

# Rural Women's Health Issues in Canada

## An Overview and Implications for Policy and Research

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*Cet article résume les problèmes clés de santé physique, mentale et sociale chez les agricultrices canadiennes et décrit les récentes initiatives en politique et en recherches qui se préoccupent de leurs problèmes. Des suggestions pour l'avenir sont abordées.*

A review of the literature on rural health in Canada reveals that research about rural women's health is a relatively new area of scholarship. Nevertheless, the limited data reveal that within the rural Canadian context, physical, mental, and social health issues challenge women's ability to attain and maintain their health. Health policy in Canada has only recently begun to address rural health issues; health policy that specifically addresses rural women's issues is virtually nonexistent. This article summarizes key rural women's health issues and recent relevant initiatives, and suggests future directions for policy and research to advance rural women's health.

### The Rural Canadian Context

A commonly agreed-upon definition of "rural" does not exist in Canada. The various definitions that are proposed emphasize diverse criteria, such as population size, density, labour market, or settlement context (Office of Rural Health). Although characteristics of the rural context and rural people differ for each definition, some similar themes and conclusions are evident. Approximately 95 per cent of Canada's land mass is rural, and about 30 per cent of Canada's population (about nine million people) and about 20 per cent of women live in rural settings (Kirby and LeBreton; Sutherns, McPhedran, and Haworth-Brockman). Rural settings across Canada are diverse, ranging from coastal regions on the eastern and western boundaries, prairie and agrarian regions centrally, and northern areas that are characterized by forests, lakes, and subarctic conditions. Rural Canada includes small towns, as well as rural and remote settings

where few or no people live. Low population density and issues related to isolation and limited access to resources increase the further one moves from urban centers and from the forty-ninth parallel of latitude (Romanow). Rural areas also have higher unemployment levels and lower educational levels compared to the rest of the country (Kirby and LeBreton). In many small communities, young people of working age often leave to look for better opportunities, while seniors leave in search of better health care. Consequently, older individuals, children, and youth under 20 years are over-represented in rural areas (Kirby and LeBreton). In addition, more than half of Aboriginal peoples live in rural and remote Canada (Kirby and LeBreton).

The health status of people who live in rural communities, especially people in northern communities, is poorer than the rest of the Canadian population (Romanow). The life expectancy for rural people is less than the Canadian average, and disability rates, infant mortality rates, and deaths from cancer and circulatory diseases are higher in rural areas (Romanow). Indeed,

the health of a community appears to be inversely related to the remoteness of its location ... there is ... a progressive deterioration in health as one moves from ... urban centers into the remote hinterland areas. (Romanow 162)

Rural health needs stem from a variety of sources, including occupations such as farming and mining, demographic trends such as increased seniors' populations in some rural areas, and needs associated with the large number of rural Aboriginal peoples (Kirby and LeBreton). Limitations in resources that support health, such as secure jobs and affordable food, and community attitudes and expectations can also compromise health (Leipert 2002; Report of the Northern and Rural Health Task Force). Addressing these diverse issues requires a con-

certed and sustained effort on the part of many sectors of society, including government and the private sector. However, rural health needs are difficult to address when limited numbers of health care personnel exist in rural Canada, and where sparse populations and challenging weather and terrain compromise health care delivery. Recruiting and retaining health care professionals is challenging in rural and remote areas, and this is further compromised by present health care personnel shortages (Rennie, Baird-Crooks, Remus, and Engel; Romanow). The financial and social costs for rural residents to travel to access care and resources elsewhere are often prohibitive and further compromise residents' ability to address health issues.

Limited research exists about rural women's health in Canada (Sutherns, McPhedran, and Haworth-Brockman). Although some knowledge is available regarding the health of Aboriginal women and farm women, research regarding the health of rural women who do not live on farms, who are from diverse cultural backgrounds, and who experience disability is more limited. In addition, more information is needed about the health of both young and elderly rural women and of women with lifestyles that do not conform to the predominant heterosexual couple-oriented rural lifestyle, such as lesbian women and women who are single, divorced, or widowed.

