Health Inequities and Moral Distress Among Community Health Nurses During the COVID-19 Pandemic

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Abstract

The core values of community health nursing practice are rooted in the social determinants of health, health equity and social justice. Throughout the COVID-19 pandemic, community health nurses (CHNs) witnessed first-hand the impact on individuals in situations of marginalization. This research inquiry explored how health inequities among client populations contributed to experiences of moral distress among CHNs in Canada during the pandemic. A total of 245 CHNs from across Canada participated in an online survey. Participants reported that during the pandemic individuals living in situations of marginalization were disproportionately impacted. CHNs were unable to provide the necessary health promotion interventions and experienced high levels of moral distress. The negative impact of the pandemic on individuals living in situations of marginalization illuminated the intersecting social and structural inequities that drive negative health outcomes and emphasized the need to adopt an equity focus for current and future pandemic planning, response, and recovery.

Key Words: Health inequities, social justice, moral distress, community health nurses, Covid-19

On March 11th, 2020, the World Health Organization (WHO) declared the novel coronavirus outbreak a global pandemic (WHO, 2020). Countries around the world enacted public health measures to curtail the spread of the virus; lockdowns were imposed, in-person services were moved online, and individuals exposed to the novel coronavirus, along with any close contacts, were required to self-isolate. Individuals experiencing disparities in the social determinants of health (SDOH) were disproportionately impacted by the pandemic, with poorer health outcomes evident in marginalized and racialized communities (Etowa et al., 2020) Snowden & Graaf, 2020; Watson et al., 2020).

The core values of community health nursing practice are rooted in the SDOH and social justice (Community Health Nurses of Canada [CHNC], 2019; Pauly et al., 2021). Moral considerations within these values are often complex and involve the balance of benefits and harms for individuals and populations (Weijer et al., 2013). Moral distress arises when nurses are unable to act in accordance with their moral judgment (Canadian

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Nurses Association, 2017). Nurses feel they know the right thing to do, but system limitations, structural restrictions, and other constraints prevent them from pursuing the right course of action (Jameton, 1984; Rodney, 2017). During the COVID-19 pandemic, the diversion of resources away from core community and public health programs and services impacted community health nurses' (CHNs) ability to promote health equity. Limited research has examined moral distress in the context of health inequities, and few studies have explored moral distress among CHNs (Wros et al., 2021). This research inquiry addressed this gap and explored how health inequities among client populations contributed to experiences of moral distress among CHNs in Canada during the COVID-19 pandemic.

Background

In Canada and around the world, the COVID-19 pandemic had a disproportionate impact on populations experiencing marginalization. Stark inequities in case numbers and health outcomes were evident in communities where overcrowded or inadequate housing conditions exist and amongst those who experience low income (Ndumbe-Eyoh, et al., 2021). The burden of adhering to public health measures has been greater for persons without paid sick leave benefits and for retail, transport, and other front-line workers whose work environments do not enable them to work from home (Watson et al., 2020). Racialized communities, Black, Indigenous and People of Colour (BIPOC), undocumented migrants, and new immigrants have experienced a higher concentration of cases and more severe outcomes from COVID-19 (Etowa et al., 2020; Watson et al., 2020). These disparities illuminate the cumulative, adverse effect of poverty, racism, poor housing, and other SDOH on the risks associated with COVID-19 (Ndumbe-Eyoh, et al., 2021).

Health inequities arise from the unequal distribution of the determinants of health and place individuals and groups already experiencing disadvantage at further risk of poor health outcomes (Braveman & Gruskin, 2003). COVID-19 has intensified existing health inequities and exposed intersecting structures and systems that perpetuate inequitable outcomes (Ndumbe-Eyoh et al., 2021). Promoting health equity is a moral aim and standard of community health nursing practice, and CHNs have a moral commitment to address inequities (CHNC, 2019). However, prioritizing health equity can cause ethical tensions when the values of public health, community health nurses, and the broader health system do not align (Pauly et al., 2021).

