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

Synthesis of Themes

By Rebecca Sutherns, PhD

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Synthesis of Themes

Introduction

This section synthesizes the findings that emerged from all of the data sources for this project: both literature reviews, both focus groups summaries and the national consultation. The two following sections outline the research and policy recommendations emerging from these findings.

Overall, there was a high degree of consistency both among the focus groups and between the focus groups, the national consultation priorities and the literature review findings. Where an issue was emphasized particularly strongly, and/or was highlighted in one area of data collection but not in others, this is pointed out in the text.

The Big Picture

Regarding general issues of health and rurality, women spoke of "juggling acts" and tradeoffs they face as they grapple with the personal consequences of structures and systems that have failed them. The women who participated in the focus groups raised four main issues, also echoed in the literature reviews, which provided the backdrop for more detailed observations:

1. *Rural women are largely invisible to policy makers.*
   Participants felt ignored and misunderstood by policy makers who are used to

operating in urban contexts. Similarly, research on rural women in Canada is scarce in the literature.

2. *The health-care system is perceived as underfunded and deteriorating.*
   Women around the country described the health-care system as strained, vulnerable, unreliable and insufficient to meet their needs. This parallels the preoccupation in the literature with poor rural access to health services.

3. *Efforts to restructure that system have exacerbated rather than improved an already vulnerable situation.*
   According to participants and the literature, cutbacks in services inherent in health reform have led to more travel, more stress, and less personalized care for rural and Northern residents.

4. *Financial insecurity, primarily as a result of unemployment, job insecurity, low wages or seasonal work, is a key determinant of health for rural women and their families.*
   Many rural places are single industry towns and/or rely heavily on seasonal primary resource production such as farming and fishing. Income streams are frequently limited or inconsistent, and the implications on health are far reaching. These include, but are certainly not limited to, greater stress and isolation and poorer access to health services.

Despite grave concerns about the state of rural-health care, participants did stress the health benefits of living rurally. As one participant in Cobourg said, "We have all these wonderful trees and rocks and the lake and to me that's an extremely beneficial thing." Rural-health care may be in crisis, but for many women rural health is not. In either case, rurality is an influential determinant of women's health, often functioning both positively and negatively in their lives. Specifically how that happens differs according to the wide diversity of rural people themselves.

What do Rural, Remote and Northern Mean in Canada?

Definitions

In much of the literature on rural and remote health, there is considerable debate over definitions of terms. There is no standard definition of rural, remote or northern used in policy, research or planning, because different criteria, levels of analysis and methodologies are used. This is further complicated because how rural is "defined" in research studies and policy documents is often implied and not explicitly stated.[1]

Largely in response to this ongoing debate, this project did not start with a glossary containing firm definitions for concepts such as rural, remote, northern and health. This was an intentional element of the design, emerging from a desire to learn from participants' understandings of what it means to be a rural, remote or Northern woman. This approach caused some difficulty for the women, as they seemed to be expecting to be told what the researchers' definitions of terms were.

In the end, women did not craft precise definitions of rurality and health, though they had a clear, "common sense" understanding of what those terms meant to them. In the case of one group of Métis women, they resisted the labels "rural", "remote" and "Northern" altogether, preferring to be identified only as "Fort Chipewyan women."[2]

Many of the other women considered themselves rural, although some excluded themselves from that category since they did not live on farms. Few self-identified as remote. "Remote" places were seen as totally isolated, often fly-in communities with limited road access and no telephone service. "Rural" in many cases was equated with travel time and having to drive to get anywhere. It was also variously associated with low populations, dispersed or limited services, closeness to the land and knowing and being known by one's neighbours. The distinction between "farm" and "town" was notable within the category of rural, as it often shaped women's experiences of rural life. "Northern" was talked about less often, but in some cases described places that are neither rural nor remote, but that nevertheless present their own challenges for women's health.

Upon further reflection, participants began questioning the idea of remoteness, asking "remote from what or whom?" Many Francophone participants, for instance, felt remote because of their distance from French-language health and social services.[3] Others talked about feeling remote when friends and family were not living nearby, or when Internet access was not available. Remoteness was therefore not always similarly understood in relation to a fixed [urban] point of reference.