Nevertheless, the limited knowledge about rural women's health in Canada does reveal some common themes. For example, rural women often have difficulty accessing health care that is respectful, that includes them as equal partners, that focuses on health promotion, and that is provided by female health care providers, who are often preferred by rural women (Leipert and Reutter 2005; Sutherns, McPhedran, and Haworth-Brockman). Even if resources exist, distance and lack of transportation compromise or preclude access. In addition, rural women often carry double, triple, or quadruple workloads as they engage in commitments to family, farm, community, and employment, and this leaves little time and energy for women to attend to their own health needs (Kubik and Moore 2003a; Prairie Women's Health Centre of Excellence). As a result, rural women experience a variety of physical, mental, and social health issues that may not be as prevalent or not exist in urban counterparts.

## **Rural Women's Health Issues**

### ***Physical Health Issues***

Rural women have a higher risk of dying from motor vehicle accidents, poisoning, suicide, diabetes, and cancer (Sutherns, McPhedran, and Haworth-Brockman). For rural women who live on farms, it is important to note that the agriculture industry has become Canada's most dangerous industry, with farmers being five times more likely to be killed and at risk for more disabling injuries compared to workers in other industries (Kubik and Moore

2003b). Farm machinery is designed for the male physique. When women use this type of machinery, it is usually intermittently and infrequently, such as during seeding or harvesting. These women are at risk, as they are less physically able to operate machinery and less knowledgeable about and familiar with farm equipment operation. In addition, increased use of agricultural chemicals and the tendency to focus on the safety of male farmers in the handling of these products increase women's exposure to and risks from farm chemicals (Argue, Stirling, and Diaz; McDuffie). By focusing on the health of farm men with little or no attention to the health of farm women, these women may not realize that their unprotected handling of chemically saturated clothing may pose hazards to their health. As a result, farm women may have increased risks of breast cancer, non-Hodgkin's lymphoma, and other chemically-related health effects (McDuffie).

Rural women are also at risk of physical violence and abuse (Hornosty and Doherty). Isolation, patriarchal attitudes that objectify and devalue women, and the presence of a "gun culture" where owning and using weapons are condoned and where access to weapons is enhanced, contribute to violence in the lives of rural women (Fishwick; Goeckerman, Hamberger, and Barber). Lack of access to health care providers who are sensitive to violence issues, limited or no resources such as counselors and shelters, early marriage, higher fertility rates, and lower education and employment in rural areas also contribute to rural women experiencing violence and being less able to address or get free from violent relationships (Hornosty and Doherty; Leipert 1999; Leipert and Reutter 2005).

Other physical health issues relate to risks of hunger, malnutrition, and homelessness (Ryan-Nicholls). These risks are a result of the immense stresses and strains that rural communities are undergoing and the limited understanding of and support for rural communities (Blake and Nurse; Diaz, Jaffe, and Stirling). In many parts of rural Canada, especially on the prairies and in maritime communities, annual family incomes are some of the lowest in the country (Amaratunga 2000a; Diaz, Jaffe, and Stirling). Limited government commitment to and support for rural communities, coupled with depleted natural resources and a global economy, contribute to lower annual incomes and limited employment, housing, and other options in rural communities. Consequently, rural residents have fewer job opportunities and lower incomes which result in limited ability to access adequate food, clothing, and housing, and compromised quality of life. Fewer options for affordable housing and the high cost of food in rural and remote communities further contribute to hunger and nutrition problems and to housing that may be unstable, inadequate, or too expensive.

Women's physical health is also affected by limited access to appropriate and timely health care (Leipert and

Reutter 2005; Prairie Women's Health Centre of Excellence; Sutherns, McPhedran, and Haworth-Brockman). For example, studies have shown that women in Canada do poorly if they must travel long distances to give birth. In Saskatchewan, a largely rural province, the 1993 closure of 53 rural hospitals was followed by an increase in its perinatal mortality rate (Kirby and LeBreton). Rural women experience not only limited diagnostic and treatment services, but also compromised or non-existent health promotion, illness and injury prevention, and rehabilitation resources. Some of these resources and

Another factor that affects rural women's access is that health care in rural settings is often provided by male physicians or physicians from other countries (Kirby and LeBreton). Care that is provided by male physicians may be problematic in that the values and priorities of male physicians may influence the practice of public health nurses and female physicians in ways that are not conducive to the health of rural women (Leipert 1999). For example, male physicians in rural settings have discouraged female physicians and public health nurses from providing PAP smear services, even though some rural

