

Review Level: Delegated

Approved Local Adult Participants: 0

Approved Local Minor Participants: 0

Protocol Title: Understanding Women's Health Promotion in Rural Canadian Churches: A Photovoice

Phenomenology Study

Department & Institution: Faculty of Health Sciences, University of Western Ontario

Sponsor:

Ethics Approval Date: October 28, 2011

Expiry Date: August 31, 2014

Documents Reviewed & Approved & Documents Received for Information:

Document Name	Comments	Version Date
UWO Protocol		
Letter of Information & Consent		2011/10/12
Other	Participant Information for the Camera Orientation Session	
Letter of Information	Letter of Information for Person Having Her/His Picture Taken	2011/10/12
Advertisement	Email Script	
Advertisement	Telephone Script	
Assent		

This is to notify you that The University of Western Ontario Research Ethics Board for Health Sciences Research Involving Human Subjects (HSREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the Health Canada/ICH Good Clinical Practice Practices: Consolidated Guidelines, and the applicable laws and regulations of Ontario has reviewed and granted approval to the above referenced revision(s) or amendment(s) on the approval date noted above. The membership of this REB also complies with the membership requirements for REB's as defined in Division 5 of the Food and Drug Regulations.

The ethics approval for this study shall remain valid until the expiry date noted above assuming timely and acceptable responses to the HSREB's periodic requests for surveillance and monitoring information. If you require an updated approval notice prior to that time you must request it using the UWO Updated Approval Request Form.

Members of the HSREB who are named as investigators in research studies, or declare a conflict of interest, do not participate in discussion related to, nor vote on, such studies when they are presented to the HSREB.

The Chair of the HSREB is Dr. Joseph Gilbert. The UWO HSREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000940.

The University of Western Ontario

Office of Research Ethics

Support Services Building Room 5150 • London, Ontario • CANADA - N6G 1G9
PH: 519-661-3036 • F: 519-850-2466 • ethics@uwo.ca • www.uwo.ca/research/ethics

Appendix F



Letter of Information for Study Participants

**Arthur Labatt Family
SCHOOL OF NURSING**

Letter of Information

Study Title: Understanding Women's Health Promotion in Rural Canadian Churches:
A Photovoice Phenomenology Study

Study Investigators:

Dr. Beverly Leipert, PhD, RN

Associate Professor

Arthur Labatt Family School of Nursing
University of Western Ontario

Robyn Plunkett, MScN, RN

PhD candidate

Arthur Labatt Family School of Nursing
University of Western Ontario

You are being invited to take part in a study being conducted by researchers from the University of Western Ontario. These researchers are studying the health promotion needs, resources, and experiences of rural women in the rural church. Women who live in a small town or rural area with fewer than 30,000 inhabitants and who consider the church to be a past, present, or possible influence on their health are invited to participate in the study.

What will I have to do if I choose to take part?

If you agree to participate, you will initially meet in a group with other women participating in the study. In this audio-recorded one hour meeting, the researchers will describe the research and provide you with a disposable camera and instructions about its use in the research. You will then be asked to take pictures in your community that show how the church influences or could influence your health or the health of other rural women. You may take pictures of any health needs or resources that are important to your health.

Prior to taking photographs of people, you will need to provide written information to those people and ask for their consent to allow their picture to be taken. If pictures of children are taken, you will need to obtain the written consent of the parents or guardians of the children. You will be provided with the information and consent form for the people whose pictures you take. You will also be given a note book and asked to keep a log of what you photograph, and what you decide not to photograph, and other thoughts you have about women, church, and health. Two weeks later the note book and camera will be collected from you. Films will be developed and both printed photographs and digital versions will be produced. Duplicate prints will be made for you.