Moral distress arises when nurses are unable to meet their moral obligations to clients be it individuals, families, or the public (Austin, 2012). To date, most of the research on moral distress in nurses has focused on acute care settings (Henrich et al., 2017; Lusignani et al., 2017; Pergert et al., 2018). Only a few studies have explored moral distress in nurses working in and with communities. Consistent with their acute care colleagues, CHNs report work overload, overwhelming client need, and the lack of qualified staff as sources of moral distress (Barth et al., 2019; Jones-Bonofiglio, 2020). While CHNs face many of the same challenges as nurses in acute settings, practicing with and in communities, where the impact of the SDOH on individuals and populations is both visible and tangible, presents unique ethical challenges (Jones-Bonofiglio, 2020). Additionally, the political influence over public health priorities, limitations placed on nursing practice by employers or the provincial/territorial health systems, the need to navigate structural factors of health inequities, and the social vulnerability of their clients have been reported as sources of moral distress among CHNs (Barth et al., 2019; Jones-Bonfiglio, 2020).

Moral distress in community health nursing practice has received little attention in the academic literature (Guzys et al., 2021) and the tension between the professional values and practices of CHNs, which emphasize health equity and social justice, and the public health measures enacted during the COVID-19 pandemic remain largely unexplored. CHNs were on the front lines of the COVID-19 pandemic and have witnessed the impact of the pandemic and the pandemic response on health inequities among client populations. How these experiences contributed to the moral distress of CHNs is currently unknown. To address this

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gap, the following research questions were examined.

1. What are the experiences of moral distress among CHNs during the pandemic?
2. What factors contribute to moral distress among CHNs during the pandemic?
3. How do health inequities among client populations contribute to moral distress among CHNs during the pandemic?

Methods

Theoretical Perspective

The Canadian Community Health Nursing Professional Practice Model provided the theoretical underpinnings for this study (CHNC, 2019). The model recognizes that community health nursing is rooted in the value of caring, principles of primary health care, individual and community partnerships, and social justice and professional practice standards that meet the needs of diverse population groups. In their daily practice, CHNs recognize and address the influence of the SDOH on the health of clients (individuals, families, communities, populations) and advocate for health equity. Management practices in the model value autonomous practice, working to full scope of practice and collaborative decision-making (CHNC, 2019).

Design

Following approval from the Brandon University Research Ethics Committee and the St. Francis Xavier University Research Ethics Board, an online survey was distributed via email to all members of the Community Health Nurses of Canada and associated provincial and territorial networks. A snowball sampling approach was used and participants who received the survey were invited to forward the link to other CHNs who met the inclusion criteria. The inclusion criteria identified all nurses who were working in a community setting during the COVID-19 pandemic in Canada and were available for a six-week period during the summer of 2021. Nurses working only in an acute care setting were excluded from participating. The timeframe for the survey corresponded with the end of the 3rd wave of COVID-19 and the initial stages of the vaccine roll out in Canada.

The online survey was pilot tested with four CHNs prior to widespread distribution. The final survey included 25 questions. This article will report the findings on the first 22 questions, which included 13 questions on demographic characteristics (Table 1) and nine questions about the experience of health inequities and moral distress during the COVID-19 pandemic. Four open-response questions asked participants to describe their experiences with health inequities and moral distress during the COVID-19 pandemic and to describe the factors that contributed to their feelings of moral distress during the pandemic. The survey design also included three dichotomous response questions requiring a yes/no answer that triggered a particular navigational pathway and one question asking participants to rate, on a five-point Likert scale (strongly agree to strongly disagree), the impact of potential constraints (e.g., workload, time) to carry out health promotion/illness prevention interventions for client populations during COVID-19. The final fixed response question asked participants to rate their level of moral distress using the moral distress thermometer (MDT). The MDT was chosen as it is a single item tool, provides a rapid measure of moral distress in nurses, and has established validity (Wocial & Weaver, 2012). The MDT uses an 11-point scale with both numeric (0-10) and verbal descriptors (none to worst possible) to rate the current level of moral distress (Wocial & Weaver, 2012). The definition of moral distress included in the CNA (2017) Code of Ethics was provided within the survey and participants rated their level of moral distress on the MDT based on this definition.

