

Summary Report

Rural, Remote and Northern Women's Health



Policy and Research Directions



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British Columbia
Centre of Excellence
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**British Columbia Centre of
Excellence for Women's Health**
BC Women's Hospital
and Health Centre
E311 – 4500 Oak Street
Vancouver, BC Canada V6H 3N1
www.bccewh.bc.ca
Tel: (604) 875-2633
Fax: (604) 875-3716
bccewh@cw.bc.ca



PRAIRIE WOMEN'S HEALTH
CENTRE OF EXCELLENCE
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**Prairie Women's Health
Centre of Excellence**
56 The Promenade
Winnipeg, MB
Canada R3B 3H9
www.pwhce.ca
Tel: (204) 982-6630
Fax: (204) 982-6637
pwhce@uwinnipeg.ca

**National Network on Environments
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**Réseau pancanadien sur la santé
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**National Network on Environments
and Women's Health**
Centre for Health Studies
York University
4700 Keele Street
Suite 214 York Lanes
Toronto, ON Canada M3J 1P3
www.yorku.ca/nnewh
Tel: (416) 736-5941
Fax: (416) 736-5986
nnewh@yorku.ca



**Atlantic Centre of Excellence
for Women's Health**
305-5475 Spring Garden Road
Halifax, NS
Canada B3J 3T2
www.acewh.dal.ca
Tel: (902) 494-7850
Toll Free: 1-888-658-1112
Fax: (902) 494-7852
acewh@dal.ca

**Centres of Excellence
for Women's Health**
Women's Health Bureau
Health Canada
Postal Locator 1903C
3rd Floor
Jeanne Mance Building
Tunney's Pasture
Ottawa, ON Canada K1A 0K9
Tel: (613) 952-0795 Fax: (613) 941-8592
cewhp@hc-sc.gc.ca



centres d'excellence
pour LA SANTÉ DES FEMMES

centres of excellence
for WOMEN'S HEALTH

**Canadian Women's
Health Network**
Suite 203
419 Graham Avenue
Winnipeg, MB
Canada R3C 0M3
Tel: (204) 942-5500 Fax: (204) 989-2355
Information Line (toll free): 1-888-818-9172
TTY (toll free): 1-866-694-6367
cwhn@cwhn.ca
www.cwhn.ca



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Health Network**

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THE RESEARCH AND DEVELOPMENT OF THIS STUDY WAS FUNDED BY THE WOMEN'S HEALTH CONTRIBUTION PROGRAM, HEALTH CANADA. THIS DOCUMENT EXPRESSES THE VIEWS AND OPINIONS OF THE AUTHORS AND DOES NOT NECESSARILY REPRESENT THE OFFICIAL POLICY OR OPINIONS OF HEALTH CANADA. THIS PUBLICATION CANNOT BE REPRODUCED, IN PART OR IN WHOLE, WITHOUT THE WRITTEN CONSENT OF THE CENTRES OF EXCELLENCE FOR WOMEN'S HEALTH.

PRODUCTION

Executive Editor	Margaret Haworth-Brockman
Translation	Carole Carlson
Design	Éditique
Coordination	Pamela Chalmers

Projects 1-5 of the National Project on Rural and Remote Women's Health

Project #73 of the Prairie Women's Health Centre of Excellence

ISBN 0-9689692-7-5



Rural, Remote and Northern Women's Health: Policy and Research Directions Final Summary Report

by Rebecca Sutherns, PhD
Marilou McPhedran
and Margaret Haworth-Brockman

With chapters by: Christine Dallaire, PhD
Ivy Lynn Bourgeault, PhD
Pauktuutit, Inuit Women's Association

and the Research Steering Committee

Barbara Neis

Madeline Boscoe

Ivy Lynn Bourgeault

Barbara Clow

Christine Dallaire

Lorraine Greaves

Karima Hashmani

Margaret Haworth-Brockman

Catherine Kulisek

Guyline Leclerc

Marilou McPhedran

Rebecca Sutherns

Lillian Sabiston

Lynn Skillen

JoAnne Zamparo

Rural, Remote and Northern Women's Health:
Policy and Research Directions

Results from Focus Groups
Conducted in English with Women
Living in Rural and Remote
Communities in Canada

Prepared by
Ivy Lynn Bourgeault, PhD* with the assistance of
Kelly White and Karima Hashmani*****

Project #5 of National Rural and Remote
Women's Health Study

* Health Studies Programme and Department of Sociology
McMaster University

** Centre for Health and Well-being University of Western Ontario

*** National Network on Environments and Women's Health
York University

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Results from Focus Groups Conducted in English with Women Living in Rural and Remote Communities in Canada

Acknowledgements

This project was been undertaken as a joint venture by the federally-funded Centres of Excellence for Women's Health and is funded by Health Canada, through the Women's Health Bureau, with additional financial support from the Institute of Gender and Health of the Canadian Institutes for Health Research.

The members of the National Research Steering Committee on Rural and Remote Women's Health were integral to this research and include: Ivy Bourgeault, Barbara Clow, Christine Dallaire, Lorraine Greaves, Karima Hashmani, Margaret

Haworth-Brockman, Catherine Kulisek, Marlene Larocque, Guylaine Leclerc, Marilou McPhedran, Barbara Neis (Chair), Lilliane Sabiston, Lynn Skillen, Rebecca Sutherns, Jo-Anne Zamparo.

The following focus group facilitators were also instrumental to the effective conduct of the study: Deborah Barron-McNabb, Aimee Clark, Noreen Johns, Glenna Laing, Gail Lush, Edith McPhedran, Coleen Purdon, Lynn Skillen, Lana M. Sullivan.

Thanks to all the women who participated in the focus groups discussed herein.

Introduction

Provisions for rural and remote health care have garnered increasing attention by Canadian policy makers and health-care planners not the least of which has included provisions in the recently released Royal Commission on the Future of Health Canada in Canada. As we grapple with the effects of restructuring and providing equitable access to care to people in rural and remote communities, the consideration of gender and women's health is necessary to complete the picture of health needs, service provision and utilization.

In response to this critically important issue, a National Research Steering Committee on

Rural and Remote Women's Health (NRSC) was created from the network of researchers affiliated with the Centres of Excellence in Women's Health (CEWH). One of the first tasks undertaken by the NRSC was to commission a literature review of the current knowledge in rural women's health. In addition, the NRSC initiated the conduct of several small focus groups with women living in rural and remote areas across Canada from April 2002 to January 2003. This report summarizes the findings from 20 focus groups conducted in English with rural and remote women across Canada.

Key Objectives/Research Questions

The key issues which guided the overall National Study of Rural and Remote Women's Health and Health Care in Canada included the following:

In terms of health ...

- What are the things that promote the health of women living in rural and remote areas of Canada?
- What are the things that threaten the health of women living in rural and remote areas of Canada?

In terms of health care ...

- How satisfied are women with the quality of health care in their area?

In terms of rural/remote living ...

- What is it that makes a woman's life rural and/or remote?

- In what specific ways does living rurally or remotely affect the health of women?

In terms of policy to address the above ...

- What policy issues are women living in rural and/or remote areas concerned about?
- What do they want changed to better promote their health?

Finally, in terms of the need for further research ...

- Are there rural and remote women's health issues about which more information is needed in order to prompt appropriate action?

Methods

Survey and Interview Guide

Following the key research objectives noted above, a short demographic survey (Appendix D) and a focus group interview guide (Appendix E) were developed by Dr. Rebecca Sutherns under the direction of the NRSC. The Research Steering Committee approved the final versions of the guidelines and questions to be used by facilitators in April 2002, after they had been reviewed for plain language and clarity (see Appendix F for full instructions to facilitators).

Ethics Review was provided by York University under application by Marilou McPhedran and Suzanne MacDonald PhD. Ethics reviews were also conducted through other universities with which some of the facilitators were affiliated. Each Centre was responsible for coordinating the ethics processes for the facilitators in their regions.

Facilitators were expected to adhere to the guidelines and the theme areas of the questions provided. Additional questions were provided to facilitators to prompt discussion within a focus group if needed. Some facilitators revised the questions and the format to simplify the language. This kind of flexibility was approved of in principle by the Research Steering Committee, according to the principles of responsive qualitative research; that is, as long as the intent and content did not significantly differ from the parameters approved by the ethics review. Some of the survey questions were also found to be inappropriate for some of the women participating. For instance the original survey sheet inquired about general household income, with the lowest category being “\$15,000 and up”. For many rural and remote women, household income is well below \$15,000 annually.

Recruitment of Participants

Each of the Centres of Excellence for Women’s Health sponsored a certain number of regional focus groups in British Columbia, the Prairies, and the Atlantic coast. NNEWH as a national organization invited La Table Feministe, a community partner of NNEWH to facilitate the focus groups with Francophone minority women (these are discussed at length in *Results From Francophone Focus Groups with Women in Rural and Remote Communities* by C. Dallaire and G. Leclerc¹). Ivy Bourgeault also secured additional funding from the Institute of Gender and Health of the Canadian

Institutes of Health Research in order to conduct additional focus groups: five in Ontario and one in Alberta.

The practical difficulties of getting to rural and remote women or bringing them together for a focus group varied across Canada, and so did the costs. This meant that late in 2002 the Research Steering Committee and the National Steering Committee were able to fund more focus groups, as the budget allowed. A second focus group in Saskatchewan was held in the central farm regions, following a particularly devastating crop year. NNEWH invited the

National Anti-Poverty Organization (NAPO) to conduct focus groups among women in the Northwest Territories. This facilitator advised that the widest diversity of women would be reached through use of teleconference and telephone interviews. For a full

description of the location of the various focus groups and the number of participants in each group, please refer to Table 1 below. For background on the various communities please refer to the Appendix.

Table 1 Geographic Distribution of Focus Groups‡

Location	Facilitator	Number of Participants
Creston, BC	Lana Sullivan	8*
Port Alice, BC	Lana Sullivan	9*
Tumbler Ridge, BC	Lana Sullivan	5*
Vermillion, AB	Glenna Laing	6*
Clive, AB	Edith McPhedran	13*
Fort Chipewyan, AB	Lynn Skillen	10*
Yorkton, SK	Noreen Johns	10*
Watrous, SK	Noreen Johns	11*
Oakbank, MB	Deborah Barron-McNabb	7*
Lion's Head, ON	Coleen Purdon	4*
Markdale, ON	Ivy Bourgeault	4*
Woodstock, ON	Ivy Bourgeault	5*
Woodstock, ON	Ivy Bourgeault	4*
Cobourg, ON	Ivy Bourgeault	6*
Forteau/Port Hope Simpson/Mary's Harbour, NFLD/LB	Gail Lush	9*
Marystown, NFLD/LB	Gail Lush	6*
Fort Smith, NWT	Aimee Clark	16†
Hay River, NWT	Aimee Clark	9†
Inuvik, NWT	Aimee Clark	15†
Yellowknife, NWT	Aimee Clark	7†

* indicates those focus groups for which verbatim transcripts were included in the thematic analysis.

† there are multiple groups within these categories with group sizes ranging from 2 to 7.

‡Please note that there was one other group conducted in Nain, Nunatsiavut, NFLD/LAB but this was prior to the development of the focus group guide and demographic survey instrument, and thus it is not included for analysis in this report.

Within each of the communities noted above, participants were selected through a variety of methods. In the NWT, for example, the facilitator faxed every health centre in the NWT with the focus group information and asked for interested participants. Faxes were followed up with phone calls. In Fort Smith, advertising for participants was through the CBC North station. Information sheets were also left at the post office for pick up. Notices were also put up on the various community news bulletin boards around town. In many cases, people who were known to the facilitator were invited to participate or asked to recommend participants. In other cases, particular

health and social service agencies were contacted to organize groups. Some of these groups involved pre-existing social support groups, like Heart Health groups. By and large, everyone who was interested in participating was included and indeed, there was a great deal of interest in the project. Many who were interested, however, could not participate due to scheduling or travel restrictions. Thus, our sample is largely one of convenience. Although this may limit the generalizability of our findings, we believe the themes that are raised by the participants are transferable to other women living in rural and remote communities.

Conduct of Focus Groups

All groups began with an explanation of the study both specifically and within the broader context of the national study. Participants were then asked to sign a consent form (Appendix G) and to complete a self-administered demographic survey. No identifiers were included on the survey and participants were told that completing the survey questions was voluntary and that the information contained therein would be kept confidential.

Following the completion of the survey, the facilitator would turn on the tape recorder and start with the focus group interview guide questions. During the conduct of the taped group interview, women could ask for

any of their comments to be stricken from the record. The focus groups lasted from 1.5 to 3 hours. In some cases this was not long enough to cover all theme areas.

All taped focus groups were transcribed for analysis by the same professional with the exception of the Ft. Chipewyan focus group, the Francophone groups and the groups conducted in the Northwest Territories, which were done separately. Please note that transcripts for the NWT focus groups were not received in time for the preparation of this report. Data made available in the Facilitators' Reports for the latter were incorporated in the report where possible.

Analysis of the Focus Group Data

Demographic data presented here were drawn from those tabulations prepared by Karima Hashmani at the National Network on Environments and Women's Health.

The transcriptions from 16 of the 20 focus groups, including 117 out of 164 women, were analyzed thematically using a coding scheme developed from a subset of the inter-

views conducted by Ivy Bourgeault and revised/expanded by members of the NRSC. The coding scheme largely followed the questions set out in the interview guide but reflected broader conceptual categories. This coding scheme was then applied to relevant words, phrases, and sentences within the transcripts by a professionally trained research assistant—Kelly White—with the assistance of the NUDIST qualitative data analysis program. Ivy Bourgeault cross-coded a sub sample of the interviews to help ensure reliability and validity of the applica-

tion of the thematic codes. Where necessary, revisions of the coded segments were undertaken.

The presentation of the data that follows begins with a description of women’s demographic backgrounds. This is then followed by a summary of the key themes highlighted by women in the focus groups organized into five broad conceptual categories including their views on: health, health care, rurality, and their recommendations for policy and research.

Results

Description of Participants

Figures 1 to 4 describe the age, level of education, income, and occupation of the women who participated in the English-language focus groups.

Quite clearly young women (in the 16-25 and in the 26-35 age categories) were significantly underrepresented in the focus groups. The level of education completed by participants was above average for rural

communities. It is difficult to make any comments on the income data in light of the difficulties many participants had in determining whether the question was asking for personal or family income. The occupational categories may reflect the age distribution of participants. That is, the low numbers of students likely parallels the low numbers of young women in the study.