An individual interview with the researcher will then be arranged. In this interview, which will last approximately 2 hours and be audiotape recorded, you will be asked to describe your photos and how they represent your experience of health promotion and the rural church. A group interview with you and 6 to 8 other women study participants will then be arranged. This interview will last about two hours and will be audiotape recorded. In this interview, you will be asked to select from your pictures two photos that best represent your experience of health promotion in the church. These photographs will be projected onto a screen to enable all participants to view the images. The researcher will ask you about what message is conveyed by your picture, what made you select this picture over others, and if there were other pictures that you would have liked to have taken but couldn't and what kept you from taking these pictures. At the end of the group interview, you will be asked to complete a short written form to provide information about your age, marital status, and social situation.

Are there any risks or discomforts?

There are no known risks to participating in this research.

What are the benefits of taking part?

Your first hand experience of rural life and the church's influences on rural women's health is very important information that only you have. With your permission, your photographs and the information you share may be presented to others through journals, publications, and at conferences and meetings. Your views may help to influence the social and health programs and policies that are put in place for rural women in churches and faith communities. Results may also help people and churches in rural settings think about rural women's health and make changes. You may benefit personally from your participation by gaining more information about the church and rural women's health and a sense of empowerment by being part of the research.

Compensation

At the end of the group interview, you will receive \$40 to support your travel costs and to thank you for participating in the research.

What happens to the information that I tell you?

The interviews will be audiotape recorded. What you say on the tape will be typed out. The only people who will listen to the tapes will be the researchers and the person who transcribes or types out the tapes. To protect your identity, only numbers will be used to identify pictures, tapes, and transcripts of the tapes. The consent form, pictures, tapes, and transcripts will be locked in a secure place at the University of Western Ontario and kept for future consultation by the researchers. If you reveal information about abuse of someone who is under 18 years of age, the researcher will discuss this with you. This information cannot be kept confidential – by law it must be reported to the local child protection agency. Representatives of the University of Western Ontario Health Sciences Research Ethics Board may contact you or require access to your study-related records to monitor the conduct of the research. If the results of the study are

published, your name will not be used and no information that discloses your identity will be released or published without your permission.

Other Information about this Study:

Participation in this study is voluntary, you may refuse to participate, refuse to answer any questions or withdraw from the study at any time. If you do drop out of the study, any information that you have provided may still be used in the research findings. You do not have to answer any questions on the form or in the group interview. You do not have to talk about anything in the interview if you do not want to. Being in this study or dropping out will not affect your care in a hospital or in the community.

If you have any questions or require additional information, please telephone collect to Dr. Beverly Leipert. If you have any questions about the conduct of this study or your rights as a research participant you may contact the Office of Research Ethics, University of Western Ontario at (519) 661-3036, or by email at: ethics@uwo.ca.

This letter is for you to keep.

Appendix G
Consent Form for Study Participation

**Understanding Women's Health Promotion in Rural Canadian Churches:
A Photovoice Phenomenology Study**

INVESTIGATOR : Robyn Plunkett

RESEARCH SUPERVISOR: Dr. Beverly Leipert

I have read the Letter of Information, all of my questions have been answered, and I agree to participate in this study. I also agree that any pictures of me and my environment and property may be used for the following purposes:

- 1) In articles: _____ Yes _____ No
- 2) In print and slide form: _____ Yes _____ No

I agree that any pictures of me and my environment and property may be identified:

- 1) In articles: _____ Yes _____ No
- 2) In print and slide form: _____ Yes _____ No

Signature of Participant

Date

Printed Name of Participant

Signature of Person Obtaining Consent

Date

Printed Name of Person Obtaining Consent



Appendix H



Letter of Information for Person Having Her/His Picture Taken

**Arthur Labatt Family
SCHOOL OF NURSING**

Letter of Information for Person Having Her/His Picture Taken

Study Title: Understanding Women's Health Promotion in Rural Canadian Churches:
A Photovoice Phenomenology Study

Study Investigators:

Dr. Beverly Leipert, PhD, RN
Associate Professor
Arthur Labatt Family School of Nursing
University of Western Ontario

Robyn Plunkett, MScN, RN
PhD candidate
Arthur Labatt Family School of Nursing
University of Western Ontario

You are being invited to take part in a study being conducted by researchers from the University of Western Ontario. These researchers are studying the health promotion needs, resources, and experiences of rural women in the rural church.