Descriptive statistics (frequency distributions) were used to describe and synthesize the quantitative data. Framework analysis (FA) was used to analyze the qualitative data. FA provided a structured and rigorous process for conducting the qualitative analysis while maintaining the flexibility required to identify and characterize themes that emerged from the data (Ritchie & Spencer, 1994). The 'framework' method involved five distinct yet interconnected stages: familiarization, thematic framework identification, indexing, charting,

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and mapping and interpretation (Ritchie & Spencer, 1994). Familiarization involved each researcher reading and rereading the entire transcript, to gain an awareness of the data and to identify preliminary themes. A thematic framework was then developed. The initial framework combined *a priori* themes, identified from the literature on moral distress, and emergent themes identified through open coding (Goldsmith, 2021). The thematic framework was then applied to the entire dataset. During indexing, themes were affirmed and amended, and some dropped entirely (Ritchie & Spencer, 1994). A detailed chart was then created summarizing the indexed data by theme and capturing relevant quotations, transcript page, and line numbers (Gale et al. 2013). In the final stage, key concepts and sub-concepts were identified and the connections between main concepts were mapped.

The dataset was divided into three separate transcripts, with each transcript containing the data for specific survey questions. Two researchers were assigned to analyze each transcript, with the Principal Investigator, analyzing the entire data set. Throughout the analysis, researchers worked independently (familiarization, open coding) and collectively to develop and revise the thematic framework and to reach consensus on the final interpretation and mapping. The creative and analytic skills of the researchers were essential to derive meaning and salience from the data (Ritchie & Spencer, 1994). Rigour was supported by maintaining an audit trail of analysis decisions and communicating the analysis to the team.

Findings

Participants

A total of 245 participant responses were received and included in the analysis. The demographic characteristics of participants are outlined in Table 1.

Table 1
Participant Characteristics

Participant Characteristic	Frequency (%)
Geographic Region	
Western Canada	57 (23%)
Central Canada	126 (52%)
Atlantic Canada	52 (21%)
Northern Canada	10 (4%)
Urban	62%
Urban- Inner City	52%
Urban - Other	48%
Rural	38%
Gender Identity	
Female	239 (98%)
Male/other	6 (2%)
Self-Identify	
Indigenous (First Nations, Inuit, Metis)	17 (7%)
Visible Minority	19 (8%)
Primary Practice Setting	
Public Health	159 (65%)
Primary Care	42 (17%)
Home Health	14 (6%)
Other	30 (12%)
Years of Experience as a CHN	
< 1.5 years	42 (17%)
1.5-5 years	41 (17%)
6+ years	162 (66%)

Moral Distress

A total of 200 participants (82%) reported that they had experienced moral distress during the pandemic. Of those, 75% identified that the source of moral distress was rooted in existing health inequities and 90.4% indicated that the level of moral distress they were experiencing was higher than before the pandemic. The level of moral distress rated on the MDT was perceived as mild (13%), uncomfortable (19%), distressing (25%), intense (33%), and worst possible (10%).

COVID-19 Pandemic Constraints

Four key constraints impacted the ability of participants to provide the necessary interventions to priority populations throughout the pandemic. The limited availability of resources, reactive pandemic responses, heavy workloads, and abrupt and repeated redeployments constrained their ability to provide even basic care to priority populations and to uphold the ethical standards required of CHNs.

Limited Resources to Support the Implementation of Public Health Measures

Throughout the pandemic CHNs were on the front lines conducting contact tracing and educating clients on current public health measures and isolation requirements. The lack of resources available to support individuals who were required to self-isolate was a key constraint. The limited availability of financial supports for low-income households, the lack of isolation facilities for unhoused individuals or for those living in overcrowded housing conditions, and the limited options available to support clients living in abusive relationships were reported. Participants emphasised that a key component of their role was connecting clients to resources but during the pandemic the required resources were not available.