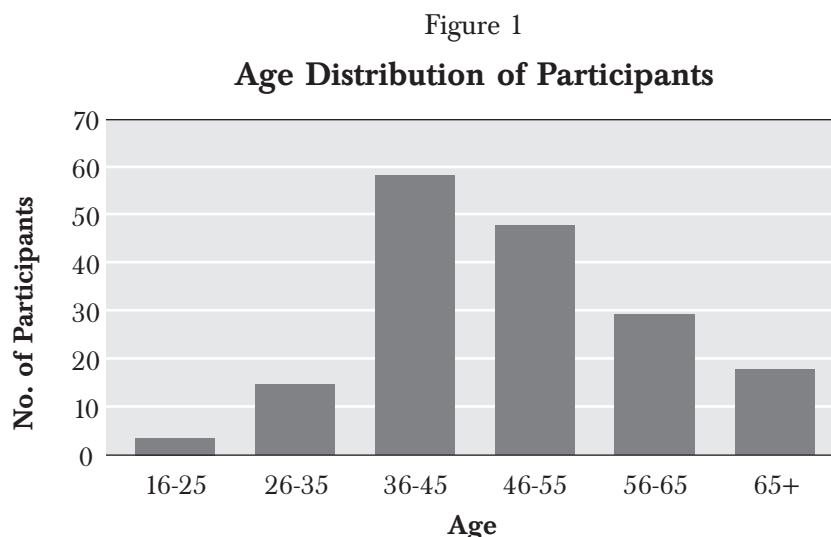


Figure 2

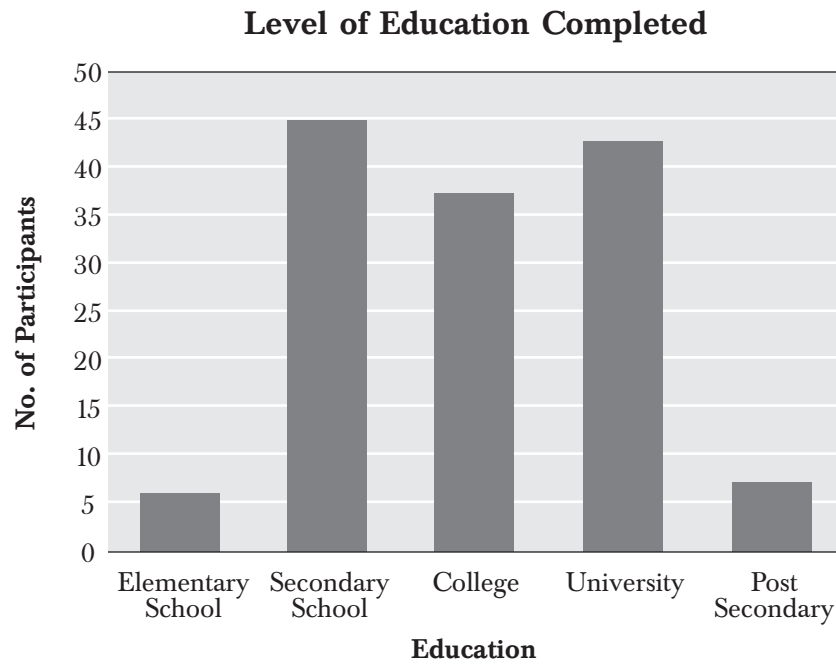


Figure 3

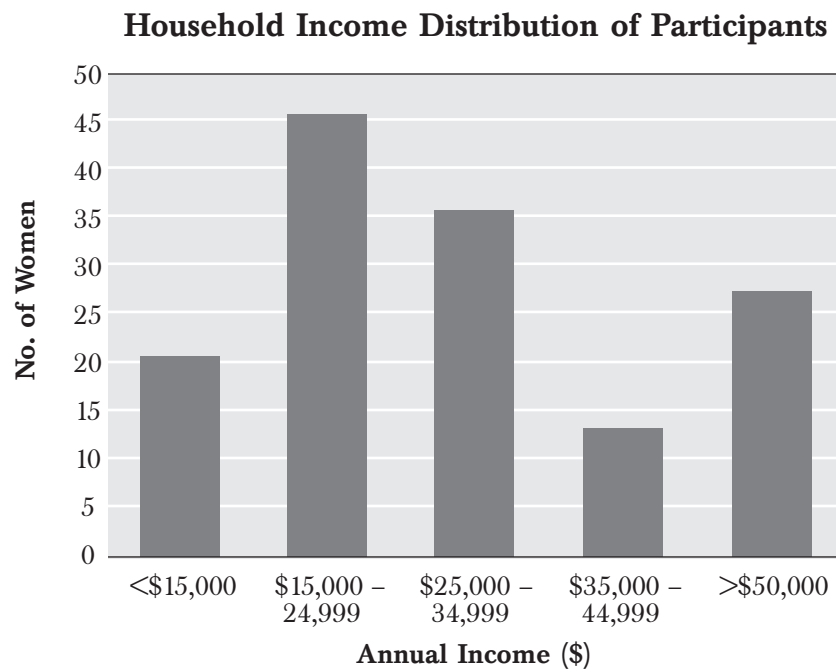
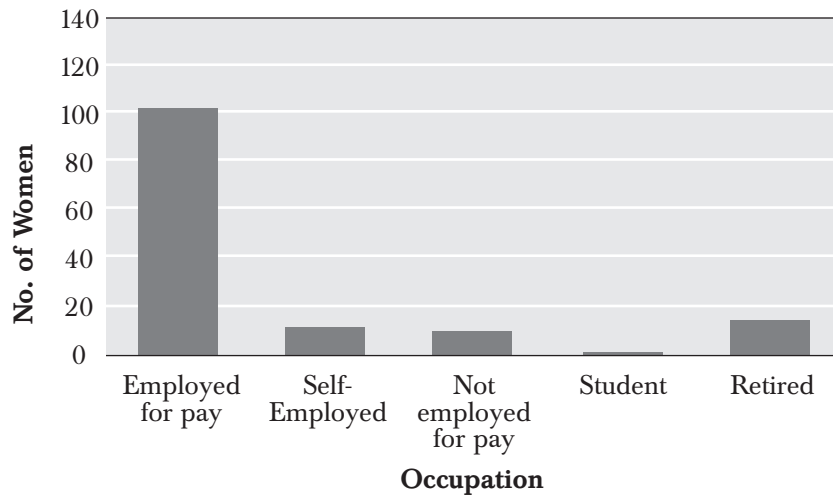


Figure 4

Occupation of Participants



Figures 5-8 present data pertaining to participants' marital status and number and age of children. Most of the women who participated in this study were married (76%) and

had children (87%). The average age of the children these women had was 23.5 years. This is largely reflective of the age of the participants.

Figure 5

Marital Status

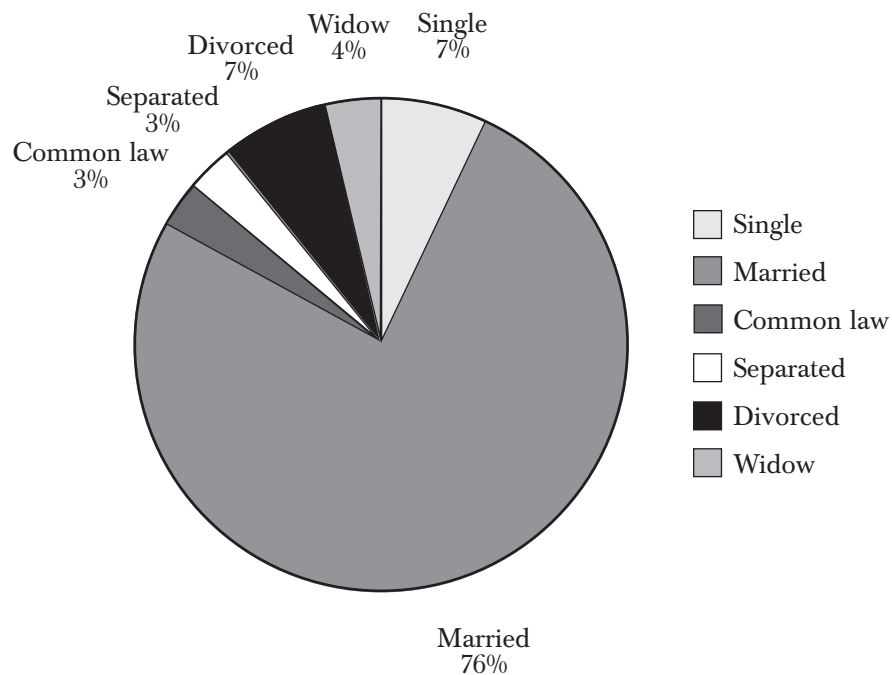


Figure 6

Participants With Children

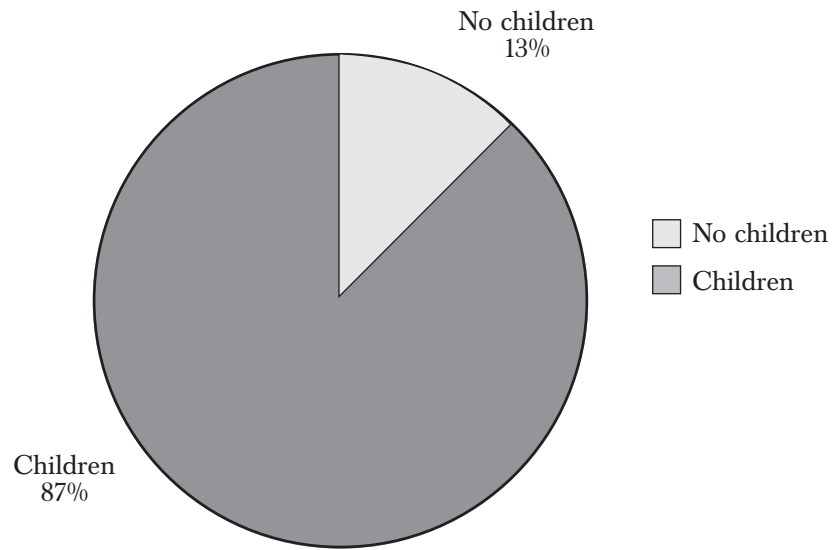


Figure 7

Number of Children Per Participant

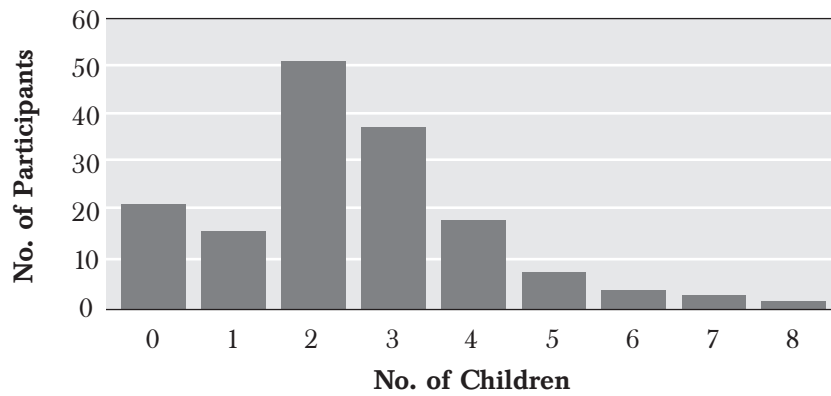
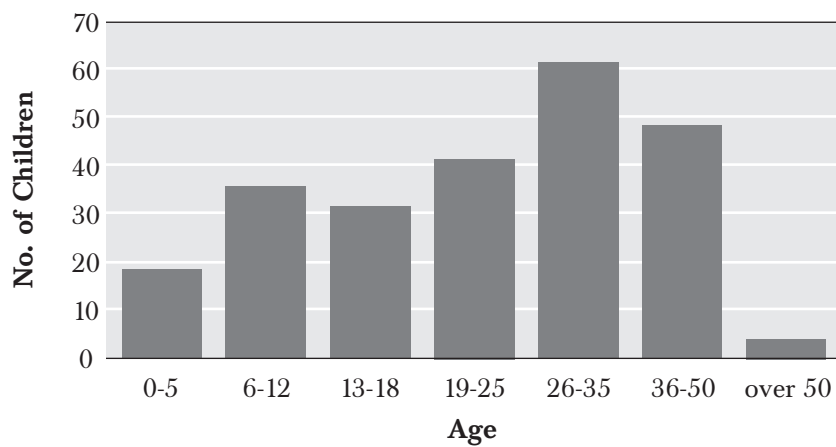


Figure 8

Age of Participants' Children



Figures 9 - 11 illustrate the range of total populations for the communities in which the various participants live, as well as the distance from home to work if they work outside of their community. From these figures we see a wide variation in

“home” populations but most lie beneath the 2,000 range. Most work within their community, but those who must travel outside of their community do not report having to travel far.

Figure 9

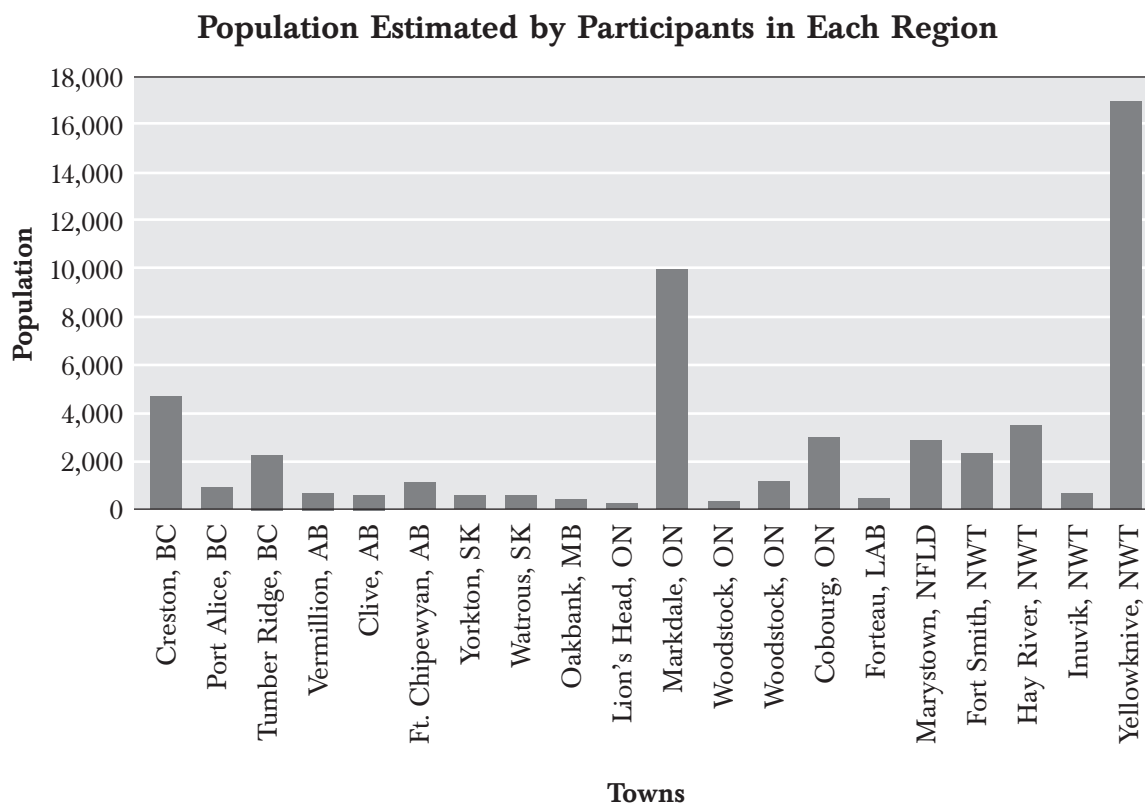


Figure 10

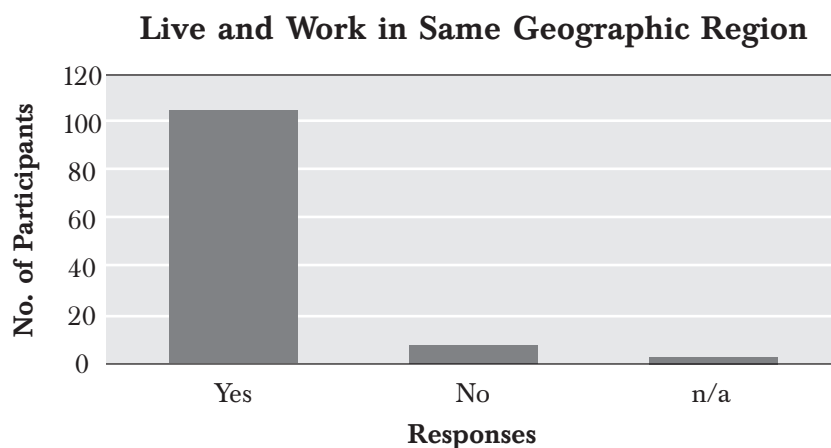
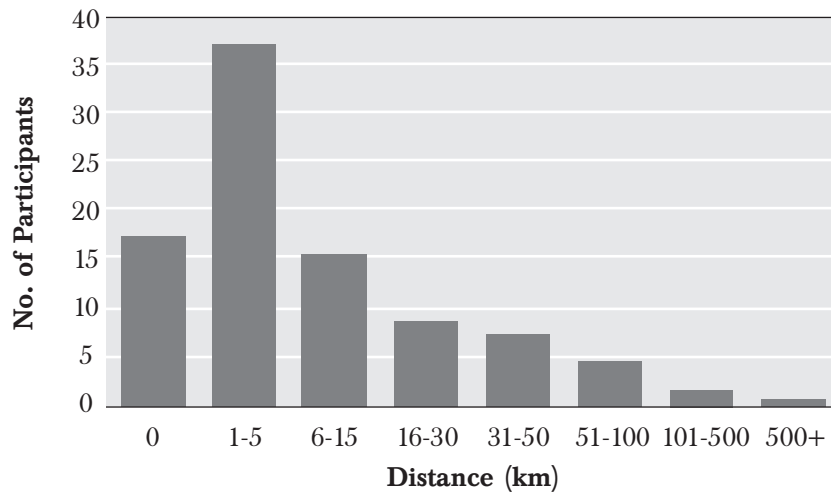


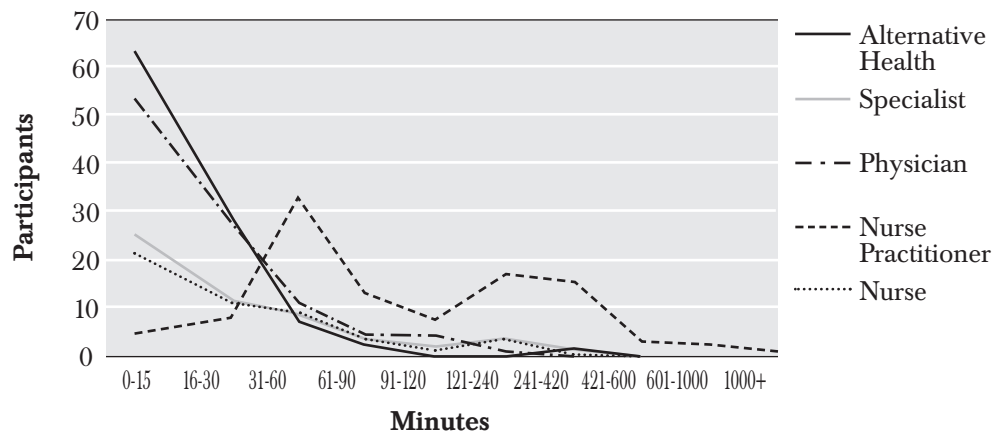
Figure 11

Distance to Work

Participants were asked about the distance and time it took to reach care from a variety of health-care providers including a nurse, nurse practitioner, physician, medical specialist and alternative care providers (broadly defined). From Figure 12 and Table 2 we can see that the order of availability from

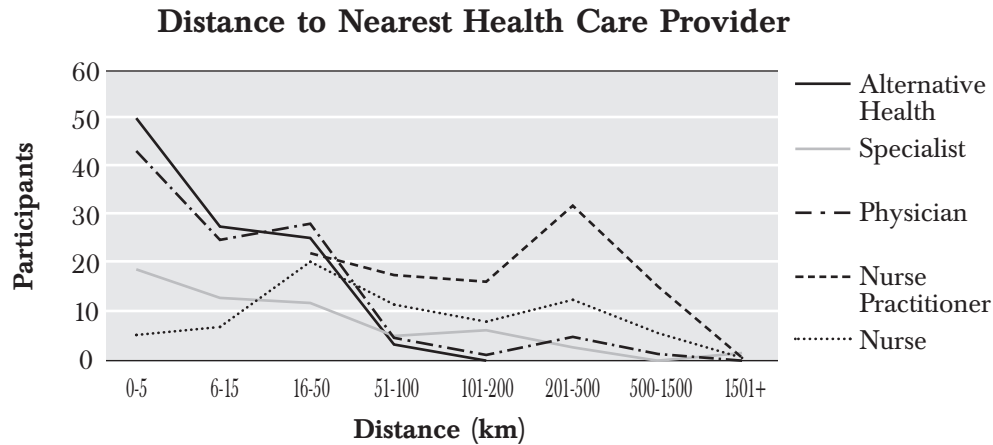
most to least available is nurse, physician, nurse practitioner, alternative health-care provider and specialist. We can also see that the least available health-care provider to participants was a nurse practitioner and that to get to medical specialists took more than 2 hours of travel time, on average.