What will I have to do if I choose to take part?

You are being asked to have your picture taken as part of a research study. In this study, the person who will take your picture has received from the researcher a disposable camera and instructions about its use. Your photographer has been asked to take pictures in her community that show how the church influences or could influence her health or the health of other rural women. Prior to having your picture taken, you have received this written information about the study, and you must also sign a Consent form giving permission for your picture to be taken. Your photographer will have the Consent form for you to sign. All of the pictures that your photographer takes will be collected and developed by the researcher.

Your photographer will then participate in a meeting with other participants who have also taken pictures in their communities. In this meeting, the women will be asked to select from their pictures two photos that best represent their experience of health promotion in the church. Your

picture may or may not be selected as one of these photographs. The photographers will discuss the relevance of the pictures they have selected in regards to women's experience of health promotion in the rural church.

Are there any risks or discomforts?

There are no known risks to participating in this research.

What are the benefits of taking part?

By allowing your picture to be taken, you are assisting others to better understand rural women's experience of health promotion in the rural church. Including your picture in this research may help people in rural settings think about rural women's health and make changes.

What happens to the picture that I am in?

To protect your identity, only numbers will be used to identify pictures and the pictures will be locked in a secure place at the University of Western Ontario. Any identifying information about you, such as your name or location, will be kept in a secure separate location from your picture. Your picture will be kept indefinitely to help us better understand rural women's experience of health promotion in the church in this and future research. If the results of the study are published, your name will not be used and no information that discloses your identity will be released or published without your permission.

Other Information about this Study:

You do not have to permit your picture to be taken if you do not wish this. Being in this study or dropping out will not affect your care in a hospital or in the community.

If you have any questions or require additional information, please telephone collect to Dr. Beverly Leipert. If you have any questions about the conduct of this study or your rights as a research participant you may contact the Office of Research Ethics, University of Western Ontario at (519) 661-3036, or by email at: ethics@uwo.ca.

This letter is for you to keep.

Appendix I
Socio-demographic Questionnaire

In what year were you born? _____

How many years have you lived in this community? _____

How many years have you lived in an urban community? _____

How many years have you been attending this church? _____

How would you describe your involvement in the church?

Very involved _____

Somewhat involved_____

Minimal involvement_____

How many times per week do you participate in church activities? _____

How would you rate your current health?

Excellent_____ Very Good_____ Average_____ Fair_____ Poor_____

What is the highest level of education that you have obtained?

Elementary School _____ Some College or Technical School _____

Some Secondary School _____ College or Technical School Diploma_____

Secondary School Diploma _____ Some University _____

University degree (please specify highest degree obtained) _____

What is your marital status?

Single _____ Married, common-law, or separated _____ Widowed _____ Divorced _____

What is your current household income?

\$0 to \$19,999 _____ \$35,000 to \$74,999 _____

\$20,000 to \$34,999 _____ \$75,000 or more _____

How many children do you have? _____

If you have children, how many live with you at home? _____

What age are your children? _____

Are you the primary caregiver for a dependent (ex. Parent, spouse, grandchild, etc.)? _____

If so, for whom? _____

What is your employment status?