> *I have been distressed to find families who did not have enough food or money for essentials. Some were hungry! I found it frustrating searching for solutions to hear time and again help would arrive via food bank "next*

> *Friday" … they needed food and essentials THAT day. How can we dare to ask people to isolate/quarantine and not have immediate help for them when needed?*

Reactive Pandemic Responses

Reactive versus proactive responses to managing the pandemic were cited as a major constraint during the COVID-19 pandemic. Participants reported that governments were unprepared, pre-pandemic planning was inadequate, and sufficient resources to address a global pandemic had not been in place. One participant wrote, "For those of us who have been involved with public health for a while, we've heard, we've known, that a pandemic would arrive. We were woefully unprepared." Another commented, "Not having resources in place for our homeless population when higher number of COVID-19 cases seen in that population. Government not planning ahead for the said population and as a result, there was an outbreak seen in that population."

Workload

Participants described heavy workloads, long workdays, and more work than they could accomplish. As one participant described, "Many 12-hour days were spent working on COVID-19 cases, and we couldn't call or assess our caseload of postpartum and parenting clients at all due to time and workload." Participants reported that workload constraints delayed (81%) or prevented (75%) the provision of necessary health promotion/illness prevention interventions and impeded their ability to provide optimum care (80%) to clients during the pandemic.

Refocus, Redeploy, Repeat

With the onset of the pandemic, many participants were redeployed to assist with the COVID-19 response. Participants were required to shift gears quickly and abruptly leave their regular caseload of clients, often with no one to replace them. Shifting priority to COVID-19 caseloads without adequate resources in place to

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support other client populations was described as a major constraint.

> *I work as a home visiting Public Health Nurse and was redeployed to a COVID functional unit with only a week's notice. With no one available to take on my case load, I was forced to prematurely discharge clients for whom service was not completed, and also had clients elect to leave the home visiting program because they were not receptive to receiving a new nurse.*

For some participants their work responsibilities changed repeatedly throughout the pandemic. Participants described moving from team to team where their roles shifted as each wave of the pandemic progressed. One participant wrote, "PHN roles have changed constantly, doing contact tracing, then not doing it, then doing it again, then not". The need to repeatedly refocus priorities impacted their ability to provide quality care.

Amplification of Existing Inequities

The pandemic and corresponding public health measures had a disproportionate impact on individuals in situations of marginalization. The cancellation of in-person services, closure of libraries and drop-in programs, isolation requirements, and the inaccessibility of COVID-19 testing and immunization facilities amplified existing inequities for individuals living in situations of marginalization. As one participant described,

> *During case and contact management, I have daily contact with individuals and families during their isolation period. Many of these individuals/families experience multiple disadvantages, e.g., homelessness, underhoused, unemployed, substance use, and mental health disorders. When case numbers are high, it is hard to relay the requirements of self-isolation and have the time to acknowledge the challenge these requirements present, e.g., order food online without credit card? stay home when relationship may be abusive? manage children with ADHD in small apartment, manage addiction*

> *treatment alone? I am reminded every day of my privileged vantage point.*

A widening of the digital divide was also evident as the pandemic response unfolded. Individuals living in poverty as well as many residents living in rural and remote communities had limited access to internet and technology. The move to online service delivery from in-person care resulted in many clients having limited or no access to services at the height of the pandemic. One participant described,

> *Clients living in poverty with limited access to technology were significantly disadvantaged during the pandemic in terms of being able to access supports—especially during times when services were operating remotely; or to keep in contact with friends/family; or to access health information.*

Sources of Moral Distress

COVID-19 pandemic constraints and the subsequent amplification of existing inequities prevented participants from addressing the needs of individuals living in situations of marginalization. The inability to act in accordance with their moral judgement generated feelings of moral distress. The main sources of moral distress reported were grouped into seven categories.