In Search of a Rural Culture

Although precise definitions of rurality proved elusive, participants did demonstrate having a clear sense of what rurality meant to them. Throughout the country, women consistently described a rural culture, although its characteristics varied. For some, living rurally meant being self-reliant and "making do" without complaining. For others, rural people were either "hicks" or "transplants." For still others, rural culture was indistinguishable from their ethnic or linguistic heritage. In all cases, women highlighted the need for culturally specific and appropriate health-care provision. So is there a rural culture in Canada? Yes and no. There are rural *cultures*. What are they like? It depends. Analyses must be context specific, and further research is needed into the factors that influence how rural culture affects women's health.

Contradictions by Another Name

This understanding of rural culture as both important and varied is key to understanding the findings of this project. At first, many of the findings appear to be at odds with one another; every observation has its corresponding contradiction. What one person describes as peaceful, another describes as isolated. What one woman perceives as helpful support from family and friends, another perceives as meddling. Living rurally may be safer in some ways, and riskier in others. Rural doctors' knowledge of their patients may result in care that is perceived as inferior and superior at the same time. Some rural families get better access to nutritious food; other more remote families report having very few affordable healthy-food choices. For some women, living rurally means walking everywhere, whereas for others rural distances make walking anywhere virtually impossible. In some provinces, living in the North means "more of the same but colder," whereas in other places, Northern living is markedly different from life further south.

What to do with these tensions? They obviously present a challenge to policy making. They should not, however, be seen as a flaw that makes these findings less convincing. Quite the opposite is true. These apparent contradictions point to the diversity of rural Canada. Rurality does have an identifiable

culture, but that culture varies according to its context. Rural life is not the same, for example, for Métis women as it is for Francophone women or for women living on Baffin Island or within commuting distance of Toronto, nor is it necessarily the same even within any of those groups. Rural culture must therefore always be taken into account, but these findings underscore the need for that culture to be explored at local levels so that its distinctive characteristics can inform appropriate policy. When it comes to rural research and policy making in Canada, one size clearly does not fit all.

Living Rurally

Women in this project spoke at length about the positive and negative aspects of living in rural areas. In this section, their observations will be discussed according to the physical and social environments of rural places.

Positive Features

In the focus groups in both languages, as well as at the national consultation, women spoke frequently about the positive influence living rurally has on their health. Their comments stand in sharp contrast to the published literature on rural health, which focuses almost exclusively on rural deficits.

Many of the participants' positive comments addressed the physical environment. They spoke, for example, of living where it is "pretty", "clean", "peaceful", "safe" and "quiet." They reported enjoying more time and less traffic than their urban counterparts. They specifically affirmed having less busy hospitals. They praised their ready access to fresh air, wildlife, beauty, recreation and the outdoors. One woman from Creston, British Columbia put it this way, "It's a lovely community…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."

Many participants were similarly positive about the social environment in rural places. They spoke of lower stress, strong community spirit, and the benefits of close ties with one's neighbours. As one Métis woman said, "When tragedy happens, it's like one big family here." They also talked about the benefits of participating in rural community groups. According to one women from Vermillion, Alberta:

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

For some, this positive social support translated into higher quality health care, due to providers knowing their patients and having a long-term commitment to the community.

Negative Features

Some of the negative features of living rurally that appear prominently in the literature were echoed by the women participating in this study, although tempered by the positive descriptions outlined above. Their concerns related to the absence or fragility of community infrastructure: insufficient childcare services, no public transportation, inadequate housing (especially for seniors and the disabled), limited local-educational opportunities and few jobs. The lack of health-care

services was frequently mentioned and will be addressed separately. As an Oakbank, Manitoba resident explained, "If you have access to childcare and transportation, to resources and to community support, then you're more able to make decisions that will help you promote health."

Other concerns addressed the physical environment, including concerns about air and water quality, severe winters and drought. One Alberta farmer described it this way,

We live with uncertainty…I still think that we have a lot of stresses that other people don't. 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 we have to draw on that other people never even touch.