Figure 12

Travel Time**Table 2** Travel Time to Various Health Care Providers

Health Care Providers	Number of Respondents	Average Travel Time
Nurse	104	19.28
Nurse Practitioner	57	42.8
Physician	103	26.38
Specialist	99	148.11
Alternative Health Care Provider	77	87.17

Figure 13

**Table 3** Distance to Various Health Care Providers

Health Care Providers	Number of Respondents	Average Travel Time
Nurse	106	12.97
Nurse Practitioner	60	69.86
Physician	109	39.35
Specialist	106	285.18
Alternative Health Care Provider	70	206.35

As indicated in Figure 13 and Table 3, travel time is a function of distance to health care practitioners.

Other Comments on Participants

Although accurate data pertaining to the ethnic background of participants were not gathered, the members of the Research Committee actively sought the participation of Métis women, who came to the Fort Chipewyan and Oakbank groups. Many of the NWT interviews included First Nations women. The first focus group held by Pauktuutit (Inuit Women's Association) at their Annual General Meeting in Nain

Labrador included Inuit women from across the high arctic, but their data are not addressed in this report because the focus group occurred prior to the development of the standardized focus group interview guide.

It is also important to note that although no systematic data were collected in this regard, some of the participants in the focus groups were both recipients as well as providers of care (hence some of the wording of the questions in the structured focus group interview guide mentioning clients).

Interview Data

As noted above, the presentation of the transcribed focus group interview data will follow the broad conceptual categories of views on health, health care, rurality and

recommendations the women highlighted for policy changes and future research. Within each of these categories, the presentation of the data will begin with a summary

table of the key themes highlighted by the participants. These tables are followed by selected, representative quotes from the interview transcripts that expand upon the themes. In the presentation of quotes, the voices of women are given primary emphasis. Hence they are only loosely contextualized with supporting text from the author. The authors' comments will be noted in the concluding "Summary and Reflections" section.

A. Impact of Rural/Remote Living on Health

In talking about their views on health, women highlighted both the positive aspects of rural/remote living in terms of health assets, as well as the liabilities to health associated with living in rural/remote areas. In both cases, aspects of both the physical as well as the social environment were noted.

Assets

Table 4 lists the various assets of living in a rural or remote community to women's health. These range from the physical environment issues of better air quality and lack

of pollution to the social environment issues of a caring community.

Physical Environment

Many participants noted the importance of the physical environment in rural and remote communities—often referred to as the 'great outdoors'—for maintaining their good health:

I think just in a small community you have access to the outdoors a lot more. You're not stuck in a big town. — Creston, B.C.

This was related to better air quality resulting from a lack of pollution that was usually associated with urban living:

I think we are in a fairly good spot. We don't have a lot of [heavy] industry right where we live. — Vermillion, Alberta

I find the air is fresher ... there's no smog. — Oakbank, Manitoba

Our environment is really healthy here. We have good fresh air. — Cobourg, Ontario

We do have cleaner air, no doubt, than what they do in the cities and towns. — Yorkton, Saskatchewan

Table 4 Health Assets from Living in a Rural/Remote Community

KEY THEME	SPECIFICS
Physical Environment	Better Air Quality/Lack of Pollution More Trees/Lakes/Natural Beauty/Recreational Paradise Better Access to Exercise Better Diet
Social Environment	More Caring Community Social/support Groups W.I. (Women's Institute) Rural Churches Information/programs Being Involved/Pulling Together Have Time to Spend with Family Crime Free/Safe Less Stress/Peaceful Less Congestion

Proximity to low cost recreational areas with trees and lakes and the general beauty of nature all figured prominently in women's responses:

I think there's a lot of opportunity for low cost recreational opportunities for families and children. The provincial park is a good example. — Vermillion, Alberta

We have all these wonderful trees and rocks and the lake and to me that's an extremely beneficial thing. — Cobourg, Ontario

The related issue of access to areas to exercise were also noted as being health promoting:

You can go for a run or a hike or bike or whatever. — Creston, B.C.

Living in the country and having a park close to where I live, it promotes my health because ... I can go to the park. I can walk around. — Oakbank, Manitoba

Fresh air, exercise. You get that here a lot more than you would in the city. Many of us walk to the store. You walk to the post office because it's not quite far enough to take your vehicle. So it's almost forced on you. It's also safe when you walk. — Forteau/Port Hope Simpson/Mary's Harbour, Nfld/Lb

It is important to note, however, that these responses may be disproportionately from women living in rural/remote towns because, as we shall see below, some farm women commented on how living in rural areas made it more difficult for them to go for a walk.

Better diet was also noted by some participants:

Lots of fruits and vegetables. Less junk food. — Cobourg, Ontario

Again, this may be representative of women who grew their own vegetables. Other women living in remote areas noted that fresh fruits and vegetables are a rarity (see below).

Social Environment

In addition to mentioning aspects of the physical environment, participants also

highlighted elements of the social environment of rural and remote communities that were health promoting. Many specifically mentioned the benefits of a 'caring community':

And that faith community is very supporting, as are many other people. You know, everybody up here is not out for self. Those are things that, it's like getting a hug by the community. — Cobourg, Ontario

The whole community will come to see you [if you] have a heart attack. When something happens like that, it's like one big family anyhow, when tragedy happens. — Fort Chipewyan, Alberta

Membership in close-knit social and support groups was described as being of critical importance for some women:

Traditionally as women we get, we draw our strength when we join together. I mean I think about our moms and tots group that we use to have. There was a lot of support. I actually had ... a lady just a month ago said to me, and her daughter is now 15 years old, say 'you know that was one of the best things for me cause I thought I was all alone, going crazy with my two children; and I found out that I was like everyone else.' ... We have greater opportunities in the country to do that, but I think we're starting to become into a city rat race. — Vermillion, Alberta

When my children were younger, there was a parent and tot play group at one of the churches in town here. And that's a great resource as mothers who have sick kids or knew someone who had this experience. Just sharing your experience with other parents. And you can draw on their experiences to find help if you need it. — Creston, B.C.

And I think that's one thing that's really strong in Port Alice is the community and people helping people. — Port Alice

Community support is great and I'm seeing a lot of that. — Clive, Alberta

One specific example of these kinds of groups was the Women's Institutes:

We've tried running Women's Wellness nights like because the biggest group that's impacted are not the younger women because they're not hesitant about going to family doctors, but the senior

women have been going to like the same doctor for about 20 years. — Marystown, Nfld/Lb

When I joined in '64 there were a number of younger women there, but that dwindled off because people went back to work or they just didn't have time to come when they were younger. — Markdale, Ontario

When you talk women's issues, I'm saying 'Look, apart from gynaecological considerations, everything is a woman's issue.' Women's Institute has given me an opportunity to have a wider vision. — participant from Yorkton, Saskatchewan.

Access to information and programs was one of the benefits of participation in community groups:

We're going to be starting a Health Canada grant in the schools and so we're looking at healthy families and healthy children and so looking at some of those things about increasing healthy eating in the schools, looking at school policy, increasing physical activity, those kinds of things. — Vermillion, Alberta

Healthy Baby Clubs is a really good one that started as a federally-funded project in Marystown and has spread across the peninsula. Mothers are referred from the family physicians or nurses or whatever and then followed through pregnancy with nutritional advice and nutritional support ... And I see something like about 90 to 95 percent of attendees to Healthy Baby Clubs breast feed and they're followed up afterwards when they go out. As a follow up to it, there's a Bright Futures where the mothers still attend and they're given support in child care and that kind of thing. But it's made the biggest impact on prenatal care that I've seen in my 30 years on the peninsula. — Marystown, Nfld/Lb²

We have Headstart. And in our Headstart, we have health promotion as one of our components. So, we do tooth brushing, dental hygiene as part of it. We teach hand washing to the children. We also do nutrition workshops; we just had one last night for parents. And we also provide resources, booklets, books and information. — Fort Chipewyan, Alberta

Groups associated with churches in rural and remote communities were also mentioned as being important for some, but less so for others:

We have fairly strong church groups but we also have lifestyle meetings ... in the evenings. There's

weigh-ins but they also have regular aerobics classes, three nights a week." — Forteau/Port Hope Simpson/Mary's Harbour, Nfld/Lb

I don't think they're involved that much in the community at all except for the parishioners coming to church and that ... they promote spirituality but that's it. — Marystown, Nfld/Lb

A lot of support meetings go on in the basement of the church ... so I guess indirectly they're supporting. — Marystown, Nfld/Lb

Thus, the role of churches in promoting rural and remote women's health appears to vary across communities and among women with differing relationships to organized religion.

Rather than mentioning specific groups for social support, many participants mentioned a general sense of being involved and pulling together that exists in their communities:

People look after each other and maybe part of that is because we know it's only us that's going to look after each other. I don't have the big supports like they do in Edmonton ... So when my neighbour's little boy was burned, she only lived beside me for two years but I'm the person she called and we went together to emergency. And I stayed with her the whole entire time. That's what community is. That wouldn't have happened in Edmonton. — Vermillion, Alberta

Being able to spend more time with family was another source of social support:

Time together as a family. Quality time, yeah is important. ... — Cobourg, Ontario

Women thought of rural and remote communities as safer and more free of crime than urban areas:

It's a lovely community and it's a wonderful place to bring up your kids. So I'm talking in a broader sense of family, but you feel good when you're in a safe place for your family. It's a lovely community. There's not a lot of great places to eat and what not. As far as entertainment, there's not a lot of options there. But I feel very safe. My kids have a lot of friends and it's a clean, healthy place, and we've got a wonderful big back yard. We have space and we have time for each other. It's not rush, rush. — Creston, B.C.

My sister lives in the city and she won't go out at night so that puts a lot of stress on her. She won't go anywhere on her own. Where I am, I have no sense of that. I feel safe and I feel comfortable, like not frightened. And that's also part of the culture of where we are as people living on the land, living with the land, makes you feel more comfortable. — Oakbank, Manitoba

The peacefulness that some associated with the rural/remote physical environments also translated to social environments, making life less stressful in comparison to life for their urban counterparts:

You also have a bit more time for yourself. Like even if it's a few minutes in the day, you can go for a walk with the cows and nobody wants to come with you so you've got time to yourself. — Yorkton, Saskatchewan.

Much better than being in an urban setting where you have all the congestion and traffic and high density of population. — Cobourg, Ontario.

To sum thus far, there were several aspects of both the physical and social environments

associated with rural/remote living that participants highlighted as being helpful in promoting their health. These are important to highlight because the tendency in the literature on rural health and health-care issues is to focus only on the negative aspects. There are important reasons why women choose to live or choose to remain in rural and remote communities, and many of these are related to features they see as promoting their health and that of their families. Having said this, participants also identified several detrimental aspects of rural/remote living for women's health. Interestingly, some of these paralleled aspects other participants saw as positive forces in their lives.

Liabilities

Participants identified liabilities in both the physical and the social environments associated with their communities. These are listed briefly below in Table 5.

Table 5 Liabilities to Health from Living in a Rural/Remote Community

KEY THEME	SPECIFICS
Physical Environment	Poorer Air Quality Poorer Water Quality Farm Chemicals Drought Substandard Housing Diet/high Food Costs Transportation Needs/Lack of Public Transportation Impact of Weather/Seasons Limited Access to Health Promoting Activities
Social Environment	Economic/Farm Stress Impact on Husbands (Needing Care) Isolation Social Expectations and Attitudes Lack of Extended Family Lack of Anonymity Substance Abuse Violence Limited Employment Impact of Restructuring Financial Insecurity/Low Income Low Education Literacy

Physical Environment

Whereas some noted that there was better air quality available in rural and remote areas, others highlighted that some communities suffer from poor air quality:

I'd like to see our air a little cleaner and a few more trees planted instead of everybody knocking them down because they help the environment. — Clive, Alberta.

We have some friends who ... live quite a ways from us, south of town, and they had an incident last summer where the spray plane thought that their land was abandoned even though it wasn't marked as such on the map and their yard where the house is was sprayed. The husband was quite ill afterwards and the family's pet rabbit who lives in a cage outdoors was killed. ... so that to me is a concern, especially with three kids under the age of six, and they like to play outside in the summer and we do have the planes go overhead ... For me I think environmentally that's probably one of the biggest risks that we face. — Vermillion, Alberta

Other threats to health associated with the physical environment include the excessive use of limestone on gravel roads and the spraying of the ditches which affects both air and water quality:

That's a negative thing because, you know, they shouldn't be putting so much of that limestone which creates a lot of dust in our environment. — Oakbank, Manitoba

Some of these concerns were associated with specific industries located in the regions—whether they were agricultural, the local limestone quarry, potash mine, or pulp and paper mill.

Paralleling concerns about air quality were concerns about water quality. In some cases these were directly connected to the tragedy that happened in Walkerton, Ontario:

We have zero-zero water. All the E. coli and the choloform, I mean we kind of taunt each other, the neighbours, "What's your rating this week?" "We're still zero-zero." — Oakbank, Manitoba

We have never had a scare with town water. Like there's never been, we had one 'boil water' I think in about 25 years. So there's never been a really big

problem with it. It's just that it's not good water ... like I don't think there's any contaminants or anything actually in it. But it smells and doesn't taste good. — Marystown, Nfld/Lb

The presence of farm chemicals in both the water and in the air is also a salient concern for some:

I'm thinking in terms of the agriculture, the chemicals, water situations. — Woodstock, Ontario

We used to grow our own food because it was healthier. Whether I plant my own garden and grow organically which I try to and the spray plane comes over the day after, I've had my whole garden killed by spray drift. So the quality of life I guess is not there any more. — Vermillion, Alberta

And I think we'll see in a couple years the result of that will be maybe more cancers, more illness. — Vermillion, Alberta

The longstanding drought on the Prairies also prompted discussions of water availability:

Yes, and on a rainy day the town fills up. People are so much more upbeat. We didn't have that this year. — Vermillion, Alberta

Another aspect of the physical environment that was considered detrimental to health in rural/remote communities was substandard housing:

Believe me, there's not enough housing. — Clive, Alberta

And some young single mothers report living in damp, dank apartments because that's all their income will [allow]; you don't have a choice you know? — Marystown, Nfld/Lb

High costs of good quality food was another important issue highlighted by some participants:

The cost of food is higher. — Clive, Alberta

Access to foods sometimes is a problem for us, to good quality foods. We don't have the same variety or the same cost benefit that the larger cities have, and so that's a real detriment. And I know especially if you're at risk, the social supports around that are very poor here. For example, we don't have the same structure around food banks that they have in the city or soup kitchens or that. So if you're destitute in rural Alberta, you have no family

*support here, you are toast. You are toast. —
Vermillion, Alberta*

*Anything that weighs anything. Chips are pretty
reasonable, but an apple you can't afford. —
Oakbank, Manitoba*

Genetically modified foods concerned some women:

*Food safety. I think there's a lot of concern
throughout the world about the GMOs and the
sooner we address it, then we'll know. But by the
time we know we may have lost all the stuff
because it's too late.
We may have no
control over it. That's
right. I think we've lost
it over Canola. —
Watrous,
Saskatchewan*

**In addition to the
high cost of food
and substandard
housing, many
women mentioned
the added burden
of the lack of public**

transportation in rural and remote areas:

*When you're in a rural area, if you were in Toronto
you might be able to walk around and find certain
services that you wouldn't be able to find as easily
in the country. And that usually needs a car and a
lot of women don't have a car. And you need gas
and all that stuff. — Woodstock, Ontario*

*If you have access to childcare and transportation,
to the resources and community support then
you're more able to make decisions that will help
you promote health. — Oakbank, Manitoba*

Weather has additional effects on transportation and transportation safety in rural and remote communities:

*There's been times here on the Southeast coast
where we've had bad weather in many months, for
20 days when there were no flights in or out. —
Forteau/Port Hope Simpson/ Mary's Harbour,
Nfld/Lb*

**The weather also limits access to health
promoting activities, particularly in winter.**

Thus, although the physical environment has many health promoting aspects, it can also be detrimental to women's health. As we shall see in the next section, the social environment in rural and remote communities also has negative as well positive aspects.