Unmet Needs

Heavy workloads, staff shortages, and the shift of nursing resources to support the COVID-19 response resulted in the inability to deliver various health promotion programs and services in schools, sexual health, and with families and other community partnerships. Participants understood the importance of the pandemic response; however, they were concerned about the impact of withdrawing these programs and services. They expressed concerns that the long-term relationships they had established with individuals, families, and communities were being threatened, which impacted their well-being.

> *Knowing that the important work we do within the community is not being done. Knowing that the relationships we have established throughout the years is being compromised during this time as*

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PHNs are unable to provide the same level of support and partnership.

Negative Impact of Public Health Measures – "Do No Harm"

Enforcing public health orders that could have harmful effects on some populations, without the availability of any resources to support them, generated significant moral distress for participants. Directing clients to self-isolate when isolation conditions were inadequate, imposing lockdowns, preventing families from visiting seniors living in long-term care facilities, and telling clients to take time off work when they had no sick leave benefits nor adequate financial means to support their family were all sources of distress. One participant noted, "forcing constant lockdowns on seniors in long-term care facilities for even one staff case, even when risk of transmission was low, felt morally distressing." Another remarked,

> *Having to instruct people to self-isolate when you know it is impossible for many reasons, for example, can't afford to stay home from work, overcrowded living conditions, no friends to help them, etc. Having to go along with agency or government decisions even when you know the outcomes will be harmful.*

One Size Doesn't Fit All

Participants identified that the lack of flexibility in public health measures and the one-size-fits-all approach that was adopted was particularly problematic for clients in situations of marginalization. One participant noted,

> *A community health clinic I was working out of closed its doors to the public to use the washroom. An individual in a wheelchair experiencing homeless[ness] was trying to access the clinic because that's where they used the washroom. As I was entering the clinic staff were turning this person away—they had no other place to go to have a bowel movement and were clearly distressed. Having to walk past this person and not have the authority to change this policy was awful.*

Participants wrote about their inability to use their professional judgement when enforcing public health orders. The eligibility criteria for vaccines allowed no flexibility for clients' circumstances or context. For rural public health nurses, the rigidity of this criteria did not reflect the reality of their practice, where clients had to drive significant distances to access immunization clinics. Turning people away from the vaccination clinic when there was a supply of vaccine available was a source of considerable distress.

> *We all understand the scarcity of vaccines early in the immunization efforts, but as we are entirely rural … to have to turn people away in a community of 150 people because they were a year or two from being eligible. Knowing full well we would not be back in that community … for at least 6 weeks…. So we really are not taking vaccine to the people, and we are not respecting the work of rural PHNs in not allowing them a little flexibility and independent thinking.*

Queue Jumping and Vaccine Prioritization

Although there were strict rules outlining vaccine eligibility, queue jumping by individuals in positions of power was described. Participants were aware that there were two sets of rules being applied; having to administer vaccines to individuals who were able to jump the queue because of their privileged position, while having to turn away others who had legitimate challenges to accessibility, was distressing. One participant wrote, "[the] Chief Nursing Officer falsified vaccine contingency list—family members were listed as high risk HCWs—they are teachers". Another participant described the distress with vaccine prioritization as follows:

> *My Health Unit area received a large vaccine supply because we were in a hot spot area with very high case numbers. We started to give 1st doses to 80+ clients but the booking system was a lottery system. A couple came in, 80-year-old and partner was 90 years. I could only give the 80-year-old the vaccine and the 90-year-old had to wait to book three weeks later. When I*

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challenged this inequity, I was told that I was acting very inappropriately.

Participants also identified the need to use principles of global equity to ensure the distribution of vaccine supplies to populations worldwide. The concentration of supplies in wealthy nations while developing nations lacked access was highlighted. In the words of one participant, "The roll out of COVID vaccine globally and locally did not honour the principles of community and equitable sharing of resources and burden/risk. Our most vulnerable were left at increased risk."

Threats to Quality Care

The shift in some provinces to contract businesses in the private sector to manage the immunization centres also generated moral distress among participants. Having managers who did not understand public health priorities, who valued the quantity of immunizations administered over client safety, and the replacement of public health nurses with "immunizers" who had only a few weeks of education and limited experience with immunization were all sources of concern.