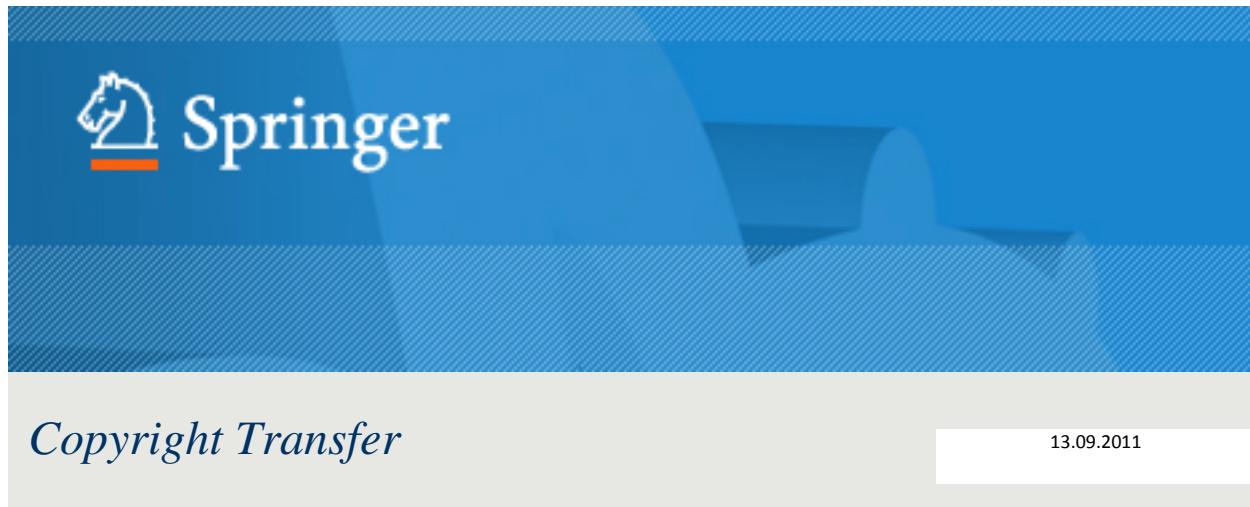
Full-time _____ Part-time _____ Retired _____ Unemployed _____ Student _____

If you are employed on a part-time basis, how many hours a week do you work? _____

Appendix J

Permission to reproduce the following article in this dissertation:

Plunkett, R., & Leipert, B. (2013). Women's health promotion in the rural church: A Canadian perspective. *Journal of Religion and Health*, 52(3), 877-889. doi: 10.1007/s10943-011-9535-z



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Honours Bachelor of Science, 2003, University of Waterloo

PEER-REVIEWED PUBLICATIONS

Plunkett, R., Leipert, B., Olson, J., & Ray, S. L. (2014). Understanding women's health promotion and the rural church. *Qualitative Health Research*, 24(12), 1721-31. doi: 10.1177/1049732314549025

Plunkett, R., Leipert, B., Ray, S. L., & Olson, J. (2014). Healthy spaces in meaningful places: Women's health promotion in the rural church. *Journal of Holistic Nursing*. Advance online publication. doi:10.1177/0898010114546191

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Leipert, B., **Plunkett, R.**, Mair, H., Meagher-Stewart, D., Scruby, L., & Wamsley, K. (2011). I couldn't imagine my life without it! Curling and health promotion: A photovoice study. *Canadian Journal of Nursing Research*, 43(1), 60-78.

Plunkett, R., Iwasiw, C., & Kerr, M. (2010). The intention to pursue graduate studies in nursing: A look at BScN students' self-efficacy and value influences. *International Journal of Nursing Education Scholarship*, 7(1). doi: 10.2202/1548-923X.2031

NON PEER-REVIEWED PUBLICATIONS

Plunkett, R. (2014). Your Church: A health promoting place for rural women. Waterloo, ON: Author.

Leipert, B., Scruby, L., Meagher-Stewart, D., **Plunkett, R.**, Mair, H., & Wamsley, K. (2012). Exploring social support, sport participation, and rural women's health using photovoice: A national curling study in Ontario, Manitoba, and Nova Scotia. London, ON: Author.