Social Environment

One of the most salient detrimental social issues of rural/remote living was linked to economic factors, including limited employ-

**ment opportunities
and the stress of
farm living:**

*I also think that
economic wise we are
encountering a lot of
stresses with the
uncertainty, as we rely
on, you know, on
weather and pricing
and stuff within a
farming community,
that those stresses,
and guarantees to
make budget and
things where you*

*have incomes that aren't regular, I think it makes a
big difference in how we deal with some economic
issues. That uncertainty that we live with; that we
don't know if it's going to be ours next year. ... I still
think that we have a lot of stresses that other
people, they have no idea what it's like to have your
whole annual income laying in a field being
snowed on. I think that there are some coping skills
that we have to draw on that other people, they
never even touch. — Clive, Alberta*

**This quote also highlights the link between
stress and social support.**

*You know the amount of hours that go into work,
whether or not it is the farm wife that juggles
umpteen roles in the community, and her family
and the farming, and her responsibilities, I think
that, and it's donated time, you know, for labour
that many wives and husbands do not draw a
wage. Their whole life is contributing to the farm,
but it's not like they have, they don't have the same
accomplishment that other occupations have. —
Clive Alberta*



Taking on the care for or in other ways shielding stress from farm husbands seems to be an added burden of farm stress for women:

I think farm women, I wanted to talk about rural farm women and the fact that they've gone through a really tough year watching their men folk work themselves to death. And I think that's getting hard on the women knowing that their income is going to be reduced because of the tough year and they see the stress in their mates' eyes. — Watrous, Saskatchewan

The flip side of a supportive community can be a lack of anonymity in rural/remote communities. Lack of anonymity can be a source of stress. It can also deter people from seeking help when they need it.

Well St. John's is more, well you can be more anonymous in St. John's because it's a again because you're not anonymous. And you're not, everybody kind of knows your business. — Marystown, Nfld/Lb

There are also social expectations and attitudes that come with rural/remote living. These include such things as respect (or lack thereof) for cultural customs, rituals and spirituality:

I work for the Department of Northern Affairs and they were starting to hire more Native people and one of the fellows they hired wanted to burn sweet grass but when he came in to purify himself, ... our supervisor didn't allow it. She had all kinds of excuses why he couldn't do that. — Oakbank, Manitoba

Isolation is an important social issue associated with rural and remote living.

Communities may be more peaceful, but they can, at times, seem too peaceful:

There are lots of suicides that are happening within communities where they do not experience the support that we do. — Clive, Alberta

Isolation and lack, well with everything centralizing now, particularly in the West. The towns are getting smaller. The services aren't there. You can't go in to all the various services; so people are getting very isolated. — Woodstock, Ontario

Although some noted the proximity of family as an asset to health, others noted the lack of extended family in rural/remote areas, likely due to the outflow of young adults to more urban areas for further education and for employment opportunities:

...[T]here are places like Corner Brook and St. John's where they don't get extended families to take them places because in this area the extended family is still fairly strong. I mean there is always cases where it isn't, but I think overall there's, you know, and the neighbour, the next door neighbour, I mean there's still a lot of caring and a lot of helping people. And everyone knows everyone else ... Forteau/Port Hope Simpson/Mary's Harbour, NFLD/LAB

You are your extended family with your neighbour. There are some working but you have no extended family to help you. You have acquaintances here in town—Tumbler Ridge, B.C.

Some women spoke of substance abuse in their communities.

Last year they were concentrating on fetal alcohol syndrome and making a couple of day sessions ... For to make people aware of the dangers of drinking during pregnancy and had the school guidance people in because some of these pregnancies occur in, it's not the alcoholics as such but it's in young women who are binge drinking on the weekends and who are pregnant a month or two before they realize they are and they've had three or four binges. And then if they admit to that they could lose custody of their children ... so I think there is only a couple, well one identified case of fetal alcohol syndrome in the province. — Marystown, Nfld/Lb

Living here you can't help but be aware of the effects of alcohol and drugs, the sexual abuse, the way in which women are treated. — Inuvuk, NWT

Drugs and alcohol use is big in Port Alice because this is a very rich community. — Port Alice, B.C.

I don't know if you'd call this a threat but there's a lot of alcohol in the rural areas that's hidden or that's accepted. — Yorkton, Saskatchewan

There was some discussion of the prevalence and experience of violence in rural and remote communities:

We don't have a place but there's um, for the most part I have to say there's very little, there's not a great need for a place, a shelter because there's very little violence overall. — Forteau/Port Hope Simpson/ Mary's Harbour, Nfld/Lb

It is difficult to know whether this quote is reflective of reality or whether it reflects a community assumption. Indeed, if the services are not there is it hard to gauge the need. Moreover, a group setting may not have been conducive for such discussions.

I personally wish it could be changed and I know it's everywhere but you know when a woman leaves an abusive situation, the amount of money that she gets is very, very minimum. And I know for myself, personally having moved from a relationship before, when you first move you need, like you need to buy ketchup and a broom and ... they look and they go 'okay, do I starve or do I get beaten?' So they go back. They go back, and it breaks my heart. I feel like saying 'come to my house.' — Tumble Ridge, B.C.

Limited employment opportunities for women in many rural/remote areas were linked to poorer mental health outcomes for women in these communities:

Employment ... would be one of the things that would contribute a lot to health and welfare here. ... and support should be there to allow them to be able to do that. — Marystown, Nfld/Lb

A lot of my friends now are just like 'Oh, I'm not working for minimum wage. I'll just get pregnant and go on welfare and they'll take care of me.' Right, I mean there's no work around here. You can't get work and you don't want to go away. If you don't go away you're stuck. — Marystown, Nfld/Lb

This community has very little ... so we have to drive, depending on whether you drive 20 miles, 12 miles or 40 miles to the nearest place to work. — Clive, Alberta

Employment shortages were particularly salient in communities in transition or undergoing other forms of economic restructuring:

Government cutbacks provincially has made it such a stressful life for so many people. And that is so detrimental to your health. My husband, for

example, got laid off and we are just so stressed out wondering what's going to happen. And every single person that we know has somehow been affected by it, whether their job has been affected or they were thinking about it or their store's going to have to close cause 6,000 people leave the community. — Creston, B.C.

Financial insecurity, low income, low education and literacy rates were several important, related issues mentioned by many of these women:

Most people have to be fed by the government and you have to depend on [it] for funding in order to survive because they can't live off the land any more. — Oakbank, Manitoba

I have another concern too that a lot of our young people on minimum wages aren't living a healthy lifestyle ... not getting the proper recreation ... as well as eating, as well as even vitamins and things. — Clive, Alberta

The main job we need to do is to bring people into that; we better educate a few people in the community so that they can come back and then start up groups. That would be one more realistic possibility. — Forteau/Port Hope Simpson/ Mary's Harbour, Nfld/Lb

[There is] little time for public education. — Yellowknife, NWT

If nothing else, literacy, you can't even read about it if you don't know how to. — Forteau/Port Hope Simpson/ Mary's Harbour, Nfld/Lb

Education, such as low literacy skills which is linked to poor health particularly among seniors because it's not that they weren't educated, they lose their skills over time in terms of literacy. — Marystown, Nfld/Lb

But I've had Grade 11 and 12 students come to me, and I shouldn't say it, but they can't read at the Grade 4 level. — Fort Chipewyan, Alberta

Thus women living in rural and remote areas identified both positive and negative aspects of rural and remote living for women's health. Indeed, the same factor—be it water or air quality or social support—could have both positive and negative effects in different areas and for different groups of women. Similar contradictory relationships,

as we shall see, were also important in these women’s views on the effects of rural and remote living on health-care services.

B. Impact of Rural/Remote Living on Health Care Services

Although most of the questions in the focus group interview guide addressed the issue of health, many women responded by discussing health care. Indeed, in some cases facilitators had to probe extensively to get women to talk beyond issues related to getting health care. In light of this, the bulk of the data falls within this category. As before, the data show a dichotomy of positive and negative features in women’s views about the effects of rural/remote living on health care. Women were more inclined, however, to focus on what was lacking in

rural and remote health-care services as compared to those available in urban areas.

First, the advantages of living in a rural/remote community for health-care services will be presented, followed by the disadvantages. Interspersed throughout the discussion of disadvantages are references to some programs that have been established to address some of the difficulties experienced.

Advantages

Although the discussion around rural and remote health care focused primarily on its inadequacies, several participants noted some of the advantages associated with living in a rural and remote community for health-care services. These are briefly noted in Table 6 below.

Table 6 Advantages of Living in a Rural/Remote Community for Health-Care Services	
KEY THEME	SPECIFICS
Structural Issues	Hospital – Not as busy Some level of services improving
Social Issues	Know health-care provider in hospital/community Easy to get appointment with family doctor

One of the benefits of living in a rural or remote community for health-care services is that if a hospital is available, it tends to be less busy than hospitals in larger urban centres. As a result, some women felt they received better care:

The best care I received was in ...a very small hospital where I didn't feel that either the doctors or the nurses were [over]-worked or over-stretched or whatever you might like to say because you're getting that in the [smaller urban centres] now. — Clive, Alberta

In some communities, available services had improved with increases in the number and range of health-care providers. Sometimes

these improvements were the result of rotating site visits:

I think it has changed for the better. Cause we got one nurse for 600 people... and then we got two and now we finally got the third one so I think it's really increased good now. And we had mental health nurse come through. I'm not sure if it's once a month or every three months, and a physiotherapist comes in, like I said I'm not sure if it's once a month or every three months. And speech pathologist comes in on a regular basis too now. And we see the doctor more regular than before. And we have a nurse practitioner stationed here. So I think we're for the better. — Forteau/Port Hope Simpson/ Mary's Harbour, Nfld/Lb

Some women mentioned that living in a small rural or remote community meant

they could get to know their health-care provider and that it was easier to get an appointment with their family doctor:

And with regards to actual appointments, I am from Corner Brook and I find you can get appointments a lot faster via our nurses here than you do at home. — Forteau/Port Hope Simpson/Mary's Harbour, Nfld/Lb

The vast majority, however, felt that it was very difficult to get an appointment in communities that were severely underserved. For example:

They're so crowded you can't even get an appointment. — Clive, Alberta

These and other inadequacies with the system will be discussed further below. It is, however, important to note the few benefits that women in rural and remote communities identify with the health care available to them.

Disadvantages

The disadvantages or inadequacies of rural/remote health care can be classified into access issues of both a social and structural nature, and quality issues. These are briefly noted in Table 7.

Access to Care Issues

One of the most salient physical or structural inadequacies of living in a rural/remote community was the distance women had to travel to get care, especially that of specialists. This was not only reflected in the information from the demographic survey (see Figures 12 and 13 and Tables 2 and 3) but also in the words of our participants:

We seem like we tend to have to go further and further, "you're so far away." — Creston, B.C.

You could drive all the way to Edmonton for this big special appointment and you get there and five minutes later they come out and you say 'what did they say?' 'Oh, just keep like that.' Well you know, we had a list of concerns, waited a month or better for some appointment 'cause he's a chronic arthritic [specialist], and you know, if you didn't get the right doctor that day, you didn't get any answer. You just came home totally frustrated even more. And you wasted a day. — Vermillion Alberta

In some cases this could have serious consequences:

The farther away from Highway 2 you live, the less chance you have of surviving a serious incident. — Clive, Alberta

Table 7 Liabilities associated with Living in a Rural/Remote Community for Health-Care Services—Access Issues

KEY THEME	SPECIFICS
Services	Great Distances to Access Care Require Significant Time off Work for Appointments Additional Cost of Staying Over Limited Access to Hospital Care Poor Hours Reduced Access to Ambulance Services Limited Access to Health Promotion Services/Programs
Information	Difficulties Accessing Health and health-care Information Specifically for Sensitive Women's Health Issues Internet Use/Other Media Telehealth

The greater distances to travel to reach care mean more time (often taken off work for appointments) and more money needed to access care that is more readily available

and accessible in urban areas. In some cases participants also had to deal with additional costs and delays associated with staying over night somewhere else:

And the financial part of it is a big problem for most women ... — Oakbank Manitoba

I mean just to travel to Marystown and back, you're looking at probably \$15 for gas and then \$25 to see your chiropractor, like you know, a lot of people just can't afford doing that. — Marystown, Nfld/Lb

Part of it too is when your health services require you to go to Timbuktu all the time then that adds a real strain. Like, I am very fortunate; I don't have chronic disease in my family. But if I had a kid or my husband had a chronic disease, I think that is huge because of the expense on a rural family. I don't think people in the city have any comprehension that that means you're actually leaving your place of work. You're not just popping into a specialist. You're taking a whole day. You're spending over night. I know when my youngest was flown to Edmonton when she was born, I mean literally I had to pack up suitcases and we moved to Edmonton for two weeks. And that was the only way that we could do it. There were babies at the Royal Alex Hospital that were abandoned. And really they were abandoned because their parents live in Fort St. John or some such place. — Vermillion, Alberta

These added costs are borne directly by the women and their families—that is, for most part, these are not costs that can be recovered under Medicare.

In addition to the physical distances involved, in many cases access to care in the local hospital was limited because it was not open 24 hours, or did not provide the kind of services needed—be it emergency or maternity care:

Markdale is twenty-four hours. So it does have 24 hours. After nine o'clock, you have to ring the doorbell. Yeah. But it's there. Yeah. Mmhmm. Is the doctor there or do they have to call him in? I think they call him in. I think they're always there. — Lion's Head, Ontario

You can't deliver in Port Alice unless you wait too long and arrive at the doorstep. — Port Alice, B.C.

In many cases, the reduced services available in local hospitals made it difficult to attract or retain health-care providers in rural/remote areas (for detailed discussion, see lack of providers section below).

Some communities have responded to the distance problem by developing a volunteer driving program where community volunteers drive women and/or their families to appointments. This is especially helpful for elderly women who cannot drive. Other programs include travelling specialists:

They travel from one community to the other all over our health district. Travelling specialists. — Yorkton, Saskatchewan

In some communities, ambulance services are relatively inaccessible and often require out-of-pocket funds:

It would seem that we don't even have an ambulance located, stationed right here. There's one in Wiarton and one at Tobermory [communities 30-45 minutes away on either side] I believe. — Lion's Head, Ontario

We've just moved up to 9-1-1 this fall. If someone

should have to have an ambulance, you might as well throw them in a vehicle if possible and take them there before the darn thing gets out there and then take that same time for it to get back. — Oakbank, Manitoba

One of the things I wanted to complain about was the cost for ambulance [includes discussion about how it is paid for if returned but not if one way] ... well can you see somebody on social assistance trying to pay for that? — Oakbank, Manitoba

In addition to concerns about emergency services, women also expressed dismay at the lack of access to health promotion services and programs:

Availability to programs that are offered in the city or anywhere else, they should be offered every-

***Availability to programs
that are offered in the
city or anywhere else,
they should be offered
everywhere.***

where. Programs should be available in all remote and rural areas that are available in Winnipeg. Maybe on a smaller scale, but they should be available. — Oakbank, Manitoba

May have a lot of services but there are barriers to accessing the services, lack of knowledge of what is available, cost of accessing services, inconsistencies in who and when services provided, lack of choice... — Fortsmith, NWT

To sum up thus far, it is clear that there are significant physical and systemic barriers to the availability and accessibility of health-care services in rural and remote communities. Social barriers also exist.

Access to Information

Lack of access to reliable health-care information was an important issue women discussed in the focus groups:

It seems like our whole society is saying 'you have responsibility for your own health' and that has changed. Twenty years ago it was the doctor that was responsible for my health. But now it is me. So the information I need needs to be extended to me. — Clive, Alberta

There are things out there we don't even know about. We have no clue. No clue. Just information about what services are available. Perhaps things that the government offers that we don't know about and maybe the government is hoping we don't find out about it. We might want it. And if we didn't ask, you know, they're saying 'well nobody asked for it so we'll just toss that tone. We'll do something else.' Well if we didn't know, how could we ask? — Clive, Alberta

Our geographic area is so large that we need more information where people can turn for support. We need things like some sort of liaison group. As it is, our communities have liaison groups with the community and mental-health services in our region. If we had some sort of women's liaison group where anyone who has any concerns, even if it's in the medical profession. If I have a client show a need for more information on diabetes or deafness, is there some group, are there groups out there who can help? Liaison committee would know to whom to go, where to look, what to look for. — Forteau/Port Hope Simpson/ Mary's Harbour, Nfld/Lb

I think having access to all the information so that we can educate ourselves about these issues, whether it's mental health or water conditions or social services or whatever. — Woodstock, Ontario

In particular, women wanted to have access to information about more sensitive women's health issues:

If we had a public nurse stationed here, someone who could have some information sessions on women's health issues or start up some kind of a program where we're taught nutritional, and an exercise program that women can take part in, that would also I think alleviate some of the stress in their lives. — Forteau/Port Hope Simpson/Mary's Harbour, Nfld/Lb

Well and certainly someone who is familiar with women's issues first of all. Like, I'm finding that there's just a real lack of knowledge around women's issues and certainly around health promotion. Women need information about menstruation, body parts and functions—how these things can affect young women/adult women. — Hay River, NWT

Access to information about women's health issues was noted by one participant as being especially important for young girls:

My husband teaches as well and he has touched on some issues that are issues for the teenagers. It embarrasses them in the classroom. He's doing it with them and they're very comfortable with him. I have spent a lot of time with teenagers and they will not, many, many of them will not go to the clinic. They don't like asking for help. They, many will prefer to go on information gathered from other teens—incorrect answers. However, when they do listen to Mr. X, for example, in the classroom, he has pointed out many times that the looks on their faces are incredulous. He's giving them information that they had no knowledge of. So there is a lack of education in our community, yes. And I do believe the teens find it difficult to go to the clinic and get this information. — Markdale, Ontario

Some of this discussion of limited access or poorly coordinated access to information was linked to the limited availability to computers and the Internet:

But in your rural areas there is not that access. You may have went to a bigger area and got access,

unless you have a computer now and can research the internet, but not everyone has that. — Clive, Alberta

But I know so many people that I've met in this town who don't even know how to turn a computer on. — Creston, B.C.