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services are delivered by care providers who parachute briefly into rural communities from elsewhere, or by telehealth technology that is used to overcome geographic distances in the provision of health care. Nevertheless, problems exist with these types of band-aid solutions. Telehealth requires adequate technology and training and effective integration into existing health delivery systems (Pong). Both telehealth and visiting providers must pay attention to communication, contexts, attitudes, and relationships with people in order to be effective. For example, if rural residents do not feel confident that visiting health care providers or telehealth advice is sensitive to their issues and contexts, they will not use these alternate service delivery systems (Leipert and Reutter 2005; Pong).

Other factors also affect women's access to the limited health care that exists in rural communities. Rural community dynamics, which are influenced by religious and conservative beliefs and values, affect rural women's access to confidential care such as birth control and abortion information (Leipert 2002). Limited and expensive transportation, physical obstacles and low incomes for women with disabilities, and language barriers for immigrant rural women and women with sensory impairment also pose challenges for care in rural communities (Prairie Women's Health Centre of Excellence; Sutherns, McPhedran, and Haworth-Brockman). Aboriginal women require care that avoids invalidating encounters such as disrespect, stereotyping, marginalization, and disregard for personal circumstances (Browne and Fiske; Leipert 2002). More appropriate are affirming encounters that encourage them as respected participants in health care, affirm personal and cultural identity, and that assist in the development of a positive, long-term relationship with the health care provider (Browne and Fiske).

women will not attend a male physician for these services (Leipert 1999). In addition, male physicians have been identified as having the most negative response to women's declaration of lesbianism (Trippet and Bain) and to women's desires to be fully informed and empowered participants in health care decisions (Leipert 2002). Rural women have also noted that physicians from other countries may not be aware of or agree with Canadian women's roles and expectations regarding their care, and that this lack of cultural sensitivity on the part of physicians compromises their care (Leipert 2002; Prairie Women's Health Centre of Excellence). If only male physicians or foreign physicians are available to provide care in rural areas and women do not have the means to travel elsewhere, their access to health care may not only be compromised, it may be completely blocked. Thus, even if health care providers exist in a community, their attitudes and values can compromise women's access to health care. Rural women's access to health care can be enhanced by female public health nurses, physicians, and other care providers, as women often feel more comfortable addressing sensitive topics with another woman and they perceive that female care providers accord more respect, time, and care to women (Leipert 2002; Sutherns, McPhedran, and Haworth-Brockman).

#### ***Mental Health Issues***

Mental health issues are as significant for rural women as physical health issues (National Rural Women's Health Conference). Despair, depression, and psychological distress are becoming increasingly common for women in rural settings in Canada (Kubik and Moore 2003b; Leipert and Reutter 2005; Sutherns, McPhedran, and Haworth-Brockman). Vast distances and sparse or declining populations compromise access to social support that

helps women address isolation and loneliness (Leipert 2002). Lack of public recognition, undervaluing of women and women's work in rural settings, social exclusion, and stresses placed on resource-based economies also contribute to women's mental health issues (Amaratunga 2000b; Kubik and Moore 2003b). Women may feel invisible, underappreciated, and vulnerable in such situations. To address these feelings and economic circumstances, women may decide to take on additional responsibilities both inside and outside of the home. For example, many farm women supplement the family income through off-farm

are less or not accessible to rural women (Leipert and Reutter 2005; Sutherns, McPhedran, Haworth-Brockman). Indeed, this type of service provision may serve to further jeopardize the health of women if, for example, community members and abusive partners become aware of women's use of these services.

### **Social Support and Rural Women's Health**

One of the main ways that women in isolated settings stay healthy is through social support (Amaratunga 2000b;

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employment or increased efforts in on-farm labour (Kubik and Moore 2003a). By adding these responsibilities to their multiple family and community roles and commitments, rural women may overextend themselves and compromise their mental health in the process.