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Participants also spoke negatively about social dimensions of rural life. Some mentioned drug and alcohol addictions, as well as family violence. As one woman from the Northwest Territories put it, "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." Others talked about the loneliness of seeing their extended family members leaving the area, usually for educational or employment reasons. Some felt socially isolated because of not being "from there", in some cases despite having lived in a place for many years. Many women reported feeling invisible, but at the same time never anonymous in a small community. This lack of confidentiality was linked to stigmas or taboos, particularly among young people, that result in people leaving the community or failing to access services within it for fear of being seen or talked about. Coakes and Kelly (1997) have described these tensions this way, "as a way of coping with being too close [in small communities], individuals create emotional distance, in turn exacerbating any feelings of isolation. In effect, individuals are simultaneously too close and too distant."[4]

Gender issues were highlighted as another negative feature of rural life. Rural society was repeatedly characterized as conservative in their expectations of women. Stress, role strain and burnout among rural women were emphasized again and again. Women reported fatigue from having to work multiple jobs, both inside and outside the home, or frustration at being limited in what roles they were allowed or forced to perform. They specifically mentioned "volunteer burnout", and the pressure in a small community of "having to get involved or it won't get done." This juggling act was linked to being "too busy to be sick" or to seek health care. One Francophone participant addressed women's role strain this way, "It boils down to voicing our expectations, the expectations society puts on us, the expectations we put on ourselves, the expectations our husband puts on us, the expectations our children put on our shoulders. Some days, I ask myself how women manage." Another woman specifically highlighted the stresses on caregivers:

The women who take care of their parents end up putting their own health in jeopardy because they are doing work they are not trained for…These women end up getting sick themselves because they don't have the necessary tools and they don't have the necessary training. They work ridiculous hours without getting paid…and they end up living in poverty.

Health as Health Care

Another of the most consistent findings was the tendency for women to equate health with health care. On its own this may not be surprising, as this trend is strongly echoed in the rural health literature and popular media. What is more striking is the way in which rural women characterized their health and lifestyle as positive but rural health care as sorely inadequate. To the extent that researchers and the media focus exclusively on health care, at the expense of broader understandings of health, they miss the positive health features of living rurally.

Amount of Care

Poor access to health services was mentioned without exception in every focus group, as well as at the national consultation and in the literature. Women were aware of the difficulties facing health-care workers and policy makers in meeting the needs of rural people. They therefore often seemed reluctant to communicate dissatisfaction without qualifying it with expressions of appreciation for the efforts being made to provide care. On the whole, however, participants were very concerned with the level of service they can readily receive.

Within this theme, what stood out was women's lack of emphasis on physicians. They spoke of the need for more dentists, optometrists, midwives, home-care workers, mental-health workers and physiotherapists. They wanted easier access to complementary or alternative-health practitioners. They talked about ambulance services being scarce or expensive. They discussed the stress they experience when local health services are no longer available, or closures are threatened. They reported frustration at their lack of access to health information. They acknowledged the lack of physicians, but moved the conversation quickly beyond that.

When they did talk about doctors, participants frequently lamented the lack of access to family physicians in Canada.[5] They mentioned the scarcity of specialists in rural areas, and long waiting lists. Perhaps more interestingly, women talked about the implications of doctor shortages on their lives: in addition to having to travel, which will be discussed in a later section, physician scarcity limits choice. Many women spoke passionately about preferring to be in the care of a female doctor, a preference clearly echoed in the literature[6], but they rarely have that option in rural places. Others spoke of their desire for a second medical opinion, but when finding any doctor is problematic, consulting a second one is nearly impossible.

Quality of Care

The availability of health-care services is closely tied to the perceived quality of those services. For many in rural Canada, satisfaction with health care quality is seen as a luxury when basic access to primary care is unavailable. When you have no choice of doctor, there is little point in thinking about whether or not you are happy with the services that doctor provides.

