Original Article

Health beliefs of rural Canadians: Implications for practice

Elizabeth Thomlinson,1 Meg Kathleen McDonagh,1 Kathryn Baird Crooks2 and Margaret Lees3

1Faculty of Nursing, University of Calgary, Calgary, 2Medicine Hat College, Medicine Hat and 3Keewatin Community College, The Pas, Canada

Abstract

Objective: The objective of the present study was to examine the health beliefs, values and practices of rural residents living in two geographically diverse regions of western Canada.

Design: An ethnographic study with semistructured interviews of 55 persons was conducted with participants ranging in age from 19 to 84 years.

Results: Being healthy was described as having balance in one’s life, taking into consideration the relationship between the physical, mental, social, and spiritual aspects of the person. Health-seeking behaviours spanned the gamut of diet, exercise, sleep, home remedies, a belief in a spiritual being, to consulting health professionals. Resources that participants valued included professionals who listened, friends, neighbours, church, music, elders, ambulance service and the internet.

Conclusions: It is important that professionals view the person beyond the disease and take into account more than the physical manifestations of an illness. A key component is the demonstration of respect for all persons regardless of age. It is essential that health professionals develop websites providing accurate health-care information. Participants noted the need to recruit and retain professionals in rural regions.

KEY WORDS: ethnography, remote, resources, rural, values.

Introduction

Health beliefs, values and practices of rural Canadians living in southern Alberta and central and northern Manitoba were explored in a two-part ethnographic study using interviews and rural visits. The investigators had all spent many years in clinical practice in rural and northern sites and had noted differences between the health practices of rural residents with those in urban settings. A comprehensive literature search found no published articles on the health beliefs and practices of rural Canadians. The majority of rural research in Canada has focused on the recruitment and retention of health-care professionals, community development and resiliency, and on specific groups or disease entities, such as diabetes in the Aboriginal population. The purpose of the present study was to examine the health beliefs, values and practices of Aboriginal people living in two geographically diverse regions of the prairie provinces of western Canada. An understanding of these factors could assist health professionals in the provision of appropriate and acceptable nursing and health care to rural and northern residents and in the development and delivery of collaborative health programs.

Rural defined

Knowledge of the rural context is fundamental to understanding issues related to rural health care and its delivery. Demographers, sociologists, geographers, and health professionals have developed various definitions and gradations of ‘rural’. However, there remains no universally accepted definition of rural. This lack of consensus poses several challenges, the most notable being that researchers, clinicians, health policy makers, and health-care delivery agencies are unable to compare their findings or experiences with colleagues who have described their rural populations using different attributes or descriptors.

It can be suggested that rural regions differ from urban centres in four ways: (i) geography; (ii) distance from markets; (iii) population density; and (iv) reliance on primary resources. While these factors are common to rural regions of any country, there are also unique variations between countries and between specific locales within a given province or state. These variations bring with them unique opportunities and challenges for the people who reside there. It is in part the
specific variables and unique aspects of a place that influence the perceptions of those who live there and, therefore, contribute to the beliefs of each rural group. While some rural qualities, such as self-reliance and resilience, are shared commonly amongst rural people, there is insufficient evidence to say that there are other unique health beliefs and practices that make specific rural populations distinct.

Statistics Canada has developed six alternative definitions of ‘rural’ and suggest that the appropriate definition be chosen based on the particular question being addressed. One definition for ‘rural and small town’ is the population living in towns and municipalities outside the commuting zone of larger urban centres (i.e. outside the commuting zone of centres with populations of 10 000 or more). Using this definition, the latest census data identifies 20.3% of Canada’s population as rural. For the purpose of the present study, rural was defined as communities of less than 1000 persons and/or regions with a population density of less than 400 persons per square kilometre. ‘Northern’ was defined as the region north of the north/south line developed in working papers by the Geography Division of Statistics Canada. This particular definition is based on 16 combined social, biotic, economic, and climatic aspects of geography. The north/south line, therefore, varies dependent on geography, climate, economic growth and multiple other factors.

Although Troughton noted that Canada is in an era of rural decline, the census data depicts that the population of rural and small town Canada is actually increasing within several clearly defined areas. The rural regions that have shown the most growth are the fringe areas surrounding large cities. For example, there has been a dramatic population increase in the Edmonton – Red Deer – Calgary corridor of south central Alberta. This growth, however, is not indicative of the general depopulation in the rest of rural Canada.