Unless you have a computer now and can research the internet, but not everyone has that — Clive, Alberta

There is access now cause libraries have them, most public libraries have them. Do you think people would use them for health information? I think they do. Probably the people that need that information most wouldn't know how to turn them. — Marystown, Nfld/Lb

The digital divide. Isn't that it? Bridging the digital divide. If you don't have the money for a computer or you can't travel five or six hours for travelling or two hours for travelling, if you're in some little place or a smaller community — Woodstock, Ontario

But others were concerned about the quality of information available on the Internet:

When I go on the computer, how do I tell between a good article and a bunk article? How do I tell it's written by someone who is knowledgeable? — Clive, Alberta

Lack of access to information was also linked to literacy levels (noted in the section on health above):

If nothing else, literacy, you can't even read about it if you don't know how to read. You can't find out information. Everyone is now saying 'Look to the internet.' Well if you don't know the computer, if you're not comfortable using the computer then

you can't very well look to the internet to find answers. — Forteau/Port Hope Simpson/Mary's Harbour, Nfld/Lb

Telehealth was mentioned specifically as a service that could help address some of the structural and social barriers to accessing good quality health-care information. But for many, this was not available:

It is not available at the present time, but maybe the time is ripe for coordinating that as we are moving into easy access to resources via the technology that we have, that we need to utilize the technology, whatever way it is, through you know Telehealth or whatever. — Clive, Alberta

In addition to these issues of access to health care and health-care information, women in the focus groups discussed other inadequacies associated with living in a rural/remote community in terms of quantity and quality of services. These are noted briefly below in Table 8 and in the following section.

Quantity of Health-Care Services

Women addressed the drawbacks of living in a rural or remote area related to health-care services, emphasizing the many things they lacked. They usually began with the lack of physicians:

Basically, we just have lack of doctors — Yorkton, Saskatchewan

I have heard of families that have lived here for over six years and still don't have a family physician — Cobourg, Ontario



Table 8 Inadequacies of Living in a Rural/Remote Community for health-care Services—Quantity and Quality Issues	
KEY THEME	SPECIFICS
Quantity Issues	Lack of ... Physicians Affects Choice and Ability to Get a Second Opinion Nurse Practitioners Midwives Dentists Optometrists Mental Health Services Rehabilitation Services Home Care Services Special Needs Delays/Wait Lists/Times Funding Cuts/Threats of Closures Negative Impact of Restructuring
Quality Issues	Physicians Too Busy/Burnout Lack of Knowledge of Women's Health Issues/Too Male Too Insensitive/Stereotypical Attitudes Towards Women/ Patronized as Rural Women—I.e., Not Smart Too Close (i.e., know too well to divulge sensitive information) Concerns with Confidentiality Lack of Commitment to Community Lack of Continuity/Consistency

In some cases, this had serious consequences:

Well I had an experience last month with my miscarriage that just shocked me. I started haemorrhaging on a Saturday and ... my husband took me into the hospital here and the nurse was looking kind of green around the gills looking at me lose all this blood, and the doctor didn't look too happy either so they called an ambulance because there was no doctor here. The doctor was away for the weekend. The anaesthetist was away for the weekend. And then they shipped me off in the ambulance to Lloydminster. And the worst part then was after, well and the nurse and the doctor got me so scared I was asking if I was going to bleed to death. At first my main concern was just losing my baby. And then I thought 'well am I going to die?' and then I get to Lloyd and I sat there from 4:30 until 5:00 on the gurney. — Vermillion, Alberta

Many appreciated the personal reasons behind the shortage of physicians:

It is not necessarily the money they make though, it's the fact that there's no one to relieve them on call. — Creston, B.C.

And the ones that are leaving now, you know, are leaving most likely because others won't come here or some are leaving, others are saying 'well, I'm not going to get study with this huge work load' We're just not very marketable. — Creston, B.C.

At the same time, however, they felt the consequences of the lack of physicians including lack of choice and difficulties getting a second opinion about medical care:

Sometimes not having a choice but to see a doctor that you dislike because there is no other doctor. — Oakbank, Manitoba

If you're not satisfied with what you have, most of the time it's too bad. — Woodstock, Ontario

Others specifically noted the lack of female physicians or nurse practitioners. This was

seen as important, particularly for sensitive women's health issues (see further comments on this below in the section on quality):

Issues which would be raised if "there'd be more female physicians and nurse practitioners" — Vermillion, Alberta

Maybe we could get more nurse practitioners out into the communities and alleviate and relieve the problems, stresses on our medical professions like the doctors' office. — Clive, Alberta

Some were interested in being able to access the services of midwives for maternity care services:

What services do you perceive as lacking? Midwifery. Mhhmm. Midwifery would be wonderful. And it would take so much pressure off the doctors. — Vermillion, Alberta

I do really think that midwives are finally now accepted in Canada. It's been a while to come. And I think they should be pushed in smaller communities more and more because a doctor does a delivery so rarely, whereas a midwife, that's all she really does. — Creston, B.C.

It's obvious that women want more services from midwives and it's not there as yet — Yorkton.

A lack of access to dental services was also highlighted. In this case, access was limited not only by distance but also by the lack of dental plans among rural and remote residents:

I had had to take a whole day off work just to go to the dentist — Tumbler Ridge, B.C.

The fact that there's no dental plans. So the poorest dental problems are with rural children. — Yorkton, Saskatchewan

The dentist is in every second week for two days, and he also has the contract with Nunee health. And you can't get in to see him. ... The line-up is so long. And he'll take the treaty³ over anybody else, because he's going to get paid for that whole week. — Fort Chipewyan, Alberta

Similar comments were made about access to optometrists and other eye practitioners:

What about the people who go without eye care because they can't afford to get an eye exam? — Oakbank, Manitoba

The lack of mental health services was particularly salient for many women in the focus groups:

We have a big lack of therapy here. Somebody does come a couple days, part days a week, but there's too much backlog for you to get in. — Cobourg, Ontario

[There are] very, very long waiting lists for them to get in to see the mental health professionals ... Mentally ill people need to see someone within the week if not a few days after they leave a hospital or they're going to relapse and be back to the hospital so they become revolving door clients ... Mentally ill people, because they're mentally ill, do not have, for lack of a better word, the know-how to get out and go search for the resources. So they need persons ... reaching out to them in our communities. — Clive, Alberta

The wait list for mental health to see someone on the Burin Peninsula I think is something like eight months or longer. That's the wait list. — Marystown, Nfld/Lb

Rehabilitation services were often considered a luxury. Although some women and their families have limited access to such services on a rotating or visiting basis, even these are severely lacking:

And we do have a physiotherapist but we don't have the equipment and the physiotherapist doesn't have much room to work in. — Yorkton, Saskatchewan

For many of the women who were providing care to sick or disabled family members, the lack of home care services was particularly salient:

The home-care situation is deplorable here. ... The home care is just not there. Right now she's paying for a lot of it on her own, out of her own income. — Marystown, Nfld/Lb

And government won't pay for home care for 24 hours or what they need it. There's no family around to provide it, and they can't afford it themselves. And so you make do. Then obviously both people, both their health suffers. — Marystown, Nfld/Lb

Some of the private nursing care that you can hire yourself don't come out to our rural areas. — Clive, Alberta

Other special needs services were also described as ill-coordinated and lacking in other ways as well:

And it's just like this has been nonsense for years and years, not just with special needs but with all aspects of social services. . . . When I first started dealing with social services in this community for a special needs son, the gentleman came in. He was a really nice guy and I felt sorry for him. But that wasn't my job. My job was to be a client and he was supposed to be there to help our family. And he came into our home and says, you know, he wears many different hats, this day he was Native Affairs and today he's, and this, you know, special needs children thing is all new to him and we may probably might have to help him do it and by the way, we're in the market for foster homes. We really need foster homes. And this was our very first meeting with this guy and it was like by the time he left, I was offering him more answers and so forth. And that was then, and things haven't changed. We're going through the same thing now is trying to get some honesty. And I thought it was just me until the service provider said to me 'This is what they said and I know it's bogus. I know what they just said was bullshit.' And I said 'I thought the same thing.' And it's just like, no, that's what we're dealing with, you know. So social services in the North especially in an isolated community, whether it be Native Affairs, whether it be women's issues, whether it be special needs adults and children, it's totally lacking in the North, totally. — Tumbler Ridge, B.C.

The lack of health-care providers results in significant delays, increased waiting lists and longer waiting times for care:

I've had to sit at the emergency several times in the past and oh, the service is unbelievable — Woodstock, Ontario

Not being able to access care in a timely fashion meant that there was less chance for the early detection of problems:

I think the other problem for rural women, so many of the different cancers are treatable if you catch them early. But we're out here and who is going to catch them? First, I think you have to educate the women so that they know to recognize a possible problem. Then you have to be able to send them somewhere to look after it. And there are a lot of steps in that that just are missing out here. — Vermillion, Alberta

Many also noted that instead of getting better, health care restructuring in the form of funding cuts and threats of closures has exacerbated a bad situation, making it worse:

For those of us in rural areas, we live with the threat that we could lose the services that we have. — participant from Vermillion, Alberta

We live under the threat all the time in the rural communities of our hospitals. — Clive, Alberta

But with these cuts that have come in, further cuts, doctors don't want to come here. And that's frightening. We know we don't have the specialists ... We made those choices. But it is frightening knowing that doctors can't practice their anaesthetics here or surgery. — Creston, B.C.

In addition to the consequences of the lack of health-care providers for access to second opinions, and for waiting times and delays in general, women living in rural and remote communities spoke clearly of the implications this had for other aspects of quality of care.

Quality of Health Care Services

Some women differed as to whether the services available in rural and remote areas were similar in quality to those available in urban areas: For example, one woman noted:

Well the quality is there, it is just being able to access it. — Clive, Alberta

Others felt that the quality didn't compare. For example, one participant stated that:

The quality of the nursing isn't there because there are fewer nurses. — Clive, Alberta

Not having enough providers makes those who are available too busy and this woman felt this has consequences for quality of care:

This guy that's been there for 20 years has a case load of people, I mean he just can't do justice to the amount of people that he has on his list, his patient list, because everybody is trying to speak with him. — Oakbank, Manitoba

Many women also noted the lack of knowledge of women's health issues among

physicians in rural and remote communities, most of whom are male. In some cases, these participants perceived physicians to be particularly insensitive, often displaying stereotypical attitudes towards women.

Many participants also reported being patronized as “dumb” rural/remote women:

I'm finding that there's just a real lack of knowledge around women's issues and certainly around health promotion. It tends to be much more 'well here, take a pill.' or 'it's in your head' that kind of attitude rather than, you know, looking at further causes. — Vermillion, Alberta

[Physicians don't] appreciate the concerns that women are bringing to them. — Vermillion, Alberta

My doctor is brutal. He stands up before I'm finished. He's at the door. He's already dismissed me. He just wants to know maybe physically what your symptoms are ... but anything else that's going on [forget it]. — Woodstock, Ontario

In some cases, women travel great distances to access care from a female provider. One woman recalled how she travelled over four hours so her PAP smear could be conducted by a woman:

For my pap smear I go to Midway of all places cause there's a lady there that took me in, and she's really ... and that's how far I will go because I do not want a man, and that's a choice I make. — Creston. B.C.

I can't think of a male doctor understanding when my ovaries are hurting or whatever. I mean he doesn't know what I'm feeling. At least a woman I feel comfortable with. — Creston. B.C.

I hate to sound prejudiced, but I think that a woman doc/physician or a nurse practitioner would understand our health problems much better. — Vermillion, Alberta

I just find that women doctors understand women's issues a lot better. Where a man, I almost feel like they're sometimes grasping at straws, 'okay, let's try this.' 'Oh yeah, let's try this.' And it's like 'no, I'm not going to be your guinea pig.' — Creston. B.C.

Many felt that they had better care from health-care providers who were women:

My health has always been improved I feel by the services that I've received from other women. There seems to be more empathy and more time involved. — Woodstock, Ontario

Some women seek access to alternative practitioners when they are available :

If the medical doctors are fluffing you off and not giving you the help we need, we have to be able to go to an alternative medicine, alternative practitioner or somebody that will help and maybe give you the help that you do need, that we know it does work. — Clive, Alberta

In addition to concerns regarding the gender of their physicians, some women were also concerned about how well they knew their physician. That is, although some participants in some cases felt that knowing their physician well was one of the positive features of rural/remote living, others felt that this sometimes made it difficult to

divulge sensitive information, particularly if they were the physician for other family members:

You know if you have to see the doctor socially. Like the doctor is a friend of your parents or the social environment. I've had to have a lot of pap

smears because I had cervical cancer in the past. So I just feel I'm so much more comfortable having a woman to begin with, and also out of the social



context. So that's important to me. — Woodstock, Ontario

Others identified concerns regarding confidentiality:

I think confidentiality is a concern in a small town and it isn't brought up — Creston, B.C.

I think the other big problem over the years is lack of confidentiality, because whatever you went to the nursing station for, basically everybody in town knew about it in the next few days. — Fort Chipewyan, Alberta

The high turnover of health-care providers in some communities made some participants question their commitment to the community:

Doctors [are] leaving all the time. — Vermillion, Alberta

I think sometimes with us being a rural centre, some of the doctors that are coming in from other countries are just using our communities as spring boards to get to bigger, larger centres. This is where they land and then off they go to the larger centres. — Vermillion, Alberta

We've had quite a big turnover of doctors whereas the regional nurses for the most part are nurses that have lived there for a number of years and actually belong to the community. — Forteau/Port Hope Simpson/ Mary's Harbour, Nfld/Lb

High turnover raised other concerns relating to continuity and consistency of care:

There was one specialist who was coming in and then something happened and then there wasn't anybody coming in and then there was somebody coming but it was somebody different, and you sort of, you don't, there's not any sort of consistency. You don't know who is available from time to time. — Vermillion, Alberta

We have a problem in some of the communities with continuity of family physicians.... so every six months or so you could have a different doctor. So there's no, you know, facility to carry through. — Marystown, Nfld/Lb

I'd say they go years without having paps done and the things that you were saying because the doctors are turning over every six months, the doctor is not going to suggest to them that they have it done. And most women are not going to

approach the doctor about those things either. So I think a lot of it is being neglected, just not getting done. — Marystown, Nfld/Lb

At the same time, however, they noted that much of the turnover was due to being too busy and a high burnout rate among health-care providers:

The high staff turnover and burnout rate for the front line workers affect the continuity of care — Yellowknife, NWT

In sum, the basic picture that was drawn for us about the state of health care for women in rural and remote areas was rather bleak. They faced a lack of health-care providers across the spectrum and those that they did have available to them were in some cases seen as inadequate and insensitive to their needs as women. The women in the focus groups went to great lengths both in terms of time and money to get care—whether that was for basic services or for those provided by another woman. They understood the reasons behind the challenges, but nevertheless hoped that something better would be available to them. In the next section on women's views of rural/remote living, these experiences of health and health care figured prominently.

C. Definition and Experience of Being Rural or Remote

The women who participated in our focus groups had a very strong sense of what it meant to live in a rural or remote community. Their responses were placed into two categories and as with their views on the impact of rural/remote living on health, within each of these categories, both positive and negative facets were identified. The first category addresses the structural issues including distance to services and other people, the differences between farm-rural and town-rural, and between rural and remote. The second category addresses the

social issues associated with being known to all, having to make do, and dealing with stereotypes of rural women. These are briefly noted in Table 9.

Structural Issues

The issues of distance and driving are important elements of rural and remote living as well as rural and remote health care. Indeed, when asked what living rurally or remotely meant to participants, their first response was often “driving”. In some

remote communities, the women noted the added barrier of having to fly to get anywhere. Either way, living in a rural and remote community meant a lot of travelling:

Everything you do, you have to travel. — Vermillion, Alberta

I think the distance from services. . . . I mean everything isn't available here for you so you have to go to it — participants from Lion's Head, Ontario

It takes a hundred kilometres to go to town to buy groceries. I mean then your kid has hockey. So it's a huge amount of travel. — Yorkton, Saskatchewan

Table 9 Overall Sense of Living in a Rural/Remote Community

KEY THEME	SPECIFICS
Structural Issues	Distance Solitude, Silence, and Space Safety Isolation Farm vs. Town Rural vs. Remote Transportation Options Communications
Social Issues	Everyone Knows You You Own Your Home Poverty Having to “Make Do”/Simple Life Discrimination by Those in the City/south Country “Hicks” Impact on Self-esteem “Transplants” [From City to Farm/rural]

For some women who didn't drive, this posed significant problems:

And a lot of people don't have access to transportation. You take with an older person probably a lot of people don't have a vehicle. — Marystown, Nfld/Lb

You're responsible for getting there. — Clive, Alberta

Like to go to the doctor's even, although it's only less than five minutes away from me, because I don't drive, unless my husband takes time off work, I have to count on someone else to take me. — Lion's Head, Ontario

Related to the issue of distances to others and to services were feelings of solitude, silence and space:

You can't hear your neighbours next door. There's no, you know like all the noise and traffic in the city would just grate on my nerves. I mean it's easier to live with calves during weaning time than it is to hear your neighbours fighting next door. — Clive, Alberta

Being able to go out and walk and not have to worry about the traffic. — Lion's Head, Ontario

The space and freedom for ourselves and our children. — Clive, Alberta

For many this translated into a feeling of safety:

You're safe to walk around the community ... not like in the city where you might have to worry about being mugged or whatever. — Tumbler Ridge, B.C.

The other side of this, however, was the feeling of being isolated, lonely and vulnerable:

A part of the problem too in relation to attitudes and living in a rural community, a lot of people feel lonely or isolated or depressed. — Clive, Alberta

If you don't have a car and can't drive, then isolation can definitely set in when you're in a rural area. — Markdale, Ontario

I think there is an immense need to address loneliness that rural women experience. We talk a lot about community and all of that but the isolation of where we live has great beauty, but it also has great capacity to level us. — Yorkton, Saskatchewan.