Nevertheless, women did widely report four main concerns with the quality of their health care services. The busyness of health-care workers was the first concern. This busyness has many implications, including long waits, rushed care and burnout of health professionals. As woman from Alberta recounted, "The best care I ever 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." Second, women reported concern over the lack of female health care providers and its impact on care quality. They spoke, for

example, of their reluctance to discuss sensitive issues with a male physician. They also recounted experiences where male doctors were insensitive or patronizing. A third concern had to do with being known too well by local physicians. Although some women felt that being known by their physician led to more personalized care, several others expressed concern about potential breaches of confidentiality and/or doctors becoming careless. In some rural places, women reported a perceived lack of commitment by physicians who were not planning to stay long in the community, resulting in a lack of continuity of care.

At a broader level, some women reported concerns with the quality of rural-health policy. They spoke of being too far away from urban-based decision makers, who do not understand how health-care delivery models need to adapt to rural realities. They stressed, for example, that "mapping distance as the crow flies" is not an adequate tool for rural-health planning. Because distance emerged as such a frequent recurring theme, it warrants a separate discussion below.

When women spoke of being satisfied with their health care, that expression of satisfaction was frequently followed with, "but…," or it seemed to reflect low expectations rather than high-quality care. The one notable exception to the concerns raised about rural-health care quality was the community-health centre model. It was mentioned in numerous groups, and was spoken of very highly in terms of its holistic approach and its rootedness in rural communities.

In contrast, the literature on rural women's health in Canada speaks very little to issues of quality beyond the ability to access services. There is considerable research on health-care quality and reports of satisfaction, but it does not deal explicitly with rural women's concerns.

Implications of Distance

One of the characterizing features of rural life is the need to travel away from home to obtain services of any kind. Women spoke at length about the far-reaching implications of what some might see only as an inconvenience. They talked about the financial, emotional and social costs of travelling to obtain health care. Gas or flights are expensive, as are hotel rooms, parking, food, childcare and forfeited income. They also reported high levels of stress associated with being away from their family, especially during health crises, and having to make complicated arrangements to help family members and employers cope with their absence.

These multiple costs and inconveniences are largely borne by women, as they are often responsible for scheduling activities, maintaining the home and monitoring the emotional climate of the family. As one Francophone participant put it, "Obviously, it's often women that give the support needed. They take time off work, they pay the babysitter, they travel. So it always ends up falling on the woman's shoulders, financially or socially."

Moreover, the costs of distance are incurred regardless of whether the appointment proves helpful or not. Some women reported having appointments cancelled once they got there, or taking a whole day to travel to a five-minute appointment. They felt their time was considered less valuable than that of health-care providers, most of whom did not take into consideration how difficult it had been even for the women to get there. For example, one Vermillion, Alberta woman told her story this way:

You could drive all the way to Edmonton for this big special appointment, and you get there and five minutes later you come out. 'What did they say?' 'Oh, just keep it like that.' Well, you know, we had a list of concerns and had waited a month or

better for that same appointment…and you didn't get any answer. You just came home totally frustrated even more. And you wasted a day.

Another woman described chronic disease as "a huge expense on a rural family." She went on to explain:

I don't think people in the city have any comprehension that it 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 overnight. When my youngest was flown to Edmonton when she was born, I mean I literally had to pack up suitcases and move to Edmonton for two weeks. That was the only way we could do it.

The implications of these costs are clear, and they extend beyond financial costs. Many times women reported not bothering to seek care until they were very sick, just to avoid the hassle. Appointments for preventive measures are therefore rarely made.

Other dimensions of distance had to do with weather and transportation. Although a regional centre with health services may not appear far away on a map, at certain times of the year it may be virtually inaccessible due to winter weather. Since public transportation is rarely available in rural places, if women do not have a vehicle, they cannot get to services even if they are not very far away. As one focus group participant put it, "To go to the doctor's, although it's less than five minutes away, because I don't drive, unless my husband takes time off work, I have to count on someone else to take me."

Seasonality of work also affects health-care access in rural places. Since many rural residents are employed seasonally, they try not to leave home to seek health care during peak work times such as harvest so as not to miss the opportunity to earn income at that time. If services were available locally, seasonality would have less of an influence on access.

These findings point to the importance of qualitative data in helping to understand health utilization behaviour. Space and distance are clearly social as well as physical phenomena. Currently, Canadian literature on rural health-seeking behaviours and the social geography of health remains limited.