Rural Canadians have increased levels of poverty, higher unemployment, shorter life expectancy and a higher infant mortality rate than their urban counterparts. Canada’s Aboriginal people who tend to be rural dwellers are at higher risk than the Canadian population as a whole for suicide, unintentional injuries, diabetes and other chronic illnesses. Aboriginal populations face significantly higher unemployment rates, lower levels of education, income and health status than the average for the general Canadian population.

How the concept of health is viewed and valued by individuals is the result of multiple factors such as shared family values, modelled behaviours of family and friends, and past personal experiences. Sellers et al. noted that it is possible for health beliefs to be culture bound and to play a dominant role in health-related decisions and behaviours. Long found that rural dwellers tend to view health from a role performance perspective that meant being able to work and meet family obligations. In contrast, urban residents focused more ‘on the comfort, cosmetic and life-prolonging aspects of health’.

Johnson et al. said that the geographical place of residence may be an important factor in the health behaviours of individuals. This, in turn, raises questions; such as, is it the lack of services in rural communities that influence the development of these behaviours or are these behaviours intrinsic to those who choose to live in these areas; and are health behaviours demonstrated by rural western Canadians consistent with those of residents from other countries?
Health beliefs
Pullen et al. found that ‘people living in rural areas are less likely to engage in preventive health behaviours’.\(^{19}\) They also found evidence to support the notion that how one defines health will influence the type of health promoting behaviours that are practised.

To understand how people think about health events, the Health Belief Model\(^ {16}\) offers a useful framework by describing four factors that can be assessed which influence health related decision-making. These factors are one’s susceptibility to an event, its perceived seriousness, the benefits of taking action, and the barriers to taking action. Each of these factors is ascribed some degree of value based on the individual’s values, beliefs and circumstances. The positive and negative attributes of each factor are weighed until the individual makes a decision regarding their course of action.\(^ {20}\) Health beliefs surrounding incentives, outcomes, and self-efficacy expectations then influence decisions made about how one’s symptoms are interpreted.

Method
Ethnography
In an ethnographic method the researchers seek to understand how the participants interpret their experiences and make decisions that influence their behaviour within the context of their rural/northern environments. Boyle suggested that all ethnography is holistic within the context of their rural/northern environments and actions, asking questions, and keeping field notes.\(^ {21}\) Rather than a holistic standard ethnographic study of the rural/remote context, a focused ethnography was chosen for the present study. Morse described a focused ethnography as time-limited, small group, and topic orientated.\(^ {22}\) The present two-part study focused on a specific aspect of the context, the health beliefs and practices of rural and northern residents, from an emic or insider’s perspective.

In an ethnographic study researchers triangulate information from various sources. The process includes listening to what is said in interviews, observing practices and actions, asking questions, and keeping field notes that incorporate the physical and cultural context.

The research questions that the investigators posed to each participant included:
1. What does health and illness mean to rural and northern residents?
2. Is there a difference between sickness and illness? If so, can you describe the difference?
3. What health-seeking behaviours do rural and northern residents identify as important?
4. What resources did the participants access and which were important for them to continue to access?
5. Recognising that the terms rural and northern hold different meanings and have been defined in various ways, all participants were asked what rural meant to them. When the second part of the present study was undertaken those participants were asked their definitions of northern.

Dependent upon participants’ responses to the questions above, further data was sometimes sought by asking for more detailed responses through the use of probing questions in addition to questions for the purpose of clarification and validation.

Ethics
Ethical approval was provided by the Conjoint Health Research Ethics Board at the University of Calgary. All participants were over 18 years of age and signed consent forms that emphasised that only grouped findings would be reported. Confidentiality of participants was maintained through the removal of names and identifiers.

Participants
Participants were sought through newspaper advertisements and through a snowball effect by word of mouth from other participants. In the first stage of the present study, participants were selected from municipal districts and small towns within 300 km of Calgary. Participants included 29 men and women who ranged in age from 21 to 84. In the second stage 26 men and women, ranging in age from 21 to 76, living in central and northern Manitoba participated in interviews. Occupations in both regions included farming, ranching, homemaking, retirees, educators, small business operators, administrative assistants, and a mediation counsellor.

