

So Close Yet So Far

Rurality as a Determinant of Women's Health

REBECCA SUTHERNS

A partir de deux études qualitatives, celle explorant la maternité en Ontario rurale et une autre qui identifie les politiques sur la santé des femmes rurales et celles des régions éloignées et le programme de recherches au Canada, cet article examine l'importance de la ruralité comme un déterminant de la santé des femmes et montre que vivre à la campagne influence profondément leur santé souvent d'une façon contradictoire. Les intervenantes de la santé et les planificateurs doivent alors envisager la ruralité à la fois comme bienfaitante et nuisible à la santé des femmes.

Gender and place have long been listed among the social determinants of health, but the interplay between them has been under-researched in the Canadian context. This paper draws on findings from two studies of rural women's health, one local and one national, to explore specific ways that rurality acts as a determinant of health in women's lives. It asserts that while current research and popular discourse portrays living rurally as either idyllic or more often as detrimental to one's health, the reality for many Canadian women is in fact both simultaneously. The emphasis here is on unpacking the contradictory ways in which rurality is at once an asset and a liability to women's health. Doing so reveals several important implications for those who plan for or provide healthcare for women in rural contexts.

Defining Rural

One significant feature of these studies was their reluctance to employ a fixed definition of rurality. Defining rural in a general way, as a residual category in reference to urban, tends to downplay diversity and instead relies on artificially uniform categories, which in reality are far from internally homogeneous (Bryant; Cordes). Instead, both studies worked from a dynamic, contextualized understanding of rurality as per Jonathan Murdoch and Andy Pratt, who suggest that "...rather than trying to 'pin

down' a definition of rurality or the rural, we should explore the ways in which rurality is [selectively] constructed and deployed in a variety of contexts" (423). It was therefore very important to allow women themselves to identify what living rurally meant to them.

Rural Women's Health in Canada

Despite comprising 95 per cent of Canada's territory and roughly 30 per cent of its population, rural Canada is home to just 17 per cent of Canada's family physicians and four per cent of its specialists (Rourke). This has resulted in a heavy emphasis within the Canadian rural health literature on physician shortages, largely written from the perspective of physicians themselves (Rourke; Hutton-Czapski; Kralj; Lofsky; McKendry; Pitblado and Pong; Pope and Grams; Reid, Grava-Gubins and Carroll; Rourke, Rourke and Browne; Ruderman, Holzapfel, Carroll and Cummings).

Research specifically on the health of rural women in Canada is limited (Sutherns, Wakewich, Parker and Dallaire; Dion Stout, Kipling and Stout; Gucciardi and Biernie-Lefcovithc; Leipert and Reutter; Reutter, Neufeld and Harrison; Rosenberg and Wilson). It is clear that rural women have lower labour force participation rates, higher fertility rates, a higher risk of experiencing domestic violence, and a higher likelihood of being poor than do their urban counterparts (DesMeules, Lagace, Pitblado Bollman and Pong). Particular subgroups of women, including elderly, Aboriginal or disabled women, are especially vulnerable (Newbold; Sutherns; Vissandjee, Weinfeld, Dupere and Abdool). An absence of gender analysis, the frequent aggregation of rural and urban responses, and/or the exclusion of rural perspectives altogether, have meant that rural women are largely invisible in Canadian health literature (Sutherns, Wakewich, Parker and Dallaire).

Yet there is widespread agreement within that same

literature that health is largely a social product, determined by far more than the treatment of illness (Health Canada 1974, 1996; Epp; Federal, Provincial and Territorial Advisory Committee on Population Health). Influences on health include the social and economic environment, the physical environment, personal health practices and coping skills, biology and genetic endowment, and health services. The exact ways in which these factors work together to affect health are complex, multi-directional, and not fully understood (Health Canada 1996). The analysis here examines how living rurally intersects with gender to influence health in a number of significant and often contradictory ways.

Methodology

These findings are based on two separate research projects, both designed to solicit Canadian rural women's perspectives on their own health and healthcare. The first was an exploratory doctoral study investigating women's experiences of rural maternity care in three central Ontario communities in 2000. The sites ranged in population from 1,700 to 7,500 people, and varied in the availability of local maternity care. Narrative semi-structured interviews were conducted with 36 new mothers, recruited through written invitations from their healthcare providers or hospitals, or by word of mouth. Women's accounts were supplemented by 36 additional interviews with healthcare workers and a critical analysis of relevant literature. All interviews were taped, transcribed verbatim, and then coded by keyword using Citation software. Written transcripts were returned to all of the mothers and follow-up focus groups were held with participants in each site, as additional validity checks.