Rural expectations and community dynamics, norms, and values can also contribute to mental health issues. Rural expectations associated with hardiness and self-reliance can perpetuate the stigma that is often attached to mental illness and inhibit access to help (Leipert 2002). Rural community dynamics may include blaming and the use of minimizing language to normalize unhealthy behaviours and attitudes that contribute to mental health issues (Hornosty and Doherty). For example, women may be blamed for partners' abusive behaviours or these behaviours may be viewed as normal within a marriage relationship. In addition, rural community norms and values may signal to a woman that a "failed" relationship is her fault, and that divorce is unacceptable because it will contribute to the breakup of the family farm and jeopardize economic viability. These rural expectations, dynamics, norms, and values contribute to women's reluctance to access relationship and other mental health services, perpetuate unrealistic expectations of women, and contribute to women's acceptance of community norms and their reluctance to challenge norms that are unhealthy for women.

The nature and location of mental health services in rural communities also create health issues for women. Rural women often do not have access to a range of health-promoting resources such as alternative health care and culturally appropriate care in their communities (Browne and Fiske; Leipert 2002). Because of the stigma attached to mental health issues and the lack of anonymity that exists in small communities, mental health services that are provided in stand alone or other publicly visible ways

Leipert and Reutter 2005). Social resources help women obtain practical, emotional, and affirmational support (House and Kahn 1985). In rural settings, informal social support from friends and family may be preferred to the formal support available from health care and other professionals. Social support helps rural women learn the how, where, when, and why of local actions and beliefs; address isolation and other challenges of rural life; and affirms women's knowledge and abilities (Leipert, 2002). By facilitating the sharing of advice, goods, and assistance, social support can also help counter the poverty that many rural women endure. Social support is particularly important in Canada to counter the isolation that can often result from vast geography and extreme weather.

Social health issues are especially significant for particular subgroups of rural women. Elderly women may experience feelings of diminished self-worth if they do not have the social support necessary to help them maintain independence, self-competence, and mastery (Chafey, Sullivan, and Shannon). In addition, elderly women's social support needs and strengths may be misunderstood and neglected in rural areas where physical labour and the work of men are privileged (Prairie Women's Health Centre of Excellence). Rural lesbian women may experience limited social support or outright hostility and social exclusion (Isaac, Anderson, Healey, Herringer, and Perry). Disabled women may find that limitations in employment and transportation in rural communities challenge their ability to connect with others. Being a member of a minority group can create social health issues for women in rural communities that favour cultural homogeneity or that have limited cultural sensitivity (Browne and Fiske).

Social support helps rural women develop and sustain resilience in the face of hardships by assisting them in developing hardiness, confidence, and the ability to carry

on; in making the best of resources and opportunities; and in advocating for change (Leipert 2002; Leipert and Reutter 2005). However, social support—and thus women's health—can be compromised by issues related to sparse populations, weather, distance, values, and resources in rural settings. Sparse populations limit the number and nature of the people and resources that are available to provide formal and informal support. For example, sparse populations may result in inadequate home care services in a rural community which, in turn, results in rural women taking up additional care responsibilities, thereby affecting women's time, energy, and other resources available for social support for themselves and others (Forbes and Janzen). The rural climate and geography affect if, when, and how often women can get together with others. Values in rural communities also affect the nature, purpose, and frequency of contact for social support. For example, women in a rural community may be encouraged to get together for quilting bees or child care purposes, but discouraged from meeting for less traditional reasons (Leipert 2002; Leipert and Reutter 2005) such as for Take Back the Night events and feminist reading groups.

### **Factors and Consequences of the Rural Context for Women's Health**

Rural women's physical, mental, and social health issues result from a number of contextual and personal factors. For all women in rural Canada, health issues arise due to limited access to health promotion, illness and injury prevention, diagnostic, treatment, and rehabilitative health care services. In addition, rural women often do not have access to alternative health care resources or to care that is respectful of their gender, culture, experiences, or perspectives (Leipert 2002; Sutherns, McPhedran, and Haworth-Brockman). Women who are more isolated, have more limited options, and who have less power to make change and address health issues tend to have greater health risks and less ability to deal with risks (Leipert 2002). In addition, personal factors such as age, health status, and financial resources affect rural women's experience of health issues. Rural older women, women with health problems, and women with inadequate financial resources have greater needs but fewer resources to address needs, which increases their vulnerability and risks. Thus, although all rural women are exposed to vulnerability and health issues, some women are in greater peril.