Sites
In an ethnographic study the importance and effect of the geographical location in which participants reside is one of the key considerations. Calgary sits in the foothills of the Rocky Mountains and some participants resided on ranches and rural communities within sight of the mountains. South-eastern Alberta is semiarid rolling prairie grassland, with ranching, farming and the production of natural gas and oil as chief industries. A well-defined paved highway system was available to most of these rural residents. In contrast, central and northern Manitoba includes numerous lakes and swampland, open prairie suitable for farming, forested land and the granite bedrock of the Cambrian Shield along the eastern border, which gives a broadly rolling terrain. Within this region the geographical obstacles mean that it is more difficult and costly to construct highways. Several residents were accessed through travel on gravel roads, some up to 160 kilometres from
a major centre. Field notes described the trees and bush, the lack of people and traffic and the general remoteness of those areas.

**Scientific rigour**

Qualitative researchers maintain scientific rigour in their studies through confirmability, auditability, credibility and trustworthiness. Credibility occurred through the use of skilled interviewers and rigorous review of the transcripts and field notes. An audit trail (a record of decisions and steps in the analysis) was kept so that others could follow the decisions, deliberations and approaches of the investigators, to provide confirmability and dependability. The use of direct quotes from participants to illustrate the findings helps maintain neutrality in presenting the present study.

**Results**

**Definition of health**

There was great similarity between participants in both regions regarding the definition of health (see Table 1). Being healthy included a holistic relationship between the physical, mental, social and spiritual aspects of one’s life; a balance that included ‘the big picture’. Being able to do what they wanted to do, to cope, to enjoy themselves, to not be bored and to feel they were productive citizens was important. Several participants ($n = 5$) stated that health was age related: ‘it means different things at different times in your life’. Making choices and accepting the consequences regarding one’s health included taking control and not letting others decide what was essential to their lives. There was consistency in the expressed belief that they were responsible for their own health by motivating themselves, ‘not feeling sorry for yourself’, taking time for family and friends and ‘respecting persons and nature … everyone has worth’. Several participants ($n = 7$) described a belief in a higher power: ‘having faith’. Several participants ($n = 5$) equated being healthy with not having to go to physicians or hospitals. Although a number of participants identified living with chronic illnesses, they considered themselves to be healthy; they had adapted to their illnesses.

When asked about what unhealthy meant to them, many noted smoking and drinking to excess, being overweight, ‘not able to do’, ‘nothing seems to suit you, you don’t enjoy anything you do … you think the world is against you’ and ‘not having the strength or ability to do anything’ (from someone who had experienced a serious illness).

| TABLE 1: Results |
|-------------------|-------------------|------------------|
| Key concepts      | Both regions       | Manitoba only    |
| Healthy           | Holistic relationship between physical, mental, social and spiritual aspects. | More traditional means, for example, bear grease, coal oil and sugar for croup. |
| Unhealthy         | Smoking, excesses of food or drink, ‘not able to do’. | |
| Sickness          | Short-term and curable. | Public health and community health nurses. |
| Illness           | Chronic and life threatening. | |
| Health-seeking behaviours | Maintaining a balanced lifestyle by eating healthy foods, getting plenty of sleep, walking and biking and doing what you enjoy. | A way of life; a long distance by plane or road, freedom and northern lights; ‘you don’t have every single service at your fingertips’. |
| Resources         | Family, friends and neighbours; elders; prayer and church; music; library and the internet. | |
| Rural             | A way of life; an integral part of who they are; ‘as a peaceful place away from the hustle and bustle of the city’. | |
| Northern          | | |
| Practice implications | Need for professionals to truly listen; to be treated with respect; development of websites by healthcare professionals for accurate information; long-term resident professionals to develop a level of trust. | |
There was uniformity in how the terms sickness and illness were defined. Participants consistently described that sickness was short-term and curable; whereas illness was chronic and life threatening. Illness was often equated with mental illness.

Health-seeking behaviours
Both sets of participants noted that maintaining a balanced lifestyle included eating healthy foods (three meals a day), drinking lots of water, walking and biking, getting plenty of sleep, avoiding foods with dyes, quitting smoking, getting annual flu shots, and using a dust mask to prevent respiratory problems. There was a strong emphasis on doing things that one enjoyed and ‘things to stretch out one’s life’. Aboriginal participants spoke of traditional healers and relying on ‘a spiritual entity that is bigger than myself’.