The second study, conducted from 2001-2003, was national in scope. Commissioned by the Centres of Excellence for Women's Health, it brought together academic and community-based researchers with rural women to develop a policy and research agenda for rural, remote and northern women's health in Canada. It comprised comprehensive literature reviews in French and English; 28 focus groups, video- and teleconferences involving over 200 women in all parts of Canada; roundtable discussions with health researchers and policy makers; and a national consultation (Sutherns, McPhedran and Haworth-Brockman). It was exceptional in its geographic reach to all parts of the country, including coastal communities and the high Arctic, as well as in its commitment to facilitating the direct involvement of very diverse women.

Rurality as Both Health Asset and Liability

Despite the tendency for rural health to be portrayed exclusively negatively, findings from these two studies indicate that living rurally can have simultaneously positive and negative effects on women's health. Four exam-

ples will demonstrate how rurality, acting as both a beneficial and detrimental health determinant, it is often experienced in contradictory ways.

Rural Life as Both Healthier and Riskier

Rural women spoke emphatically about the positive health effects of living rurally. They referred, for example, to the health benefits of fresh air, natural beauty, and easy access to recreational opportunities. Yet women also recognized the health risks directly related to living rurally, including concerns about air and water quality due to the presence of particular industries such as agriculture, limestone quarries, potash mines or pulp and paper mills. According to one participant,

We used to grow our own food because it was healthier ... but the spray plane comes over and I've had my whole garden killed by spray drift. So the quality of life is not there anymore.

Stress, particularly as a result of economic vulnerability, was also identified as a dimension of rural life that undermines women's health. As one Alberta farmer explained,

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.

Rural life is thus perceived as simultaneously yielding health benefits and costs.

Supported Yet Isolated

Another health asset women derive from living rurally is a strong sense of social support. The importance of social support to women's health is well documented (Brown; Bull, Hemmings and Dunn; Cohen and Syme; Oakley), and in small rural communities, social networks are likely to be especially stable, dense, and overlapping (Flora). One woman described her community as being like "one big family," while another said, "Up here, everyone is not out for self. There are times when it is like getting a big hug from the community." Another participant described it this way,

I think a lot of people who live in rural communities have a lot more support. You have probably got family and friends close to you, whereas in the city you could be quite isolated.

Many participants had lived in their communities all of their lives, as had their parents and grandparents. As a result, interaction with family was plentiful and social networks were well established.

Yet it cannot be assumed that living close to one's family

is indicative of support that is sufficient or appropriate to the need. Many women reported that the close proximity of family had a negative influence on their health, due to conflict, unwillingness of family members to provide help, or conservatism of family circles that inhibited them from exploring new avenues of support for their health. In some cases, the proximity of family made their lack of support even more frustrating. Moreover, women frequently described having difficulty building relationships in their communities, calling them “cliquey” or “closed.” As one described, “People here will be nice, but they’re not

groups because of being known by, or at times even related to, others in the group. For instance, several Ontario women reported avoiding attending a particular parenting group because of who else they knew would be there, or because of its reputation around town. As one adolescent mother described, “You know people are talking about you and saying these awful things about you, and it’s really hard.” Healthcare workers reported difficulties finding central but private locations at which to offer services, due to women’s fear not just of being seen, but of having their vehicle recognized by others. One British Columbia woman

“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.”

willing to try to become friends that you could do social stuff with.” Another said, “If you didn’t grow up here, people don’t know you and they don’t really want to know you.” Social isolation is overlaid by rural geography. For some women, geographic isolation meant living with the inconvenience of having to drive everywhere, while for others it resulted in being unable to make contact with other people at all due to a lack of transportation, money for gas, or access to the Internet. These issues are exacerbated by the seasonal nature of farm and tourism work, as well as harsh winter weather, which often serve to keep people at home. As one healthcare worker explained,

Isolation is a huge issue, just a tremendously huge issue ... sometimes for women who have moved from the city into the country, I think they’re very surprised at how isolated they are and they’re not prepared for it.

Thus social isolation and strong social support co-exist, not only in particular communities, but in the lives of individual women.

Never Anonymous But Invisible Just the Same

Another influence that affects women’s well-being both positively and negatively is the relative lack of anonymity that characterizes life in a small town. As with social support, some women spoke positively about “everybody knowing everybody.” They reported feeling “safer” and “more at home,” and they appreciated being missed if they failed to appear at the local post office or grocery store for a few days.