Quite clearly the structural issue of distance has implications in terms of social isolation (see below for full discussion of the social aspects of the definition of rural/remote living).

Other issues of a structural nature relate to the difference between farm and town with more women regarding rural living as living on the farm. For example:

But rural is being out in the country and having my own area away from other people. — Clive, Alberta

The fact that we're living in a much more clustered community sometimes give us a feeling of not being as rural maybe we think of some of those large farms. — Cobourg, Ontario

My idea of the country is being able to be a farmer and to touch the earth ... I just like to drive the tractor through the field and look behind you and see that the dirt is turned over and the smell, and the worms and the seagulls and the hawks. One time I was working the field, there were 11 hawks flying over me all day long. And I have one hawk named Margaret. She's named after my mother. ... in this one field that I work in and she sits right there and waits till my tractor comes and I mean

how can you experience that kind of think you know. And we've all sort of felt down and then been driving or walking in the woods and a deer steps out. Like there is no greater feeling than to know that nature is there to support you when you're feeling down maybe because something comes along, you know. And I think it's the ability to touch the earth. — Clive, Alberta

However, many noted that farms are not necessarily idyllic:

It's a lot easier to get hurt on the farm I think than in your little postage stamp back yard. — Clive, Alberta

Within this discussion the issue of “transplants” from cities to the farm or to rural areas was raised:

A lot of our farms have been bought up by people coming out of the city and what not. ... These farms are bought up for retreats. ... So I think maybe that's why some of us feel yes, we're rural but we're recreational rural. — Cobourg, Ontario

If you look around the community, everyone has come from the city. — Markdale, Ontario.

Participants generally distinguished between being rural and being remote:

I think there is a big difference between rural and remote. We're seven miles from town ... remote to me is when you live hundreds of miles from someplace. — Vermillion, Alberta

I think living remotely also builds responsibility into yourself. That you begin to rely on your own resources and you know that it's you who has to see through the situation. ... You have to be self-reliant. — Clive, Alberta

St. Lawrence is probably remote cause they can't get the internet up there, you know, cause they don't have phone ... lines. ... That makes them remote. — Marystown, Nfld/Lb

When I think of remote I think of the fly-in communities. — Oakbank, Manitoba

Thus distance, transportation options and communications infrastructure play an important role in participants' definitions of rural and remote.

Social Issues

Women we met tended to link rural or remote living to a feeling of being connected to a place.

How do we define our community? It's our home; it's our home, short and simple. So your community is your home. And we make the best of it. — Fort Chipewyan, Alberta

Feeling connected can mean that everyone knows each other, which can have both positive and negative consequences:

Well I think again what's nice here is I know in the city you're pretty much a number. At least here, you have a name ... and if you've been around long enough and you know other people, you're a name and you're a family and their family has had some sort of association with your family ... but that can be a good or a bad thing. — Vermillion, Alberta

When I lived in XXX I had a son that was killed in an accident and everybody was there, absolutely everybody. I don't think you'd find that in a city — Clive, Alberta

A sense of connection. Being very personable ... there's more of a connection with humanity here. — Creston, B.C.

Everybody knows your business whether it's health care or your financial situation or what your kids did last night. It doesn't matter. But then on the other hand, living in this community, everybody raises your children. — Port Alice, B.C.

Poverty is an all too common social aspect of rural/remote living.

But to be community people and to grow up and be part of a community and we live in poverty to begin with ... to grow off the land and feed off the land. — Oakbank, Manitoba

So a lot of what we learned we associated with being poor, but those values are things that everybody needs to be an independent adult and contribute to communities, to family, and to society. And we've somehow associated all of that with the poverty of our youth and sort of look at being somewhat affluent as a means of not having to do any of those things Saskatchewan is an obvious example of that. It's almost poverty struck now. — Woodstock, Ontario

[We need to] recognize there are some very poverty stricken people that don't even have the facilities or

the ability or the knowledge base. — Yorkton, Saskatchewan

The social effects of poverty, limited local services and other threats to health were sometimes exacerbated by time constraints associated with seasonal work in rural and remote areas resulting in an overall sense of having to “make do”.

What you want isn't always available. And that's just sort of a fact of life and also living rurally for us, because we farm, there are just certain times of the year where you can't go someplace ... we can't do anything in March because we're calving. So if you're sick, it's either the emergency room or forget it. If it's during harvest season, it's the same thing. — Vermillion, Alberta

Some portrayed the lack of services and isolation in somewhat more positive terms as keeping life simple and making it easier to live on lower incomes:

Lack of entertainment, shopping, and you know I guess many factors up here that you would have in most centres. But I think that we more than make up for it in other areas. ... We pick our own berries and we grow our own gardens, you know, stuff like that that you wouldn't do if you were in a larger centre. — Forteau/Port Hope Simpson/Mary's Harbour, Nfld/Lb

It's less money to live here. So therefore, you know, I had to work full time when I lived in Vancouver. And I don't even make as much now as I did then and I work like part time, and you know, it's just a lot slower pace of life which is less stress, more pleasure time. — Creston, B.C.

You're not as stressed and going like you're on a treadmill, then you have better quality of health cause you feel better, you're more at peace. You enjoy life more. — Lion's Head, Ontario

I love gardening. I love our back yard. I love our trees ... and it's exciting for me to take fruit and make jam or pies and things like that. I enjoy that. — Creston, B.C.

Many women pointed out the various stereotypes others had of rural and remote living. Some also talked about the discrimination they or others had experienced when they travelled to “the City” or the “South” for health care and other services:

Rural to me means quiet and the space and my own area where there should be less stress. That isn't always the case because so many elements, if you're a farmer forget that. — Clive, Alberta

They fail to realize that people from the remote communities, who may have never been anywhere outside of the community- feel just like those foreigners and should be given the same consideration and care. — Yellowknife, NWT

I hate to say that, but of my urban experiences in hospitals I would say that they think you're a little dumber, you're a little bit more stupid. — Vermillion, Alberta

They think that because you're here you're not really all that educated. — Markdale, Ontario

We think the woman that goes to work, she goes all dressed up in her nice clothes and when we're at home working on the farm we put on, I've never seen a woman digging in her garden in her high heels yet. So I think that has part to do with the attitudes that people have of us or the perception that other people have of us. They think we only go around cause we're scrubby people, that we look like we're down and destitute and we're really, they think because we don't have fancy clothes on that we don't have any brains as well as no clothes. — Yorkton, Saskatchewan

At the same time, however, some of the rural women had their own stereotypes of themselves:

A rural woman is someone who does a lot of home baking ... lots of quilting. — Lion's Head, Ontario

In all, women's definitions of rural/remote living tended toward an image of self-sufficiency—having to make do with a simpler life, with a lot of driving, with doing more for oneself and one's family and with being misunderstood or looked down upon by those in the City or the South.

D. Policy Recommendations

Following our participants' descriptions of the implications of rural and remote living on health and health-care issues, we asked for their opinions on how policy might be shaped to better address the problems they faced. These are briefly noted in Table 10 on

page G37 and include the broad categories of: improving accessibility; improving sensitivity; improving access to information and its targets; expanding the range of age-related services; providing more support; promoting understanding of the impacts of health-care reform; and improving the overall influence of women in rural and remote communities regarding health and health-care issues.

Many of the comments made by the participants in our focus groups regarding improving access to health-care services focused on increasing the number of physicians available in rural and remote communities. Many linked the lack of physicians with other ills in rural and remote health care, such as burnout and over-worked health-care providers:

If you had enough doctors in a community, there wouldn't be a problem about being overworked in a rural area. And if you wanted to go off to the city for a weekend with your wife, there would be other physicians in the community to cover for them. — Vermillion, Alberta

Some suggested that more foreign-trained physicians should be allowed to practice:

We hear that the Canadian government in health is now looking at foreign, the foreign doctors who are coming which is unfortunate they haven't done that years and years ago. — Lion's Head, Ontario

Others wanted to encourage more Canadian-trained physicians to practice in rural and remote communities:

I'd like to see some Canadian trained physicians coming out here. I don't know why they're all going to the cities. Why can't, we're spending big money, we all spend the same tax dollars towards universities and I think a certain proportion of physicians should come out back to us. — Vermillion Alberta

Another suggestion was to encourage semi-retired physicians to contribute:

That's another thing we do have is some retired doctors who come down one day a week or every

second week or something to do special things. —
Lion's Head, Ontario

something that had worked well in their
area.

Indeed, participants in one community in
Ontario (Markdale) noted that this was

Table 10 Suggestions for Policy Change to Improve Rural and Remote Women's Health and health-care Issues	
KEY THEME	SPECIFICS
Improve Accessibility	Allow More Foreign-trained Physicians to Practice Encourage Semi-retired Physicians to Contribute Increase Use of Female Physicians and Nurse Practitioners Rotating/outreach Services to Increase Accessibility/care Closer to Home [Such as Well-woman Clinics] Mental Health Services
Improve Sensitivity	Culturally Appropriate Services More Female health-care Providers More Time
Improve Information (and targets)	Reduced Cost of Education, Services
Expand Focus of Age-related Services	Young Children Childcare Youth/teen Issues Teen Sexuality/pregnancy Substance Use/abuse Young Adults (Out of School) Young/single Parents Middle Age/menopause Aging/seniors Issues
Better Support Better Understand Impact of Health Reforms	Victims of Violence Poor/Those on Social Assistance Funding Cutbacks Regionalization Travel Time and Costs
Improve Influence of Rural Women	Wanting a Stronger Voice Decisions Made Without Grass-roots Input

Many participants were not only interested
in increasing the complement of physicians,
they also stressed the importance of
increasing the availability of female physi-
cians and female nurse practitioners:

*The first thing is having female doctors so that the
women and the girls in the community would feel
more comfortable talking to them. — Yorkton,
Saskatchewan*

*To have more women doctors, make a person feel
more comfy going and you'd probably go more*

often. — Yorkton, Saskatchewan

Others pointed to using services that are
already available in rural and remote
communities more fully; this was mentioned
primarily in relation to community pharma-
cists:

*Lately they've been talking about pharmacists
being able to prescribe, you know, independently
from the doctors. And I believe that's an experiment
that should be tried too. Spread it out a little bit*

because a lot of the pharmacists really know their patients. You know, they know the people very well and you know, let's experiment with this. — Clive, Alberta

Another strategy mentioned to improve accessibility included rotating/outreach services, such as well-woman clinics and other speciality care to avoid the long drive and to have care closer at hand:

We need more outreach services in the mental health field as well.... We need more mental health specialists in the community. — Clive, Alberta

When you are sick it's good to have the availability of good health care close at hand. And for that reason I sometimes don't like the idea of them closing down the smaller community health-care centres and that type of thing. — Clive, Alberta

As noted above, mental health services were mentioned specifically.

In additional to these suggestions to improve accessibility, others mentioned that there needed to be improvements in the sensitivity of both health-care providers and rural and remote communities. Related to the mental health issue, some mentioned that greater knowledge and acceptance of mental health issues is also needed in rural and remote communities:

Acceptance of mental health issues and develop strong programming and services to address. — Yellowknife, NWT

There should be more people trained in compassion when they're dealing with people in crisis. — Oakbank, Manitoba

Related to this issue is the need for more culturally-appropriate services, particularly for Aboriginal women and their families:

They're supposed to be working with Aboriginal clients but they're not allowed to bring culture into their work. My thoughts on what (name) was just talking about culture and ethnicity, I think we can have communities within communities. ## Germans, and those folks probably organized together for their big German day or whatever, so it's kind of a community within a community or maybe in ours, ## Catholics probably were still

there but the Catholics ## organize a community within that community too. — Watrous, Saskatchewan

Other participants mentioned that better access to health and health-care information was necessary including better targeting of key audiences and reducing costs of educational services:

Education which may well be in the form of group sessions, public health nurse but certainly the disease prevention/health promotion model. And education, preferably beginning at the school-age group or even younger. Education involves, I mean not only educating young children but parents as well. I'll give you an example. When I spoke about getting a nutrition program going at the school, the nutritionist at the time and the public-health nurse both said to me there's a lot of opposition from the parents to take the [pop] and chips out of the school. And I said, 'well what does that tell you? That tells you that you should start educating the parents; that we should be educating parents about the importance of good nutrition. — Forteau/Port Hope Simpson/Mary's Harbour, Nfld/Lb

The first responders⁴ are darn good but we need better basic health needs such as education on nutrition and exercise and stress. Those kind of things need improvement through education. — Yorkton, Saskatchewan

Others noted the importance of expanded Age-Related Services for women and girls in rural and remote communities. This began with a discussion of services for young children and their mothers:

I want a children's centre in the community. A children's centre? That would provide what? That would provide — Headstart, daycare, infant care... — Fort Chipewyan, Alberta

Services for youths/teens were also emphasized:

We would like to see extra attention being given, especially when it comes to the youth, because they are the ones we need to reach. — Forteau/Port Hope Simpson/ Mary's Harbour, Nfld/Lb

Part of this related to issues of sexuality, pregnancy and parenting:

Birth control and family planning promotion especially geared towards younger women. — Marystown, Nfld/Lb

They do have, they impact on, the girls [to] stop smoking and pay attention to nutrition and pay better attention to their health and they're educated regarding good prenatal care and breast feeding and what not. But it has a big positive impact on them. — Oakbank, Manitoba

There's all these programs that are trying to teach these young women how to be parents. So that's very stressful on the family. And they have no support. They have to go elsewhere to have support. — Oakbank, Manitoba

Other age-related women's health services some felt needed attention were services for those between childbearing and menopause:

And the ones past child-bearing age and not yet in the menopause. That's a group too that's kind of neglected. — Marystown, Nfld/Lb

In addition to these specific age-related services for women, many mentioned that better support for victims of violence and those on social assistance was greatly needed:

And my second one is how to recognize the early signs of abuse and have places and education for people dealing with these problems. — Yorkton, Saskatchewan

Related to this was the need to better understand the impact of health reforms and other forms of restructuring on the lives of women in rural and remote communities and to begin to address these:

I mean that's affecting me personally, but on a broad level government cutbacks provincially has made it such a stressful life for so many people. And that is so detrimental to your health. — Creston, B.C.

Substance use and abuse was another concern raised not just for teens but for many in rural and remote communities:

For non-medical issues such as mental health, alcohol and drugs, abuse, there is lack of followup services, the waiting time to access services can be long or restrictions to access of services (i.e. can only be in treatment centre for 30 days) are detrimental and senseless. — Yellowknife, NWT

I don't know if you'd call this a threat, but there's a lot of alcohol in the rural areas that's hidden or that's accepted. More that it's accepted. — Yorkton, Saskatchewan

Regionalization of health-care delivery was mentioned in particular (and in particular by women in Alberta) as a policy that needs to be revised:

The policy too. Like the new region might not be as pro like lactation consultants and stuff like that so you end up losing the funding for them. — Vermillion, Alberta

I think they're cutting down on the small hospitals and they're forcing us to go to the bigger centre, and even once you get to Red Deer if they don't have the specialist you need there or even to get into a G.P. there, there's a long, long waiting list and you're having to wait there too and then they can refer you on to a bigger centre yet and it's another six months waiting list to get into them. — Clive, Alberta

They've de-centralized everything and I think that was wrong. I think they should have kept open these smaller hospitals. — Clive, Alberta

Women called for greater sensitivity to and, ideally, compensation for the excessive travel times and costs borne by women in rural and remote communities in order to get access to health care:

The cost of travel back and forth to St. John's every month or couple of months and then you know if you don't have family there, there's hostel and meals, and if that person doesn't have medical insurance, you know, then the cost could be a big factor for them. And I think that's something that's very important to be put in any questions about improvement of women's health. — Forteau/Port Hope Simpson/ Mary's Harbour, Nfld/Lb

I had an experience where I had to go back to the hospital three times a day for, you know, an intravenous, and I was told on the last day that I was going 'where are you from?' and I said "well, an hour and three quarters." "Well we could have got a health-care nurse to come to do that." But that was after we'd gone three times a day for four days. But somehow I don't think they, the urban areas, understand what rural means. They think you live within 10, 15 minutes driving time; that you can pop back and forth. — Clive, Alberta

Finally, one of the key policy recommendations from women who participated in our focus groups was to improve the overall extent to which women in rural and remote communities have influence over decisions that affect their health and health care. Indeed, many wanted a stronger voice:

The policies are in the way of our voices being what are we doing in our own communities to reduce diabetes and stress and offer support for each other; and equal representation for the North. Political recognition. Right. You want the North to have a voice. A voice. So that voice is heard. Yeah. And I'm sure that's consensus in all decisions made without grass-roots input — Hay River, NWT

The treatment of women—we are not slaves—we are equal. — Yellowknife, NWT

Can help women change and grow but the attitudes prevailing in the communities, the region, the Territories has to be supportive. — Yellowknife, NWT

Women are not relevant and important. — Watrous, Saskatchewan

In sum, for any policy to effectively address rural and remote women's health and health-care needs, these women need to

have input into the development of this policy and it needs to be formulated based on the realities that they face. Rural and remote women's health and health-care concerns need to be clearly identified so that we can improve accessibility, improve information and support services and target appropriate services to women of different ages, from different ethnic and cultural backgrounds and with different needs.

E. Suggestions for Research

In addition to asking participants for some direction for policy changes that would effectively address the health and health-care issues they raised in the context of the focus group, we also queried them about possible areas where more research would be needed to better understand rural and remote women's health and health care issues. Overwhelmingly, most participants preferred action to more research; nevertheless, some very important areas for future research were identified by the women in our groups. These are briefly noted in Table 11 below.