PEER-REVIEWED PRESENTATIONS

International Conferences

Leipert, B., Regan, S., & **Plunkett, R.** (2014). Exploring rural public health nursing policies and practices to promote rural women's health. Abstract accepted for presentation at the International Rural Health and Rural Nursing Research Conference, Bozeman, Montana, July 29-31.

Leipert, B., **Plunkett, R.**, Scruby, L., Meagher-Stewart, D., Mair, H., & Wamsley, K. (2013). Curling, rural health promotion, and community life: A national photovoice study. Podium presentation at the Fourth International Conference on Sport and Society, Chicago, IL, June 13-15.

Leipert, B., **Plunkett, R.**, Scruby, L., Meagher-Stewart, D., Mair, H., & Wamsley, K. (2012). A pictorial exploration of rural women's health and curling in Canada. Podium presentation at the International Rural Women's Studies Association Triennial Conference, Fredericton, New Brunswick, July 26-28.

Plunkett, R., Leipert, B., Olson, J., & Ray, S. L. (2012). The rural church and health promotion: Addressing rural women's health needs. Poster presented at the *Faith and Nursing Symposium: Religion and Ethics in Pluralistic Healthcare Contexts*, Trinity Western University, Langley, BC, May 10-12.

Plunkett, R., & Leipert, B. (2011). Using phenomenology and photovoice to explore rural elderly women's experience of health promotion in the church. Podium presentation at the 40th Annual Scientific and Educational Meeting of the Canadian Association on Gerontology & 4th Pan American Congress of the International Association of Gerontology and Geriatrics: New directions for ageing. Ottawa, ON, October 21-23.

Leipert, B., **Plunkett, R.**, Meagher-Stewart, D., Scruby, L., Mair, H., & Wamsley, K. (2011). Rural women's health, curling, and rural nursing: A Canadian study using photovoice. Podium presentation at the Bi-Annual International Rural Nursing and Rural Health Conference, Binghamton, NY, October 13-15.

Leipert, B., **Plunkett, R.**, Mair, H., Meagher-Stewart, D., Scruby, L., & Wamsley, K. (2011). I couldn't imagine my life without it! Curling and health promotion: A photovoice study. Poster presentation at the International Conference in Community Health Care Nursing Research Symposium, Edmonton, AB, May 4-6.

National Conferences

- Mair, H., Muldoon, M., Leipert, B., **Plunkett, R.**, Scruby, L., & Wamsley, K. (2014). You don't have to be a rock star: Curling, women's health, and safe leisure spaces. Presentation at the 14th Canadian Congress on Leisure Research (meeting of the Canadian Association for Leisure Studies), Halifax, Nova Scotia, May 21-24.
- Leipert, B., **Plunkett, R.**, Scruby, L., Meagher-Stewart, D., Mair, H., & Wamsley, K. (2013). Exploring Social Support, Sport Participation, and Rural Women's Health using Photovoice. *Sport Canada Research Initiative Conference*, Kanata, Ontario, October 29.
- Leipert, B., Regan, S., & **Plunkett, R.** (2012). Policies and Practices Relevant to Rural Public Health Nurses to Promote Rural Women's Health. Podium presentation at CIHR Institute of Gender and Health Conference *Advancing Excellence in Gender, Sex, and Health Research*, Montreal, Quebec, October 29-31.
- Leipert, B., **Plunkett, R.**, & Regan, S. Rural Aging in a Changing World: Public Health Nursing Practice and Policy in Rural Southwest Ontario (2012). Podium presentation at the 41st Annual Scientific and Educational Meeting of the Canadian Association on Gerontology, October 18-20.
- Plunkett, R.**, Leipert, B., Olson, J., & Ray, S.L. (2012). Active and Engaged: A Female Portrait of Health and Aging in Rural Churches. Poster presentation at the 41st Annual Scientific and Educational Meeting of the Canadian Association on Gerontology, Vancouver, BC, October 18-20.
- Leipert, B. D., Regan, S., and **Plunkett, R.** (2012). Working Through and Around: Policies and Practices of Rural Public Health Nurses to Promote Rural Women's Health. Podium presentation at the Rural Research Workshop (RRW) "Policy and Research in Community Investment," Ottawa, Ontario, May 24 & 25.
- Leipert, B., Regan, S., & **Plunkett, R.** (2012). Policies and Practices of Rural Public Health Nurses to Promote Rural Women's Health. Podium presentation at the 6th National Community Health Nurses Conference, Toronto, ON, May 14-16.
- Plunkett, R.**, & Leipert, B. (2011). Community Health Promotion for Rural Elderly Women: Exploring the Role of the Rural Church and Faith Community Nurses. Podium presentation at the 16th National Conference on Gerontological Nursing of the Canadian Gerontological Nursing Association, Mississauga, ON, June 8-11.
- Leipert, B., **Plunkett, R.**, Mair, H., Meagher-Stewart, D., Scruby, L., & Wamsley, K. (2010). Curling and the transformation of gender and health: A national study using photovoice. Podium presentation at the national conference Gender, Rurality, Transformation: A Conference on Gender Relations and the Changing Dynamics of Canadian Rural Life, University of Guelph, ON, May 13-14.