For others, that same lack of anonymity was a source of aggravation and served to limit their access to healthcare services. In some cases, women ceased attending support

succinctly summed up the two faces of being known when she said,

Everybody knows your business, whether it’s your healthcare 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.

Rural life is characterized at once by social isolation and by a lack of anonymity, wherein, according to Sheridan Coakes and Gail Kelly, “individuals are simultaneously too close and too distant” (27). Health has the potential to be both enhanced and undermined by such closeness.

While living under a microscope within their home communities, rural women also reported being invisible to decision-makers in wider circles. They identified the need to increase the participation of women in decision-making relating to rural and remote women’s health as a high priority, out of a recognition that the concerns of rural women do not figure prominently on the agenda of health policy makers. Participants felt strongly that living rurally puts them at a disadvantage when it comes to making their voices heard.

Rural Healthcare Quality Both Better and Worse

The implications of scarce healthcare services in rural places revealed further contradictions in women’s experiences. According to some women, a lack of local access to a range of healthcare services at times had positive implications on choice, continuity and quality of care. For example, in the Ontario sites where local maternity care was no longer available, the lack of access to services put women in a position of having to evaluate various options

for their care that they would otherwise not have considered, thereby unexpectedly expanding their choice and agency. As one woman said, "If I didn't have to make a choice, I never would have thought of a midwife." Conversely, those living in a site where obstetrics were still offered locally reported not considering any options beyond those presented by their doctor. In terms of continuity, some women reported having had the same physician for their whole lives. Sometimes this translated into more personalized, appropriate care. One woman described it this way:

"In a small community they know who you are and you know who they are.... We have a personal connection.... They're not going to treat you awful on the hospital, because nine times out of ten, they're going to see you on the street."

... In a small community they know who you are and you know who they are, so they know how you run.... [In a city] they just care for you as they would Joe Blow down the hall, whereas here they know you as a person. They know your family. Nine times out of ten they know one of your parents if not both, so it's that personal connection.... We have a personal connection; you know the care you're getting. They're not going to treat you awful on the hospital, because nine times out of ten, they're going to see you on the street.

Yet for other women, living rurally meant making sacrifices in terms of the perceived quality of healthcare. Many women wished they could access female healthcare providers, including physicians, public health nurses, midwives, lactation consultants and others. They frequently mentioned concerns about practitioners' heavy workloads, lack of sensitivity to confidentiality, and lack of thoroughness. High turnover was also a concern. Several mothers described trading convenience for quality in smaller communities.

As one participant said,

If you need a prescription or a referral, that's fine; but if you have something seriously wrong with you, you're basically putting your life in jeopardy by trusting in [local doctors].... But at 2:00 in the morning, you'd rather drive 15 minutes and get looked after even though it's not the best of care.

The lack of easy access to a range of healthcare services, often the main focus of rural health literature, therefore has numerous and often conflicting implications on women's perceptions of healthcare quality in their rural communities.

Analysis and Implications

It is clear from the above examples that each of these features of rural life can have a significant yet complex influence on women's health. It is therefore essential that health planners, policy makers and care providers take women and the rural circumstances of their lives into account, because gender and location will undoubtedly have an important effect on the services they need. That effect will not, however, be predictable or straightforward. Four specific actions would contribute significantly to

better understanding and accommodating the influence of rural living on women's health:

1. Specific guides and tools are available to assist decision makers in systematically taking both gender and rurality into account. Incorporation of gender-based analysis and rural lenses in making decisions about health policy and practice would go a long way toward ensuring that the implications of gender and location are thoroughly considered.

2. Further research is needed into the factors that shape rural women's experience of health. What influences contribute to whether any given woman is likely experience rural life as an asset or a liability in terms of her health? These initial studies have provided some clues, but more detailed investigation is needed in order to unpack further the influences, of and interactions between various determinants of health.

3. It is clear that rurality and gender will affect women's health, but diversity among regions and people means that the specific implications of gender and location need to be considered locally, in context. This is an important reminder to healthcare providers of the importance of asking questions related to the influence of rural life and gender roles on their patients' health, including issues such as access to safe and confidential services, appropriate social support, affordable transportation and childcare, who makes decisions about healthcare spending, and where the balance of power lies.

4. This research underscores the importance of investing simultaneously in a broad range of health determinants, particularly those not initially appearing to fall within the umbrella of "healthcare." Enhanced job opportunities, community infrastructure, housing and social services in rural environments, as elsewhere, have the potential to improve women's health in ways far beyond

the recruitment and retention of additional healthcare providers. Just as the negative aspects of various health determinants can have a cumulative effect on women's lives, so too can positive interventions interact cumulatively with one another to have a disproportionately positive influence.