> *Not applying protocols, not working to well established PH immunization standards… not adhering to policies, practices, or imperatives such as the seven rights of the client being immunized…. Even more basic, not landmarking the belly of the deltoid… Being applauded by leaders for productivity over proficiency AND competing for coffee cards for highest number of immunizations/shift. Safety is sacrificed, clients' needs are ignored. All my efforts of raising awareness and correcting practice are discounted and ignored.*

Futility – It's Never Enough

Participants reported working many hours of overtime. Regardless of how many hours they worked, it never seemed to be enough. The volume of work was overwhelming, and participants lacked the time and resources to adequately address the needs of clients struggling to cope during the pandemic.

Participants described feeling "helpless" and the "futility" of their efforts to support clients.

> *As I would follow up positive cases of COVID-19 and try to help them safely access care, food, and shelter, it became so obvious that we were not aware of the extent of poverty, mental illness, addictions, immigration families in overcrowded homes, or overall conditions people were living in. It was difficult to leave them amidst the peak of the wave. I felt like I should help them so much more but felt helpless.*

Constantly Changing and Uncertain Landscape

Evolving research and rapidly changing public health recommendations were a source of distress for participants. The knowledge that the information and direction they were providing clients today might change when new evidence emerged was distressing, especially when the new recommendations contradicted earlier advice. As one participant explained, "encouraging people to receive AstraZeneca vaccine and then having the product pulled felt very bad."

Compounding Factors

Feelings of moral distress were further impacted by five compounding factors. These factors were not considered a source of moral distress by participants, but rather, as factors that intensified their feeling of moral distress. In essence, these factors made an already challenging situation even more difficult.

Pre-pandemic Health System Constraints

The pandemic placed constraints on the ability of participants to adequately address health inequities; however, pre-pandemic health system constraints further compounded the issues. Nursing shortages, limited funding for community/public health programming and services, and the lack of adequate resources to support client populations all existed prior to the onset of the COVID-19 pandemic. As one participant noted, they were "Short staffed [with an] increase in workload – already busy prior to pandemic". The pandemic placed additional constraints on already stressed community and

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public health systems requiring them to function well beyond capacity.

Leadership, Management, and Communication

The demands of the pandemic required a rapid and coordinated response. Poor communication and ineffective leadership placed additional stress on participants. Many participants did not feel supported or valued by managers and described having "no voice" nor opportunities for input into decisions. Participants, as direct care providers, had valuable knowledge of the needs posed by health inequities among individuals and populations, yet they were not included in decisions.

> *Helplessness, frustration, and deep sadness because of the inability to help due to hierarchical structures for decision making, planning, and implementation of "public health care" that doesn't include or consider the voices of nurses who speak on behalf of those they directly work with and care for, that experience significant and extraordinary health inequities created by systems and institutions using a general one-size-fits-all approach.*

Hearing Anger, Denial, Criticism, and Distress

Throughout the pandemic CHNs were responsible for contacting clients to communicate test results, informing individuals that they had been in close contact with a positive case, and providing information regarding isolation requirements. Many of these conversations were difficult, and some clients reacted with fear, anger, or denial. Hearing the significant distress of some clients, while trying to address misinformation and the unwillingness to adhere to public health recommendations of others, was exhausting. One participant noted, "Working so hard to try and limit the spread of COVID, and having clients not listen to the guidance with conspiracy theories/anti-vax beliefs." A second described, "I had to call clients and let them know they were a high-risk contact of a positive case…I was screamed at by so many patients who were scared … it was awful!"

Participants also described the impact of continuous media coverage of the pandemic.

Participants were working diligently, trying to protect the public from COVID-19, yet media coverage was often critical of the pandemic response. Participants reported feeling "overwhelmed" with "everything COVID". The focus of their work was entirely on COVID-19 and when they left work, the pandemic response was still the focus, featured prominently in the news.