As a result of personal and contextual factors, rural women experience the health-related consequences of not being able to access a diverse range of appropriate services and resources to promote and sustain their health, having to postpone access to health care, or foregoing health care altogether. As a result of these consequences, rural women are likely to experience a greater number of and more severe health-related issues, live with adverse health issues

longer before addressing them, and have less ability to recover from or address health-related issues.

### **Discussion**

Rural health and rural women's health are relatively new areas of focus at the national level in Canada. In 2002, two federal government-initiated reports focused on the health of Canadians: Michael Kirby's and Marjory LeBreton's *The Health Of Canadians—The Federal Role*, and Roy Romanow's *Building On Values: The Future Of Health Care In Canada*. Each report devoted one chapter to a discussion of rural health. Both chapters explore the nature of the rural context and issues facing rural and remote communities and make recommendations to improve the health of rural residents.

Although these reports present information that is relevant to rural health in general, rural women's health is not significantly addressed. For example, recommendations from the reports focus on enhancing the numbers of health care professionals, especially physicians, in rural and remote communities, and on treatment, diagnostic and drug services. Other services and approaches that rural women require and which they are often denied or compromised in acquiring, such as respectful inclusive care, health promotion and illness, disease, and injury prevention services, and services provided by nurses, midwives, counselors, and women's health centers, receive little attention in these documents. In addition, recommendations that address the social determinants that are so important for the health of rural women are virtually nonexistent. For example, the effects of and ways to address rural sociocultural values and behaviours, rural poverty, and rural education to enhance women's health require greater emphasis in these documents. More knowledge is needed about the strengths of rural women and about how they cope and "make things work" in rural settings. This knowledge can help rural people and rural communities realize, include, and build on local capacities. In order to advance the health of women in rural Canada, it is important to remember that health is much more than the absence of illness. National reports must take a broader more inclusive perspective on the health of rural people if they are to be effective in advancing rural women's health.

In September 2003, a report prepared by the Canadian Institute for Health Information (CIHI) was released that focused on the health of Canadian women. *The Women's Health Surveillance Report* (CIHI) summarizes important information about women's health, such as gender differences and disparities in the distribution of determinants of health, health behaviours, health outcomes, and health care utilization. The report also examines health issues of vulnerable subgroups of women such as younger and older women and women with disabilities, and addresses several social and physical health issues for women across the

nation. In spite of its importance, the report is limited in its explication of information about health issues of rural and remote women. Essentially, the report discusses rural women's health in terms of mortality rates, physical violence, and sexual assault in comparison with urban counterparts. Importantly, the report identifies a gap in knowledge in health information about women who live in rural and remote Canada, and notes that this gap limits policy development to address rural and remote women's health issues. General recommendations are made to enhance knowledge about rural and remote women's health.

In June 2004, the Prairie Centre of Excellence for Women's Health released a report that focused exclusively on the health of rural and remote women in Canada (Sutherns, McPhedran, and Haworth-Brockman). This report, the first to focus on rural and remote women on a national scale, summarizes much of the extant literature about rural and remote women in Canada and combines this knowledge with research conducted with rural women throughout the country to propose a policy framework and research agenda for rural and remote women's health. The report is valuable on a number of levels. For the first time, rural and remote women's health in Canada is comprehensively addressed in one document. The literature review is an important resource as it thematically summarizes the state of knowledge in many sectors, including peer-reviewed academic publications, government documents, community-based research, and conference presentations. By its highly consultative approach, employing focus groups across the country, the report also honours the knowledge, experience, and perspectives of rural and remote women throughout Canada. Research and policy recommendations in the document effectively address the realities and health issues of rural women's lives. Eleven priorities for research are proposed:

- Any aspect of rural women's health that addresses the importance of place, culture, and gender
- Creative models of rural health service
- Impacts of isolation on health
- Importance of cultural values for health
- Factors influencing the impact of rurality on health
- Moving from information to action
- Health issues across the life course
- Health issues relating to specific rural populations
- Getting beyond reports of satisfaction
- Rural definitions and depictions, and
- Rural occupational health and safety.