The workings of the contradictory rural myths identified previously, namely rurality as both idyllic and deficient, were evident in these studies, frequently alongside comments such as, "You know what small towns are like." As one woman said, "I think there's this myth that in rural areas everybody helps everybody out and all this stuff, and it just doesn't happen. That's unfortunately not the way it works."

Indeed, how rurality was described was often inconsistent with how life in rural places was lived, revealing that rurality operates not only materially but also symbolically in women's lives to influence their health. More contextualized analyses, grounded in lived experience and identifiable localities, are therefore required in order to reveal the specific workings of rurality.

Support for the doctoral portion of this research was generously provided by the Social Sciences and Humanities Research Council of Canada and the Canadian Health Services Research Foundation. Funding for the national study was provided by the Women's Health Bureau of Health Canada, through the Centres of Excellence for Women's Health. Additional support came from the Institute for Gender and Health, Canadian Institutes for Health Research and Status of Women Canada. Special thanks go to all of the women on the National Steering Committee and throughout Canada who contributed to this project.

Rebecca Sutherns holds a Ph.D. in Sustainable Rural Communities and is a rural mother of four.

References

- Brown, M. A. "Social Support During Pregnancy: A Unidimensional or Multidimensional Construct?" *Nursing Research* 35(1) (1996): 4-9.
- Bryant, C. and A. E. Joseph. "Canada's Rural Population: Trends in Space, Implications in Place." *Canadian Geographer* 45 (1) (Spring 2001):132-7.
- Bull, D., L. Hemmings and P. Dunn. "The Support Needs of Pregnant and Parenting Adolescents in Rural Communities." *Australian Journal of Rural Health* 5 (1997):64-9.
- Coakes, S. J. and G. J. Kelly. "Community Competence and Empowerment: Strategies for Rural Change in Women's Health Service Planning and Delivery." *Australian Journal of Rural Health* 5 (1997): 26-30.
- Cohen, S. and S. L. Syme. "Issues in the Study and Application of Social Support." *Social Support and Health*. Eds. S. Cohen and S. Syme. Orlando: Academic Press Inc., 1985. 3-22.
- Cordes, S. M. "The Changing Rural Environment and the Relationship between Health Services and Rural Development." *Health Services Research* 23 (6) (1989): 757-84.
- DesMeules, M., R. Lagace, R. Pitblado, R. Bollman and R. Pong. "Assessing Rural Women's Health as Part of the National Research Program." *Canada's Rural Communities: Understanding Rural Health and its Determinants*. Ottawa: Statistics Canada and Health Canada. 2003.
- Dion Stout, M., G. Kipling and R. Stout. *Aboriginal Women's Health Research: Synthesis Report*. Centres of Excellence for Women's Health, 2001.
- Epp, J. *Ottawa Charter*. Ottawa: Government of Canada, 1986.
- Federal, Provincial and Territorial Advisory Committee on Population Health. Ottawa, 1994.
- Flora, C. B. *Rural Communities: Legacy and Change*. Boulder: Westview Press, 1992.
- Gucciardi, E. and A. Biernie-Lefcovithc. "Rural and Northern Women." Eds. D. E. Stewart, A. M. Cheung, L. E. Ferris, I. Hyman, M. M. Cohen and J. I. Williams. *Ontario Women's Health Status Report*. ISBN 0-7794-3614-8, 2002. 374- 386.
- Health Canada. *A New Perspective on the Health of Canadians*. Ed. M. Lalonde. Ottawa: Health Canada, 1974.
- Health Canada. *Report on the Health of Canadians*. 1996. <<http://www.hc-sc.gc.ca/hppb/phdd/report/1996/chap1e.htm> Ottawa> Date Accessed 08/06/2004.
- Hutton-Czapski, P. "Family Practice Maternity Care." *Canadian Family Physician* 44 (April 1998): 707-8.
- Kralj, B. "Physician Human Resources in Ontario: A Looming Crisis." *Ontario Medical Review* (April 1999): 16-20.
- Leipert B. and L. Reutter. "Women's Health and Community Health Nursing Practice in Geographically Isolated Settings: A Canadian Perspective." *Healthcare for Women International* 19 (6) (Nov-Dec. 1998): 575-88.
- Lofsky, S. "Obstetric Human Resources in Ontario, 1996-97." *Ontario Medical Review* 65 (November 1998): 24-31.
- McKendry, R. *Doctor. Physicians for Ontario: Too Many? Too Few? For 2000 and Beyond*. Toronto: Ontario Ministry of Health and Long-Term Care, 1999.
- Murdoch, J. and A. C. Pratt. "Rural Studies: Modernism, Postmodernism and the 'Post-Rural.'" *Journal of Rural Studies* 9 (4) (1993): 411-27.
- Newbold, K. B. "Problems in Search of Solutions: Health and Canadian Aboriginals." *Journal of Community Health* 23 (1) (February 1998): 59-73.
- Oakley, A. *Social Support and Motherhood*. Oxford: Blackwell, 1992.
- Pitblado, R. and R. Pong. *Geographic Distribution of*