> *News coverage locally criticizing public health here despite our entire workforce working as hard as they could to manage but no focus on the positive pieces/accomplishments. This is very demoralizing…. Not feeling like you had a break, even when not working, COVID is everywhere.*

Personal and Family Lives

The impact of the pandemic on the personal and family lives of participants compounded their sense of distress. Participants were responsible for supporting their clients, but their personal and family lives were also impacted by the pandemic. As one participant explained,

> *Besides the roller coaster at work, I am a mother of two children who either has online school, or activities that I was also responsible for. My husband is self-employed so we had stress whether the business would survive or not. My family all live outside of [my province] and most in the USA. We usually visit each other twice a year. It has been hard not to see my sister or my aging parents.*

Safety of the Work Environment

Early in the pandemic, CHNs reported that they did not have adequate access to appropriate personal protective equipment. When the novel coronavirus first emerged, there was limited information on transmissibility. One participant commented that their distress stemmed from, "[a] fear of the unknown re: spread of the new virus [and] the lack of physical resources (PPE)." Another participant commented, "as a single mom, I was burdened with the real fear that I could contract COVID and die ... or pass COVID onto my children".

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Discussion

Jones-Bonofiglio (2020) observed that, "Marginalization and vulnerability can be found across all health care sectors, but perhaps it is in community settings where individuals' life circumstances are most visible, tangible, and undeniable" (p. 68). Throughout the pandemic CHNs bore witness to the visible, tangible, and undeniable realities that COVID-19 had on the lives of individuals, families, and communities already living in situations of marginalization and have had to navigate complex ethical challenges as the needs of one population was prioritized over the needs of another. As the pandemic unfolded the intersectionality of the SDOH became increasingly evident as poverty, inadequate housing, rurality, employment, race, disability, age, gender, amongst other determinants, influenced the impact of public health measures on individuals and communities.

The findings of this study lend further support to the growing body of evidence that the COVID-19 pandemic and the pandemic response had a disproportionate impact on individuals and communities in situations of marginalization (Bhaskar et al., 2020; Watson et al., 2020). As one participant wrote, "We were all in the same storm—but, not in the same boat. This pandemic was much more difficult for those with less". Witnessing these inequities without the ability to adequately respond to the needs of individuals was a major source of moral distress for CHNs.

Earlier research by Falk-Rafael and Betker (2012a) reported similar feelings of distress amongst public health nurses (PHNs). As employees of bureaucratic agencies, PHNs felt constrained from exercising their moral agency as many of the actions needed to address inequities extended beyond the context of their collaborative partnerships and nurse-client relationships and required policy changes, support, and resources from higher structural and system levels. Moral distress was related, "both to being constrained from exercising their moral agency and to knowing that because of those constraints the social injustices they witnessed would not be redressed" (p. 110). Similarly, the results of this current study demonstrate that advancing social justice remained a priority for CHNs during the pandemic; however, constraints on their practice and the subsequent inability to address the health inequities that increased during the COVID-19 pandemic contributed to their feelings of moral distress. The heightened level of moral distress reported during the pandemic may reveal a toxic work environment for nurses (Austin, 2012), highlighting the need to address the underlying sociopolitical structures that perpetuate inequities and prevent CHNs from exercising their moral agency.

Prior to the COVID-19 pandemic, the public health system in Canada was under siege. Years of disinvestment and chronic underfunding had weakened public health infrastructure (Guyon et al., 2017) and as a result, it was ill equipped to meet the added demands of the COVID-19 pandemic. The pandemic response required extensive human resources to conduct contact tracing, testing, and immunization services. To address this increased demand, ideologically driven provincial governments chose to fund public/private partnerships to deliver public health services rather than invest the necessary resources to strengthen the public health system. The hiring of minimally trained staff to conduct contact tracing and administer immunizations, valuing efficiency over quality care, and the lack of adherence to well established public health practices and protocols by private contractors were raised as concerns by participants. This corporatization of the public health system that saw the contracting out of professional services, the push toward extreme efficiency, and the continuous redeployment of staff shifted the focus of practice away from the existing partnerships and social justice activities that were at the core of community health nursing practice and toward a marketplace model ill-suited to address the complex health needs of populations experiencing marginalization (Austin, 2012; Falk-Rafael & Betker, 2012a]. These results highlight the importance of reinvesting in community-based care and the public health system, building capacity to respond to emerging health crises by applying an equity lens to pandemic planning, response, and recovery.