Table 11 Suggestions for Research to Address Rural and Remote Women's Health and Health Care Issues	
KEY QUESTION	SPECIFICS
Impact of Age on Access to Services	Denying access to older women
Specific Concerns for Rural and Remote Communities	Concern with Effects of Drugs and Alcohol Negative Media Image
Urban/Rural Comparison Of Women's Health	Does an Urban Approach to Health Care Work for Rural People? Caregiver Issues Value of Women's Work
Knowledge Transfer/ Dissemination	Research should be "used" or about "usable" topics and made accessible Concern with duplication of research studies Mentoring

Several participants were interested in knowing more about the effects of age on access to services.

Well there's clinics in the city that they won't accept new patients unless you're under a certain age bracket. Like you have to be up to 19. They'll accept anybody under 19. But if you have the same problem as somebody who is 19, and you're 20 or something like that, they won't accept you... Well it's like why should you be denied the same health care for the same issue just because you're a year older. — Oakbank, Manitoba

Some of these concerns addressed older and elderly women's difficulties accessing care:

The only thing that I can say is that I think as people get older, they lose their ability to travel living in the country because some doctor says that you can't drive or your family you're a hazard on the road. And I think that this is maybe a barrier to living in this country. There might be worse barriers in town. — Clive, Alberta

Other specific concerns included redirecting research towards stopping smoking and abuse problems before they started among young women in rural and remote communities:

That's what I'm saying. Maybe the research is not on the impact of smoking on young women. It's more research on how to motivate young women not to smoke, not to start smoking, or when they do, how to quit. And it's not just smoking I think. That's what I say. It's # drugs. All sorts of different — Cobourg, Ontario

Some were interested in research into the negative media image that rural and remote communities seem to have:

It is maybe even more important that you doing the survey realize and recognize the good in rural areas, not only list off the bad. I think we have a lot

of good systems, maybe unofficial organization, but still we have things that work in small towns that would, that big cities would never be able to come close to. And I think in studies like this that has to be recognized because often time all we hear is the negative. We don't hear the positives

and the positive gets dropped. —

*Forteau/Port Hope
Simpson/Mary's
Harbour, Nfld/Lb*

I would say the only time we really get in the media is when there's something negative happening here, and they really blow it up when every student in the high school fails the math test on these provincial achievement tests that they do. —

Fort Chipewyan, Alberta

This discussion also raised issues of a comparative nature between urban and rural/remote women's health and health care. Many questioned whether an urban approach to health care is appropriate for rural people:

They need to know that our health needs as women are just as important as the women in the cities. We're not any different rural women. We need the same facilities. We need the same type of people available. We need the same education. And it has to be available. We have to have it here for us that we don't have to ... It's a lot easier to bring one or two people to a hundred than it is to send the hundred to two people. —

*Forteau/Port Hope Simpson/ Mary's Harbour,
Nfld/Lb*

Some other participants mentioned that research should address issues of caregiving as well as valuing the work that women do:

So supporting care givers. Yes, totally. Because we're the ones that are doing it. In a family, it's not the dad that goes 'Oh I think there's a', it's usually the mom. And it's usually when the kid is sick it's usually the mom who is the caregiver who stays home. So if she's working she stays home. If she's not working it still throws a wrench in her life for that time frame. — Vermillion, Alberta

Some of the organizations that are backing this need for research information to get their messages across and we feel that that would be research worth doing. Another one is the true value of farm women's work in economic terms to prove value that justifies financial input by levels of government. We think that's a great unrecognized resource. — Yorkton, Saskatchewan.

Other comments about research needs addressed form in addition to content. For example, participants highlighted how any research that is conducted should be “used” or about “usable” topics and made accessible:

If it makes no difference in the practices and it's not being disseminated in language that is comprehensible for us rural women. — Clive, Alberta

If the research doesn't get implemented at our level it is useless to us. — Vermillion, Alberta

I think the people should fund the research should have the responsibility to distribute it afterwards and make sure it goes into policies and policy-making and is used in health care decisions. — Marystown, Nfld/Lb

Thus research transfer was very important to women. Other concerns with research were regarding the duplication of research studies:

I also think it needs to be like I said disseminated in a manner, share it and let's see some results. And know what's out there so that two people aren't doing the same research at two different ends of the country. Like there's got to be some pool that they can actually do it collectively and maybe speed it up. — Clive, Alberta

If you've already got a study and it's a good study, use the results from that study. Don't go spending money on another study and just run over the same ground. — Vermillion, Alberta

Others, as noted above, wanted to focus more on action as opposed to research:

You can do the research and the papers sit up on somebody's desk. Just because we know that, even if we know what the facts are, if the government or some public agency is not going to use what they found in the research, were are we going with it?

— Marystown, Nfld/Lb

In sum, women in this study had some very important issues to raise about future research on rural and remote women's health and health care issues both in terms of content and form. It is critical for these concerns to be addressed.

***Rural and remote
women's health and
health-care concerns
need to be clearly
identified...***

Summary and Reflections

In sum, we found many commonalities as well as some unique challenges raised by the 164 women in the 20 focus groups that were conducted across rural and remote Canada. Some of the key points can be summarised as follows:

I. Impact of Rural/Remote Living on Health

- The impacts of rural and remote living on women's health can be both positive (i.e., assets) and negative (i.e., detriments)
- Both physical and social features of rural and remote areas can influence health
- The same feature can have both positive and negative impacts
- Thus, rural and remote living yields both benefits and drawbacks for women's health.

Assets of Rural/Remote Living for Women's Health

- *Physical assets:* air quality/lack of pollution, trees/lakes/beauty/recreational paradise, access to exercise and better diet.
- *Social assets:* being part of a caring community, access to social/support groups including the WI (Women's Institute) and rural churches; access to information and programs through these venues, being involved/pulling together, have time to spend with family, crime free/safe, less stress, less congestion, more peace.

Detriments of Rural/Remote Living for Women's Health

- *Physical detriments:* poor air and water quality, exposure to farm chemicals, impact of the drought, substandard housing, high food costs, lack of public

transportation, impact of weather/seasonality, and limited access to health promoting activities

- *Social detriments:* economic stress of farming, the related concern of caring for husband under stress, isolation, social expectations and attitudes, lack of extended family, lack of anonymity, substance abuse, violence, limited employment, communities in transition or suffering from economic restructuring, financial insecurity/low income, low education and low literacy rates.

Reflections

The focus groups identified a fairly good balance of positive and negative aspects of rural and remote living for women's health. Perhaps this is indicative of the importance of these issues for women living in rural and remote communities or it is reflective of the questions posed during the focus groups. Either way, there was good quality data gathered on this issue.

II. Impact of Rural/Remote Living on Health Care Services

- Although most of the questions in the focus group interview guide addressed the issue of health, most women responded by discussing health care. In light of this, the bulk of the data falls within the category of health care services.
- A similar dichotomy of positive and negative features noted in participants' views of the impact of rural/remote living on health was also salient in their discussions of health care but the majority of the discussion addressed the various elements that were lacking in rural and remote health care services. Many women made

direct comparisons with the health services they felt were available in urban areas.

Benefits

- In terms of *structural* issues, hospitals were considered not as busy and therefore better quality of care was provided. Others mentioned that the level of some services was improving.
- In terms of *social* issues, there are better opportunities to get to know one's health care provider in the community. In some cases this can make it easier to get an appointment with one's family doctor

Drawbacks

- *Structural barriers*: distance to services, access to hospital and ambulance services as well as health promotion services/programs.
- *Social barriers*: those mentioned mainly related to constraints on access to information specifically related to sensitive women's health issues and included discussions of internet use and other media.
- Women discussed local initiatives developed to mitigate some of these barriers. These included: volunteer driver programs, rotating specialist visits and telehealth where available (see more details in policy section below).
- With respect to *quantity* of services, there was a lack of physicians, nurse practitioners, midwives, dentists, optometrists, mental health services, rehabilitation services, home care services, special needs, and alternative practitioners. Shortages limited choice and ability to get a second opinion, increased delays/wait lists/times. Recent funding cuts and restructuring

seemed to have exacerbated these inadequacies in the system.

- With respect to *quality* of services, women noted how busy the physicians and other health-care providers in their area are, suggested that this has led to burnout of health-care providers, and to a lack of continuity and consistency of care. Others noted that some of the physicians in rural and remote areas lack knowledge of women's health issues and in some cases are insensitive to women's concerns and even hold stereotypical attitudes towards women making some of the participants feel patronized as rural women—i.e., that they are not particularly smart. Other concerns highlighted how knowing one's health-care provider well made it difficult to divulge sensitive information and others had concerns with confidentiality.

Reflections

The balance of positive and negative aspects of rural and remote living for women's health was not mirrored in women's views of rural/remote health care. Perhaps this is reflective of reality, but it is important to keep in mind that there were no specific questions probing for the positive aspects of rural/remote health care. Indeed, it is interesting that the only formal question which addressed health care focused on the issue of satisfaction. In many cases, women would say they were satisfied but would then delve into a rather scathing critique of the services available to them. This 'satisfied, but' phenomenon requires further exploration. It is likely related to what one expects from living in a rural area (see summary comments below)

III. Definition and Experience of Being Rural or Remote

- These women had a very strong sense of what it meant to live in a rural or remote community.
- Their responses were categorized into structural and social issues and, within these categories, into positive and negative facets.
 - *Structural* issues: distance to services and the differences between farm-rural and town-rural and between rural and remote.
 - *Social* issues: everyone knowing each other (for better or worse), having to make do, living the 'simple' life, and the experience of various stereotypes people had of rural women (i.e., poor, carefree, and unintelligent).

IV. Policy Recommendations

The participants were able to identify several ways in which policy might be shaped to better address the health and health-care issues they faced. These included:

- improving accessibility, particularly to physicians through a variety of measures including recruiting more foreign-trained physicians and encouraging more Canadian-trained physicians to practice;
- improving the sensitivity of rural and remote health-care providers to women's issues and cultural issues;
- improving accessibility to health and health-care information;
- expanding the range of age-related services for women ;
- providing more support to those who are victims of violence and poverty;
- better understanding of the impacts of health-care reform on the health of rural and remote women; and

- improving the overall influence of women in rural and remote communities regarding health and health-care issues.

V. Research Recommendations

The women in our study made several recommendations for future research both in terms of content and form. These included:

- the effect of age on access to health care services
- specific concerns for rural and remote communities including substance abuse and the negative stereotypes of rural/remote living;
- comparative research between urban and rural/remote areas to prevent the transfer of inappropriate urban approaches to care in rural/remote communities; and
- better transfer of research knowledge to the communities that could most benefit from it.

Some Reflections on Future Research

Although the focus groups that were conducted yielded several important findings, there are nevertheless some gaps in our knowledge of rural women's health issues that remain. Specifically, we touch upon some of the more general health and health promotion issues, but we touch very little on *rural women's health and health care issues across the life course*. Perhaps in subsequent questioning we could attempt to have participants draw out issues across the life course so that even though we may not have younger women participate in the group (though we should endeavour to secure participants from these age groups) we could address some of the following issues affecting:

rural adolescent women;
young rural adult women;
young rural mothers, etc.

highlighting issues of sexuality and early reproductive-health issues, workplace-health issues (across the life course), maternity issues—including maternity care and child-care—midlife-reproductive health and sexuality issues, eldercare and later-life issues, and health planning and programming appropriate to women. It would be interesting to get data on whether adult children are located in close proximity (why and why not). This could have important implications for care and sustainability of rural communities.

We would also do well with specific groups that discuss issues of *violence against women in rural communities* because mixed groups in which some have experienced violence and others not (or not wishing to disclose) will not result in the kind of disclosure of information we would find most helpful in a drafting policy and a research agenda related to this issue. The same could be said about *mental health issues* and issues related to *substance abuse*. *Disability issues* should also be addressed—women with disabilities in

rural/remote areas and women taking care of loved ones with disabilities. Indeed, we need to collect more data specifically about caregiving. We know that providing care to a sick or disabled child or parent is quite isolating, but how is this specifically experienced in a rural/remote setting? Is the isolation exacerbated or supported by the ‘caring community’?

Data pertaining to participants’ ethnic background was also not gathered and is something that should be considered for future research. Moreover, more attention should be paid to ensuring participation from key equity groups such as Aboriginal women, women from visible minorities, Mennonite women and Hutterite women who live in rural and remote areas. We should also strive to separate out *rural town*, *rural farm* and *remote* (perhaps also *remote drive* and *remote fly*) as much as possible to help extricate the key differences as well as highlight commonalities. This would necessitate some purposive sampling in follow-up research.



Appendix

A Brief Note about the Locations

Creston, B.C. is located on Hwy..... 3, 28 kms south of Kootenay Lake and 11 km north of the U.S. border. It is home to a diversified set of industries and has experienced population growth in the past decade. Although Creston was officially incorporated in 1924, the first white settlers arrived in the area as residents in 1891. By 1896 it was a well-developed gold-mining town with a population of 1,500. Despite its resource base nature, Creston has always had a relatively diversified economy—tourism, brewery, agriculture, lumber and mining. This has led to increased economic stability, larger populations and a less vulnerable attitude about the future of the town.

Port Alice, B.C. is located on the northern tip of Vancouver Island and is approximately 45 minutes drive from Port McNeill and Port Hardy, and about a five hours drive away from Nainaimo. The village was built initially to house the workers of a pulp mill working for Colonial Pulp and paper Company in 1917. Much of the original townsite was destroyed in fires in 1941 and 1960 and a massive tidal wave caused by an earthquake in Alaska in 1964 and relocated four miles away. Residents have always been dependent on the forest industry. Access in and out is quite restricted. Twelve years ago the last baby was delivered in Port Alice, now expectant mothers travel outside of town to deliver their infants. At the end of February 2002, the services at the hospital were reduced from a 24-hour facility to a 12-hour facility.

Tumbler Ridge, B.C. is located in northeastern British Columbia and is approximately one hour's drive from Chetwynd and Dawson Creek, and about five hours drive away from Prince George. Incorporated in 1981, Tumbler Ridge was built to support the local activities of two coal-mining companies, Denison Mines and Teck Corporation. It was developed as the province's newest resource mega project. As a result, Tumbler Ridge has significantly higher income levels in comparison to provincial averages. With the recent depletion of coal, many believe that a closure announcement is imminent.

Vermillion, Alberta is located 2 hours east of Edmonton (the nearest tertiary care centre) and one hour from Lloydminster, Saskatchewan. Its economy is almost exclusively agricultural, including the local agricultural college. It was chosen to help address the farm/drought crisis issue as well as its lack of medical services. There is a general hospital available in town including emergency and maternity-care services. The physicians are almost exclusively immigrants from South Africa.

Clive, Alberta is situated in central Alberta, ten miles east of the province's main highway corridor between Edmonton and Calgary. It is a two-hour drive to Calgary or Edmonton. The next largest urban centre is Red Deer which is approximately a 45-minute to one hour drive. All specialists are located in Calgary, Edmonton or Red Deer. General practitioners and a regional hospital can be accessed in the town of Lacombe, which is a 20-minute drive. The region has a solid agricultural base that includes large intensive livestock operations. Many of the farms are third and fourth-generation family farms. The oil and gas industrial activity is also very strong, with the local presence of some of the largest gas plants located in North America.

Fort Chipewyan, Alberta is a Métis community located in northern Alberta. No other information about the community was made available in the facilitator's report.

Yorkton, Saskatchewan was chosen as a central location to everyone who had a farm background. No information about the community was made available in the facilitator's report. Included women from Manitoba and from northwest part of province and only one from Yorkton. One from Kelleher which is one hour away.

Watrous, Saskatchewan is one and a half hours southeast of Saskatoon. It has a small hospital which mainly delivers long-term care and respite but also has an emergency room. The main industry is agricultural and potash mines. Historical healing waters of Manitou beach is a spa which attracts seniors. More of a community group. Participants came from 30 miles away.

Oakbank, Manitoba

No information about the community made available in the facilitator's report.

Lion's Head, Ontario is located 30 minutes north of Owen Sound and three and a half to four hours north of London, Ontario (the nearest tertiary care centre). Its economy is mixed recreational (being on the Bruce Peninsula of which part is a National Park) and agricultural. Like Markdale, it was chosen because of its distance from care particularly in the winter season.

Markdale, Ontario is located 30 minutes south of Owen Sound and two and a half to three hours north of London, Ontario (the nearest tertiary care centre). Its economy is largely agricultural. It was chosen because of its distance from care which is particularly exacerbated in the winter season as it exists in the "snow-belt" It is also nearby to Walkerton, Ontario and therefore the issue of water safety was most salient.

Woodstock, Ontario is located 45 minutes east of London, Ontario and 90 minutes west of Toronto. It is accessible via Hwy. 401. Within the town itself, there is light industry (auto-parts manufacturing, quarry just outside of town, etc), but there is a significant agricultural community (dairy, cash crops—corn, tobacco...). It houses one of the experimental farm sites for the University of Guelph and is home to the outdoor farm show. It was chosen because of its agricultural connection and also because it is experiencing a dramatic shortage of medical personnel. It also has a sizeable elderly population.

Cobourg, Ontario is located 90 minutes east of Toronto on Hwy. 401. It has a mixed economy including recreational (located on Lake Ontario and with several other lakes within the district), farming, and a fairly large retirement community (from Toronto). Like Woodstock, it was chosen because of its shortage of medical personnel, sizeable elderly population and because of its mix of recreational and agricultural economies.

Forteau/Port Hope Simpson/Mary's Harbour, NFLD/LB

No information about the community made available in the facilitator's report.