- Physicians in Canada*. Sudbury: Centre for Rural and Northern Health Research, Laurentian University, 1999.
- Pope, A., A. S. A. Pope, G. D. Grams, C. Whiteside and A. Kazanjian. "Retention of Rural Physicians: Tipping the Decision-making Scales." *Canadian Journal of Rural Medicine* 3(4) (1998): 209-16.
- Reid, A., I. Grava-Gubins and J. Carroll. *Results of the 2001 National Family Physician Workforce Survey (weighted data)*. The Janus Project. Mississauga: College of Family Physicians of Canada, 2001.
- Reutter, L., A. Neufeld and M. A. Harrison. "Review of the Research on the Health of Low-Income Canadian Women." *Canadian Journal of Nursing Research* 32 (1) (June 2000): 75-97.
- Rosenberg, M. W. and K. Wilson. "Gender, Poverty and Location: How much Difference do they make in the Geography of Health Inequalities." *Social Science and Medicine* 51 (2) (July 2000): 275-87.
- Rourke, J. T. "Politics of Rural Healthcare: Recruitment and Retention of Physicians." *Canadian Medical Association Journal* 148 (8) (1993): 1281-4.
- Rourke, L. L., J. Rourke and J. B. Browne. "Women Family Physicians and Rural Medicine: Can the Grass be Greener in the Country?" *Canadian Family Physician* 42 (June 1996): 1063-7.
- Ruderman, J., S. G. Holzapfel, J. C. Carroll and S. Cummings. "Obstetrics Anyone? How Family Medicine Residents' Interests Changed." *Canadian Family Physician* 45 (March 1999): 638-40.
- Sutherns, R. *Women's Experiences of Maternity Care in Rural Ontario: Do Doctors Matter?* Unpublished dissertation, University of Guelph, 2001.
- Sutherns, R., M. McPhedran and M. Haworth-Brockman. *Rural, Remote and Northern Women's Health: Policy and Research Directions*. Winnipeg: Prairie Women's Health Centre of Excellence, 2003.
- Sutherns, R., P. Wakewich, B. Parker and C. Dallaire. "Rural, Remote and Northern Women's Health in Canada: A Literature Review and Thematic Bibliography." Eds. R. Sutherns, M. McPhedran and M. Haworth-Brockman. *Rural, Remote and Northern Women's Health in Canada: Policy and Research Directions*. Winnipeg: Prairie Women's Health Centre of Excellence, 2003. E1-E57
- Vissandjee, B., M. Weinfeld, S. Dupere and S. Abdool. "Sex, Gender, Ethnicity and Access to Healthcare Services; Research and Policy Challenges for Immigrant Women in Canada." *International Journal of Migration and Integration* 2 (1) (Winter 2001): 55-75.

CHERYL R. COWTAN

A Wreath of Memories

A basket of pine cones
sat in my mother's cellar.
After a few dusty years,
I couldn't help but ask her.

Why did you not leave these
outside for the squirrels?
Why gather up pine cones?
Such seed dropping whorls!

She tipped out the basket,
sorting the cones into piles.
Then described each discovery
right down to tree aisles.

"Jack Pine from your Nanny's
last home before she died.
Red Cedar buds from the place
we lived on seventh line.

On the canoe portage
of my sweet honeymoon.
Your father and I found
these giant, wooden blooms."

She held a Hemlock seed.
"Oh yes, and this one.
I found in your forest,
when your first son was born."

My tears dripped down slowly,
as she shared her memories.
I had judged her kind heart
over a few dusty seeds.

She glued all the pine cones
into a beautiful wreath,
and before she passed on,
she passed the memories to me.

Cheryl R Cowtan, a proud mother of two, attends York University's Education and English programmes. Formerly a Social Worker, Cheryl often writes about social issues. She is currently working on a poetry manuscript about violence against women.