Variations in What Was Said

Overall, there was a high degree of consistency in what was said during the various phases of data collection for this study. There were, however, moments where emphases differed so dramatically that they warrant separate mention. Reasons for these inconsistencies are offered as possibilities only.

For example, the topics ranked of highest importance at the national consultation included the impact of poverty and of violence on health. Although these structural determinants of health figure prominently in the literature also, they did not emerge out of the focus group data strongly at all. This likely reflects the composition of the focus-group participants and the safety they felt to disclose sensitive information more than the actual salience of those issues.

Similarly, in the literature and the focus groups, scarcity of physicians was a common theme. At the national consultation, this was not mentioned at all. Again, the absence of the issue is not likely a reflection of its lack of importance. In this case, it may be attributable to the participants at the consultation focusing their energy on changes they felt were both more fundamental and more achievable. Physician shortages have been well documented; it is time for some new ideas and perspectives on rural health to emerge.

The literature on rural health, although not primarily biomedical, is heavily focused on specific diseases and conditions. Very rarely did those come up in the focus groups or at the national consultation. It could be that in a group setting, participants did not feel that a particular health condition of importance to them would be as relevant to the group as a whole. The discrepancy may also reflect the desire of women to deal with root causes and larger contextual issues relating to rural health rather than taking specific diseases as their starting point; an approach consistent with the models of health care women most often report preferring.

The research literature also spends much more time on definitional issues than did the women themselves. Participants had a strong, almost intuitive sense of what was meant by rural and remote and were interested in moving beyond definitions quite quickly.

Conversely, the rural-health literature in Canada has little to say about the positive aspects of living rurally. The focus group and consultation participants spoke much more freely and at length about what is attractive to them about life in rural places. Some women were quite explicit about having deliberately chosen rural life, fully aware of the tradeoffs and compromises that entails.

Finally, the need for a research centre that focuses on the concerns of remote and Northern women was raised at the National Consultation. There is limited research literature on remote and Northern women in Canada, but the need for a Northern research centre was only briefly mentioned in any focus groups.

Summary

The key messages of this study can be summarized as follows:

- Rurality is a significant determinant of women's health. Its influence must be explicitly considered in health research and planning.
- Rurality is more than a geographic concept. It is also a cultural one, and that cultural influence can be far-reaching and powerful in women's lives.
- Rural Canada is highly diverse. The specific influences of rural spaces and cultures on health must therefore be studied in context, and care models adjusted accordingly.
- Rural health has both positive and negative dimensions. Women feel strongly that both sides should be taken into account.
- Women understand that health is more than health care, yet the two are often seen as synonymous. Rural-health care is viewed overwhelmingly negatively, particularly in terms of access to services.
- Income security, social support and gender intersect with rurality as influential determinants of health.

The themes described here will be revisited in the following two sections, first in terms of their influence on research priorities and finally in terms of their implications for policy making.

Endnotes

1 See www.hc-sc.gc.ca/english/ruralhealth/paper.html for a paper published by the Office of Rural Health in Health Canada that addresses definitions of rurality.

2 Skillen L. (2003). "We're Fort Chipewyan Women" Reflections of Métis women on health and health care. Final Report (unpublished). University of Alberta. Conducted as a focus group for the national study.

3 Because not all of the Francophone focus groups were held in rural locations, and some of the participating women no longer lived rurally, they may not have been as isolated from services as other women were who lived in more remote locations, regardless of the language spoken. Their isolation was therefore based more on language than geography.

4 Coakes, S. J., and Kelly, G. J. (1997). Community Competence and Empowerment: Strategies for Rural Change in Women's Health Service Planning and Delivery. Australian Journal of Rural Health, 5, p.27.

5 Participants were not directly asked if they had a family doctor, so it was not clear if they were reporting personal experiences with lack of access to primary care. This information will be explicitly gathered in the next phase of this project.

6 See for example Thorne, S. (1994). Women Show a Growing Preference for Treatment by Female Physicians. Canadian Medical Association Journal, 150 (9), 14667.