Physicians were only consulted after participants had tried to deal with an illness themselves, noting that they only went to the doctor sometimes after 3 days of feeling ill. A greater number of Manitoba residents spoke about traditional means that they used to treat themselves, such as use of bear grease, mustard plasters, coal oil and sugar for croup, wild ginger root, and consulting traditional healers. This group also incorporated a variety of more standard interventions, such as chicken soup, tea with lemon, cough medicine, gargling with salt water, and garlic.

Resources
Family, friends, and neighbours were cited as a major source of support. If one has a neighbour who is a nurse then that person was often consulted. As one participant noted, ‘I was the local nurse for everyone’. Manitoba residents frequently identified public health and community nurses, as well as home care as a key resource. Although Alberta respondents made general reference about nurses, no specific mention was made of public health or community nursing. Mental health workers were well regarded by both groups. Grandmothers, community elders, and traditional healers were trusted and recognised as a source of support. Church, prayer and Bible studies were resources to others.

Other resources that were noted for maintaining health were music (Canadian Broadcasting Corporation radio was especially mentioned), libraries and books, the Canada Food Guide, hiking and walking paths, medical dictionaries and reference books, and the Internet. A surprisingly large number of participants \(n = 14\) noted that they used computers to access information from the World Wide Web.

Participants strongly emphasised that one of the most valued resources is professionals who listen and ‘respect your choices’. Physicians who know the person’s history and who are known by the residents in the community were appreciated. Respondents spoke of how they valued all those who were involved in emergency medical services, whether they were volunteer workers or highly skilled professionals. Residents in the remote areas of Manitoba noted how thankful they were to now have access to ground ambulance service with fixed wing aircraft out of the larger centres. In contrast, much of southern Alberta has access to a highly sophisticated network of emergency medical services that includes the use of helicopters.

Definitions of rural/northern
These residents described both rural and northern as being a way of life: ‘that’s who I am and that’s what I have been all my life’. Their geographical location was more than just a place in which they live; it was an integral part of who they are. Participants described rural, ‘as a peaceful place away from the hustle and bustle of the city’, ‘a safer and more comfortable place to live’, and ‘a place where you know and can rely on your neighbours’. Distance was perceived as being greater under adverse weather conditions. A question raised by several long-time rural residents was, ‘are you rural if you just live in the country and make your living in the city?’

Northern was depicted as a long distance by plane or road, sparsely populated, without a town or place for shopping, and as having fresh air, freedom and northern lights. Other northern residents noted that, ‘you don’t have every single service at your fingertips’; ‘specialists cannot be everywhere and I would not expect them to be’. Residents acknowledged that because of where they chose to live they had to accept that not all services would be readily available to them.

Discussion
Implications for practice
Analysis of the data revealed several consistent themes for health-care professionals and their practices. The need for professionals to truly listen to their patients was identified as paramount. Related to this, residents felt it important to be viewed by professionals as a whole person, rather than as a disease entity. Regardless of residents’ age or condition, they desired and felt entitled to be treated with respect. In addition to these factors that directly impact individual residents, some broader, system wide implications were also identified.

Issues that relate to the resource availability and applicability included the development of websites by health-care professionals to facilitate accurate information gathering and utilisation by the rural residents. Another consideration is the need to have health professionals come and stay in the communities to which they are recruited. This would afford health professionals the opportunity to get to know their patients and,
therefore, develop a level of trust, which is not possible to achieve in short-term, transient relationships. Once this professional relationship is established with rural residents, it is important that it be maintained. This necessitates that resources be secured to support the elderly and infirm in their home communities. Such supports may include the introduction or further development of various day programs, respite care for family members and expanded home or palliative care services.

Future research
The present study explored health definitions, behaviours, values, and resources of rural and northern residents in diverse rural settings. There have been studies conducted regarding the health beliefs and practices of urban residents with particular disease entities and within specific cultural groups. However, there is a lack of information regarding whether health beliefs and practices of urban inhabitants differ from those in rural areas. This is a question to be addressed in future research studies.

Acknowledgements
University of Calgary Dean’s Research Award and a University of Calgary Research Grant to Elizabeth Thomlinson.

References
10 The Rural Secretariat. Enhancing the quality of life for rural Canadians. Ottawa: Agriculture and Agri-Food Canada, 2001