Regional Conferences

Plunkett, R., Leipert, B., Olson, J., & Ray, S. L. (2014). Advancing Rural Women's Health One Methodology at a Time. Podium presentation at the 27th Annual Arthur Labatt Family School of Nursing and Iota Omicron Chapter of Sigma Theta Tau International Research Conference, London, ON, May 9.

Plunkett, R., Leipert, B., Ray, S. L., & Olson, J. (2013). Creating healthy spaces in meaningful places: Women's health promotion in the rural church. Podium presentation at the 26th Annual Arthur Labatt Family School of Nursing and Iota Omicron Chapter of Sigma Theta Tau International Research Conference: Nursing Research, The Path to Excellence, London, ON, May 3.

Plunkett, R., Leipert, B., Ray, S., & Olson, J. (2012). Women's lived experience of health promotion in the rural church. Poster presentation at the 25th Annual Arthur Labatt Family School of Nursing and Iota Omicron Chapter of Sigma Theta Tau International Research Conference: Celebrating 25 Years of Excellence in Nursing Research Dissemination, London, ON, May 4.

Plunkett, R., & Leipert, B. (2011). Women's Health Promotion in the Rural Church: A Canadian Perspective. Podium presentation at the 24th Annual Arthur Labatt Family School of Nursing and Iota Omicron Chapter of Sigma Theta Tau Research Conference, London, ON, May 6.

Plunkett, R., Iwasiw, C., & Kerr, M. (2010). BScN Students' Intention to Pursue Graduate Studies in Nursing: The Influence of Self-Efficacy and Valuation. Podium presentation at the 23rd Annual Iota Omicron Nursing Research Conference, Arthur Labatt Family School of Nursing, London, ON, April 30.

Plunkett, R., & Leipert, B. (2010). The Meaning of Health Promotion in the Church as Experienced by Rural Women. Podium presentation at the Western Research Forum, Society of Graduate Students, University of Western Ontario, London, ON, February 27.

Plunkett, R., Iwasiw, C., & Kerr, M. (2010). Self-Efficacy, Valuation, and the Pursuit of Graduate Studies in Nursing: A Survey of Generic BScN Students. Podium presentation at the 3rd Biennial Nursing Conference, University of Windsor, Windsor, ON, January 30.

NON PEER-REVIEWED PRESENTATIONS

Leipert, B., **Plunkett, R.**, Meagher-Stewart, D., Scruby, L., Mair, H., & Wamsley, K. (2011). "I Couldn't Imagine My Life Without It!" Curling and Health Promotion: A Photovoice Study. Poster presentation at the Faculty of Health Sciences Research Day, The University of Western Ontario, London, ON, March 25.