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The primacy of relationships (Falk-Rafael & Betker, 2012b) in community health nursing practice was evident amongst participants. They described "long standing relationships" with clients and described the trust that developed between the client and CHN over time. The pandemic placed additional demands on an already taxed public health system, stretching it beyond capacity (Ndumbe-Eyoh et al., 2021). Essential health promoting services and programs were suspended as resources were shifted toward the COVID-19 response. Redeployment severed their community partnerships and relationships with clients, and key health and equity issues were not addressed (Ndumbe-Eyoh et al., 2021). These constraints on nurses' moral responses contributed to feelings of moral distress (Varcoe & Rodney 2009).

During the pandemic, CHNs reported that their attempts to sound the alarm on the negative impact of the pandemic measures on marginalized populations went unrecognized. This failure by decision makers to adequately consider the SDOH in the pandemic response mirrored the "health equity curse" described by Pauly et al., (2021), where the dominance of a biomedical agenda, with an emphasis on acute care priorities and a lack of understanding and valuing of community-based care and public health work, obscured the focus on health equity. Public health nurses were faced with the ethical burden of unmet client needs, and the moral obligation to address health equity felt like a curse (Pauly et al., 2021).

COVID-19 illuminated systemic inequities, and nurses' attempts to speak out for social justice were largely ignored. Participants reported a lack of involvement in decision making; having 'no voice', "not having a say", and "not being listened [to]" by decision makers. CHNs had expert knowledge in health equity practice, and the importance of hearing their voices cannot be overstated. Yet, around the globe, nurses' voices and perspectives were seldom included in COVID-19 decision making (Rasmussen et al., 2022; Nagle et al., 2021; Wynter et al., 2021). Compared to their medical colleagues, nurses have had limited representation in COVID-19 decision making

committees (Rasmussen et al., 2022). The predominance of the medical model of care and hierarchical power structures within health systems acted to constrain the voices of nurses (Sundin-Huard & Fain, 1999). During the pandemic, CHNs witnessed first-hand the disproportionate impact of public health measures on individuals and communities experiencing marginalization, yet their voices, and power to act as moral agents, were constrained by the social structures and hierarchical relationships in which they practiced (Austin, 2012).

Limitations

The survey was distributed 15 months after the WHO declared the COVID-19 pandemic and captured the experiences of moral distress of participants at this single point in time. As the pandemic progressed, feelings of moral distress may have changed. While the findings of this study add to our understanding of moral distress in CHNs during the pandemic, the findings must be applied to other contexts with caution.

Conclusion

The high level of moral distress experienced by CHNs during the pandemic is indicative of a system under duress. The loss of funding in the years prior to the pandemic severely impeded public health resources in Canada. Consequently, the public health system was ill-equipped to meet the additional demands associated with COVID-19 (Guyon et al., 2017). The redeployment of existing human and financial resources toward the pandemic response left little or no resources available to address other priority health and equity issues (Ndumbe-Eyoh et al., 2021). The negative impact of the pandemic response on those individuals living on the margins illuminated the intersecting social and structural inequities that drive negative health outcomes and emphasized the need to adopt an equity focus for current and future pandemic planning, response, and recovery (Ndumbe-Eyoh et al., 2021). Building the capacity of CHNs for health equity advocacy in a distressed system is important to ensure client populations are better situated to weather the effects of the next public health crisis, be it

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the result of a future pandemic, the climate crisis, or other, yet unimagined, global events (Cohen & Marshall, 2017).

Ethics

Ethical Approval was received from the Brandon University Research Ethics Committee, File # 22848, and St. Francis Xavier University, File # 25349.

Conflict of Interest

The authors declare no conflict of interest.

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