Marystown, NFLD

No information about the community made available in the facilitator's report.

Fort Smith, NWT region encompasses the area south of Great Slave Lake—hence it is named the South Slave Region. Fort Smith is a town and has a hospital. All health and social services are contained in the facility. Fort Smith is at the end of the road but sits on the Alberta border. There is road access through Wood Buffalo National Park (straddles the border).

Hay River, NWT encompasses the area south of Great Slave Lake—hence it is named the South Slave Region. The town of Hay River is the largest community south of the Lake. It has a hospital, road access, a train and airport. Hay River Community Health Board serves Enterprise and the Hay River Reserve. The physicians are fee-for-service. Hay River is known for its business community.

Inuvik, NWT region encompasses the area north of the Great Slave Lake, along the MacKenzie River, north to the Arctic Ocean. The town of Inuvik is the second largest community north of the Lake. It has a regional hospital. Inuvik Regional Health and Social Services serves 13 communities:

Inuvik	Paulatuk
Fort Good Hope	Tuktoyaktuk

Tulita	Coleville Lake
Holman	Norman Wells
Fort McPherson	Aklavik
Tsiigehtchic	Deline
Sachs Harbour	

There are three very distinct regions—Beaufort Sea, MacKenzie Valley and the Delta. Inuvik is in the MacKenzie Delta. There is road access from Inuvik across to the Yukon via the Dempster Highway. There is a full-size airport. Water transportation is used to access the other communities in the region. In winter the ice roads are used.

Yellowknife, NWT Region encompasses the area north of the Great Slave Lake. It is sandwiched between the South Slave Region and the Inuvik Region. For the purposes of this project, I included the Deh Cho and Dogrib regions in with Yellowknife. Yellowknife is the capital city. It has a city health and social services board and it has Stanton Regional hospital. Stanton is the largest hospital and is the hub of health and social services—for better or worse.

There are a total of 18 communities in these three regions:

Deh Cho	Dogrib	Yellowknife
Fort Simpson	Wha Ti	Yellowknife
Kakisa	Wekweti (Snare Lake)	Dettah
Trout Lake	Rae	Fort Resolution
Fort Liard	Edzo	Lutsel'ke
Nahanni Butte	Rae Lakes	Dettah
Jean Marie River		
Wrigley		
Fort Providence		



Endnotes

-
- 1 Section D of this report.
 - 2 Note that this is a free service.
 - 3 Referring to a First Nations person with treaty status.
 - 4 Emergency measures personnel.

Appendix D

Demographic Survey

Rural and Remote Women's Health Focus Group Demographic Survey

Thank you for agreeing to participate in this joint research project involving Centres of Excellence for Research in Women's Health in four regions of Canada. This research has been funded by the Women's Health Bureau of Health Canada. The research in this project is being administered by the National Network on Environments and Women's Health (NNEWH), based at York University in Toronto. Dr. Suzanne MacDonald and Marilou McPhedran are responsible for this study at York University. You can reach Marilou at marilou@yorku.ca or by phoning 1 416 736 5941 if you have any questions or concerns. Collect calls will be accepted if you mention that you are a focus group participant.

Before we begin today's focus group discussion, we are asking you to take a few moments to write your answers to the short survey in the space provided below. You will not be identified in the report on the results of this focus group. Information from this survey will be used to produce a summary profile of focus group participants in different parts of Canada, without any individual being identified.

Completion of this survey is voluntary. You may refuse to answer any specific questions on the survey. Please place your completed survey back in the unmarked envelope and put it into the box near the focus group facilitator. If you do not wish to complete this survey, please place the blank survey form back in its envelope and place it in the box. Thank you very much!

Questions

1. How old are you?
☐ 16-25 ☐ 26-35 ☐ 36-45 ☐ 46-55 ☐ 56-65 ☐ 65+
2. What level of schooling did you complete? _____
3. Is your personal annual income, after taxes:
☐ \$15,000 – 24,999 ☐ \$25,000 – 34,999 ☐ \$35,000 – 44,999 ☐ Above \$45 000
4. What is your occupation? _____
5. What is the approximate population of your community in the rural or remote area where you live? _____
6. What is your present marital status?
☐ Single ☐ Married ☐ Unmarried and living with partner
☐ Separated ☐ Divorced ☐ Widowed
7. If you have children, what are their ages? _____
8. a) Do you live in the same geographic area as where you work? _____
 b) How many miles one way do you have to travel to work? _____
9. If different from where you live, what is the approximate population of where you work? _____
10. Approximately how far/how long do you (or your clients/ the women you represent) have to travel to reach the closest:

nurse?	distance _____	travel time _____	don't know _____
nurse-practitioner?	distance _____	travel time _____	don't know _____
physician?	distance _____	travel time _____	don't know _____
specialist?	distance _____	travel time _____	don't know _____
alternative health care provider?	distance _____	travel time _____	don't know _____

Appendix E

Focus Group Interview Guide

- *Health*
 - What are the things, such as assets/resources/services that promote your health/the health of your clients? (Facilitator may need to prompt people here to think broadly beyond physical health and health care, e.g. spirituality, economics, workplace issues, division of labour; mental health, threats of violence, environmental concerns etc.)
 - What are things, such as barriers/attitudes/rules/lack of services that threaten your health/the health of your clients?
- *Rurality*
 - When you think of rural and/or of living remotely, what comes to mind?
 - Do you think of yourself as a rural woman? As someone who lives rurally or remotely? Both?
 - What makes your life rural and/or remote?
 - In what specific ways does living rurally or remotely affect your health or the health of those in your care? (e.g. geographic dispersion of services, income, employment conditions, access to education, social expectations and attitudes, weather/seasonality, degree of social support, quality of social relationships, housing, recreation etc.)
- *Policy Framework:*
 - “If you could have the undivided attention of key health-decision makers to talk about the state of women’s health in your community, what issues would you raise?”
 - “If you could change two things to promote better health of women in your community, what would they be?”
 - “How satisfied are you with the quality of health and health care for women and girls in your area?”
 - “Do you think the quality of health care for women in your area has changed in the past two years? In the past five years? For better or worse? Please give examples.
- *Research Agenda:*
 - “How would you define “your community”? Are there women’s health issues about which you think more information is needed in order to prompt appropriate action in your community or region?”
 - “To put it another way, have you ever felt concerned or curious about some aspect of women’s health care in your area and wished that someone would look into it further?”
 - “Based on a review of research that has already been done, the following gaps in research were identified: [**insert gaps listed in Wakewich paper here**] How important is it to the women and girls of your community for more research on each of these topics to be done?”
 - The Centres of Excellence do research that involves community members from the start. Do you have any suggestions on how to improve this model?
 - Are there any other issues relevant to policy, research and the health of rural women and girls that you think we should address?
- *Wrapping Up:*
 - “Although all of this information will be given to the Centres of Excellence for Women’s Health to be included in the research project, there may be a few themes or issues which have particularly stood out for you as you listened to everyone’s perspectives today. What are they? Is there anything else you would like to say?”
 - “I want to thank you for your time and your very helpful contributions. Your willingness to meet with me today makes this focus group possible. The focus groups of women in rural and remote areas across Canada will produce the core of the knowledge that this research project will generate. It could not be done without you. I’ve been asked by the women who are working on this project who are not here with us today to give you their sincere appreciation for helping in this way. We all hope that by giving our time and expertise to this project that we can make some real changes for women and girls living in rural and remote areas of our country. Thank you very much.”

Appendix F

Instructions to Facilitators

This is a community/academic partnered research initiative of the four Centres of Excellence for research in women's health (the Centres) and the Canadian Women's Health Network, funded by the Women's Health Bureau of Health Canada. The co-investigators of this project are Dr. Suzanne MacDonald and Marilou McPhedran of York University in Ontario. The following guidelines were developed by the Research Steering Committee of this project, chaired by Dr. Barbara Neis of Memorial University in Newfoundland and coordinated through the National Network on Environments and Women's Health—NNEWH, the Centre of Excellence based at York University. These Guidelines are to be followed by all of the Centres and their contractors in developing, conducting and reporting on focus groups with women in different regions of Canada, as an integral part of this research initiative. All documents and materials, in original form, as specified in these Guidelines and in the agreements made between NNEWH and other Centres as well as between Centres and those retained by the Centres to facilitate, record and report on the focus groups are to be delivered to Marilou McPhedran at NNEWH, 214 York Lanes, York University, 4700 Keele Street, Toronto, ON M3J 1P3, for further analysis and secure storage. Questions and suggestions should be directed to the Research Steering Committee, through Marilou at marilou@yorku.ca.

Focus Group Outcomes

- Each focus group facilitator should deliver to her respective contracting Centre, which in turn will be delivered by each Centre to NNEWH:
 - The originals of the signed consent forms, as well as the written demographic surveys completed by each focus group participant;
 - A summary of the demographic survey results, without identifying participants, including commentary on who was or was not in attendance and why, with suggestions for improvement, if any;
 - A synthesis report on findings, organized according to the subheadings of the questions beginning on page 3, below;
 - The original audio tapes of the complete discussion of each focus group (identification of the speakers is not expected), as well as the written summary prepared by the focus group recorder, including all questions asked and any answers. Note: copies of the audio tapes may be made and kept by the Centres but not by the facilitators or recorders, unless specific written permission has been granted by agreement with the respective contracting Centre and NNEWH;
 - A list of names and contact coordinates of possible invitees to the National Think Tank in January 2003, drawn from those participating in the focus groups, who have indicated an interest in attending and, in the opinion of the facilitator, would contribute their perspectives actively and add to the diversity of representation at the Think Tank (see consent forms);
 - A list of names and contact coordinates of those who indicated that they would like to receive the final report of this project (see consent forms).

Focus Group Facilitator's Responsibilities

1. The facilitator is responsible for thorough preparation including: a) ordering appropriate refreshments, b) ensuring that the audio-taping equipments and tapes are ready and in working order, c) ensuring that a recorder is in place to ensure full recording of the entire discussion, and, d) arranging for compensation for reasonable expenses. In the focus groups, the facilitator is responsible for explaining the context, expectations and objectives of the meeting, as well as the intended audiences and follow-up plans for any information generated. Wherever possible, we would like facilitators to provide the

consent form in advance to participants of the focus group(s) to give time for review. The following examples, in quotations, of what should be said to the focus group participants are given to assist facilitators and to ensure that focus group participants in different regions receive similar information:

- a. *Context*: “This meeting is one of several focus groups around the country. This is the second part of a national project hosted by the Centres of Excellence for Women’s Health. The project has an advisory committee, which includes women such as you. We hope to develop a policy framework and research agenda on rural and remote women’s health, which can be used by the federal, provincial and regional governments. The first phase was a literature review and roundtable discussion, late in 2001. Later phases will include a national conference in January 2003, followed by a final report to health policy makers and researchers. You are welcome to receive a copy of the final report. Please just leave your name and address on our mailing list.”
 - b. *Objectives of this session*: “Today we’d like to hear your thoughts about health, health care and its availability for you and your community, and other factors which affect your health. We won’t be making any decisions in this focus group and we don’t expect that we will all agree with each other about many of the points we discuss. But your comments will help us all to reach a better understanding of what health issues are important for women who live in rural Canada. We are interested in what you have to say about the availability and quality of health care services of women you know. We know that women are usually responsible for the health of all their family, but our questions today are not about your personal health or how you help care for family and friends. This afternoon’s focus group is a chance to hear your expertise and experience, which will be included in the findings of this research project. We are interested in your opinions of women’s health issues in your community.”
 - c. *Follow-up*: “The audio tapes from today’s meeting, a written transcript of the audio-tapes, a summary of today’s discussion and a summary of the written survey that you filled out will be delivered to the Research Steering Committee, and then combined with results from across the country. We will include your thoughts in the research report, which will be part of the national conference on rural and remote women’s health in 2003. Finally, a discussion paper with recommendations for a new research agenda and policy framework for rural and remote women’s health will be prepared after the Think Tank and submitted to Health Canada. As the focus group facilitator, I am responsible for preparing the summary report on this focus group without identifying any of the individual speakers and I will send you a copy to review before the summary is submitted to the Research Steering Committee. Please let me know if you would also like a copy of the final report and if you want your name listed in the report in our thanks to focus group participants. I need to have this in writing from you, as part of the consent form that you have already signed.”
2. The facilitator is responsible for obtaining signed informed consent to participate from each person in attendance, as per the attached consent form IN ADVANCE OF THE FOCUS GROUP. Facilitators should be aware of the parameters of the study (e.g. women will not be asked or encouraged to discuss personal health matters).
 3. The facilitator is responsible for ensuring that each participant completes and returns the attached demographic survey at the start of the session.
 4. The facilitator should pay attention to who is and who is not in attendance. (For example, how did people come to be there? How might the process of recruitment have excluded some women or points of view? What is likely to be present/absent in the discussion because of who is there?) This will then be reviewed with the Director of the Centre and

included in the focus group summary. Focus group participants should be invited to comment on this concern.

5. The facilitator should then guide the group through a discussion of the topics described below. Facilitators should remember that the discussion should not be limited to health care and service delivery, but should reflect a broad understanding of the social determinants of health, for example, education, economics, laws and policies, social services. It should also adopt both an appreciative and critical orientation, soliciting reflection on both what is and what is not working well for women and eliciting suggestions for achievable, positive changes. Facilitators must ensure that the questions listed are addressed, but other issues that emerge as relevant to participants should also be pursued and noted during the discussion.
6. The facilitator is responsible for ensuring that the session is both tape-recorded and accurately recorded on paper. Doing and/or checking the recording during the session should be the responsibility of a recorder rather than the facilitator.
7. The facilitator is responsible for ensuring a smooth flow to the session, including setting a positive tone, staying on topic, keeping time, taking appropriate breaks, encouraging full participation, and taking the time at the end of the group to thank the participants sincerely for their invaluable contribution of time and expertise, on behalf of all the women who are cooperating on this research project.
8. In some cases, face-to-face small group sessions may not be possible. In order to include women living remotely, the process of data collection may need to be modified through the use of telephone and/or video conferencing.
9. The facilitator is responsible for generating a focus group summary in two parts: one of the demographic data and the other of the discussion themes outlined above.
10. The facilitator should create and hold a master list of focus group participants drawn from the completed consent forms and should assume responsibility for sending copies of the summaries to those participants in a timely manner.
11. In consultation with the Centre, the facilitator should review answers on the consent form and, using her own good judgment, generate a list of potential invitees to the National Think Tank.
12. The facilitator should be prepared to provide the participants with follow-up support or appropriate referrals to community supports (if necessary). It is important to have at least one other person with the facilitator who is present and available to record the group discussion as well as to provide support to participants who could experience some difficulties/challenges that may arise during or as a result of the discussions.

Appendix G

Project Consent Form

SCHEDULE B – Consent Form

[NOTE to the Facilitator: Please try to distribute this form to participants in advance of the focus group and to follow up with a phone call in case there are questions or concerns.]

Dear Ms. _____.

Your name was given to me by _____ who suggested you might be willing to participate in a focus group we are conducting. The focus group concerns health issues for women living in rural and remote areas of Canada. These focus groups have been organized to allow us to hear your voice on the nature of the health services that you have accessed and your assessment of the quality of health care actually delivered over the past decade or so. This is a joint research project with Centres of Excellence for research in women's health in different regions of Canada that has been funded by the Women's Health Bureau of Health Canada. The research in this project is being administered by the National Network on Environments and Women's Health (NNEWH), based at York University in Toronto. Dr. Suzanne MacDonald and Marilou McPhedran are responsible for this study at York University.

The focus groups will be held on _____ from _____ to _____. We are asking for approximately a half-day of your time. You will be provided \$ ____ to help pay for any costs associated with taking part in this study (e.g. travel and child care costs). This money will be given to you at the start of the focus group session, and will be yours whether or not you refuse to answer any questions or whether or not you complete the session.

The format of the focus group will be a short written survey with questions for you to answer and some additional questions for the group discussion that will help us understand your perspective on services in rural and remote areas, including social programs and social services related to women's health. We will be asking you to suggest changes to policies and practices that would improve your access to services and improve the services available to you, other women and girls. We will not ask you to discuss your personal health matters. You may refuse to answer any specific questions on the survey or in the group. You should also feel free to offer opinions and information on issues or subjects not raised by the facilitator that you think are relevant to this research. You are free to withdraw comments at any time.

After the focus groups are completed and the tapes are transcribed, a draft report containing summaries and unidentified quotes from the focus groups will be prepared. You will be given the opportunity to review the draft report from your group. Results from these focus groups will be compiled and summarized for the project's research committee, which includes community leaders, researchers and policy makers. Findings will also be summarized in a final report to Health Canada from this project and possibly in publications generated from the research. The contents of the final report will be communicated to local communities, health care professionals, and policy makers through a national "Think Tank" to be held in early 2003.

Please feel free to contact York University Human Participants Review Sub-committee with any questions or concerns - research@yorku.ca or telephone: 1 416 736 5055. Requests for copies of the focus group summary should be directed to Marilou McPhedran, Executive Coordinator, National Network on Environments and Women's Health, York University, 214 York Lanes, 4700 Keele Street, Toronto, Ontario, M3J 1P3. Email: marilou@yorku.ca or telephone: 1 416 736 5941; fax: 1 416 736 5986.

I hereby agree to be interviewed in a focus group on women's health in rural and remote areas of Canada, subject to the conditions listed above. I agree/do not agree to be identified by my name in the acknowledgments in the final report.

I am/am not interested in a possible invitation to the national Think Tank in early 2003.

Your Name [please print]: _____

Signature: _____ Date: _____ /02

Address: _____