Three policy priorities are recommended: 1) Factor gender, place, and culture into all health policy; 2) Define health policy as more than health care services; and 3) Improve health by improving access to information, health care services, appropriate care, and decision-making.

These policy and research recommendations point to

many fruitful areas of inquiry and application. They will help broaden women's health research and practice to include all of the determinants of women's health (Health Canada), not just those that focus on women's biomedical or reproductive functions. In addition, these policy and research recommendations will ensure inclusivity and diversity, which will result in relevant and meaningful information about rural women's health issues and ways to advance rural women's health. Finally, rural women's empowerment, through the promotion of voice, access, and power, will be fostered if these research and policy recommendations are enacted.

In addition to these important documentary initiatives, in 2003 the Ontario Women's Health Council, which is a branch of the Province of Ontario Ministry of Health, and the University of Western Ontario dedicated two million dollars for the creation of a Chair in Rural Women's Health Research. This Chair position, which is located at the University of Western Ontario, is the first and only academic research position in North America to focus on rural women's health. Objectives of the position include: 1) Expand the focus of rural women's health research beyond bio-medical interests, 2) Develop and support leading research in rural women's health, 3) Facilitate rural women's health in curriculum development across disciplines, 4) Raise the profile of rural women's health research, and 5) Give rural women a voice in research. To advance these objectives, the Chair has engaged in a number of initiatives, including the establishment of multidisciplinary funding awards for graduate student research in rural women's health. All of the Chair initiatives are developed for the purpose of advancing knowledge about rural women's health. In addition, having a named Chair position in Rural Women's Health Research helps to insert rural women's health into the agenda of international, national, and local research, policy, practice, and community organizations, thereby assisting in the transfer of knowledge from theory to the real-life advancement of rural women. The creation of other Chair positions in rural women's health in other locations across the country would serve to further advance knowledge and policy and the health of rural women.

## Conclusion

Women in rural settings in Canada experience diverse physical, mental, and social health issues. However, knowledge about these issues remains sparse. Recent reports, further research, and the creation of the first Chair in Rural Women's Health Research will help to address this knowledge deficit. However, it remains to be seen whether the political will exists to address issues and recommendations that arise from these initiatives (Nagarajan). The minimal attention accorded to rural women's health in the past indicates that substantial support for rural wom-

en's health is both timely and critical. Rural women are waiting.

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## About the Guest Editors...

**Brenda Cranney** has a Ph.D. in Sociology and has worked extensively with rural women's organizations in Canada and in India. She is currently Manager of Client Services with Victim Services of Peel.

**Belinda Leach** holds the University Research Chair in Rural Gender Studies at the University of Guelph. She is the co-author of *Contingent Work, Disrupted Lives: Labour and Community in the New Rural Economy* (with Tony Winson, University of Toronto Press 2002). In partnership with rural women's organizations, she is the principal investigator in a SSHRC-funded Community University Research Alliance entitled "Rural Women Making Change."

**Martha MacDonald** is a Professor in the Economics Department, Saint Mary's University, Halifax, Nova Scotia, and is also active in the Women's Studies and Atlantic Canada Studies programs. She has worked on issues related to gender and restructuring in the fisheries and in rural resource-based communities in Atlantic Canada since the early 1980s.

**Diane Martz** has worked on rural women's health issues, especially domestic violence, which led to her working with a local community to establish a rural family support centre as a proactive response to family violence in the region. She has also recently completed a research project with the National Farmers Union looking at the changing work of farm families.

**Karen Pederson** is as a young beekeeper from Cut Knife, Saskatchewan. She farms with her parents, and extended family on a true family farm. She has immense interests in issues of trade and food sovereignty and is currently Women's President of the National Farmers Union.

**Maureen Reed** is active on issues of "gender and rural sustainability." She continues to do work on gender, forestry, and rural sustainability with a national research group and is currently working on a research project related to gendering of rural work in Saskatchewan, with particular reference to the agri-food and forestry sectors.

**Katherine Side** is an Assistant Professor in the Department of Women's Studies at Mount Saint Vincent University, Halifax, Nova Scotia. Currently, she is working on a SSHRC-funded research project, "Gender, Change and Rural Community Sustainability," in Nova Scotia and Northern Ireland.