# THE PERCEPTIONS OF STAKEHOLDERS IN CANADA AND WALES ON HEALTH EDUCATION IN RURAL COMMUNITIES: A COMPARATIVE STUDY

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## ABSTRACT

*This article is based on interviews carried out in rural communities in Canada and Wales with health care workers, educators, administrators and policymakers. The focus of the interviews was on assessing the perceived needs and available services for rural youth, either within their schools or within the immediate community. Various problems and challenges were identified, along with some creative ways of addressing these. Partnerships between the stakeholders emerged as a key to successful and optimal health education and service provision.*

## INTRODUCTION - THE WELSH AND CANADIAN CONTEXTS FOR THE COMPARATIVE STUDY

While Canada and Wales are quite different geographically, with respect to size, climate, urban and rural distribution, and population, the issues facing rural youth are remarkably similar. Both countries are officially bilingual; both have substantial rural areas, and each is struggling with issues of rural school and community sustainability in the face of globalization and economic efficiencies. An overview is presented here of an ongoing comparative study of rural youth and health care needs and services in relation to rural schools in each of our countries. Replicating a case study conducted in Southwestern Ontario, Canada, beginning in 2004 (Varpalotai & Schneider, 2005), a similar framework was used in a study jointly carried out in Wales in July, 2006. This research will continue, and expand, in Ontario (Canada) during the spring and summer of 2007. The policy contexts in Canada and Wales, with a particular focus on selected rural regions and communities in each country as well as data from the interviews conducted thus far with rural educators, health care practitioners, and policy-makers will be presented below.

## KEY HEALTH ISSUES FACING RURAL COMMUNITIES IN WALES

On the basis of population density (fewer than 150 persons per square km) Ceredigion and Powys are identified as two of the nine unitary authorities out of 22 in Wales that are classified as being rural (National Assembly for Wales, 2001). Despite pockets of relative deprivation, both of these authorities present a health profile better than the average for Wales (Wales Centre for Health, 2006a) with greater life expectancy and lower premature death rates than the Welsh average for cancer and circulatory disease. Ceredigion has also the lowest incidence of obesity and alcohol consumption. However, despite these positives, Ceredigion figures as the worst unitary authority in Wales on the

measure of geographical access to services (The National Assembly for Wales, 2005), with the majority of small areas outside the main towns falling within the worst 25% in this regard. The *Pictures of Health in Wales* report goes further by stating that 'rurality is a factor for this community which will increasingly impact on access to services in coming years' (Wales Centre for Health, 2006b).

In the *'Welsh Index of Multiple Deprivation'* (The National Assembly for Wales, 2005), the access to services measurement is based on the proportion of the population in the area having access within reasonable time on foot and/or by public transport to the following nine indicators of services: food-shop; GP surgery; primary school; secondary school; NHS dentist; post office; public library or other free internet access point; swimming pool or leisure centre; and, accident and emergency hospital. In endeavouring to improve accessibility the Ceredigion County Council has produced its strategy vision for *Ceredigion 2020* (Ceredigion County Council, 2004) and has proposed a series of key actions to support and promote the underlying issues for Health, Social Care and Wellbeing. This overarching strategy provides the vehicle for enhancing partnerships as well coordinating and improving services in the county.

Within the context of the comparative research into rural education and health, the two counties selected for this study were Ceredigion and Powys on the basis of their low population spread over a large geographical area. Stakeholders interviewed included primary and secondary head teachers, Community and Sustainable Development Officers, Learning Together coordinator, Health & Wellbeing Strategy Manager at County level, Health Promotion Specialists and Director of Public Health at County Level, the Institute of Rural Health, and senior Welsh Assembly Government personnel. The study in Wales set out to examine the views of the stakeholders with respect to addressing accessibility concerns and in doing so endeavours to highlight the partnership initiatives to promote health education and service provision within rural communities.

## THE POLICY CONTEXT IN CANADA

The recent release of a comprehensive study: "*How Healthy are Rural Canadians? An Assessment of Their Health Status and Health Determinants"* (Canadian Institute for Health Information, 2006), together with a Senate report on rural poverty: "*Understanding Freefall: The Challenge of the Rural Poor"* (Standing Senate Committee on Agriculture and Forestry, 2006) have brought to the forefront the issues facing rural communities in Canada. Interestingly, the cover page of the recent health report contains the following statement: "Patterns of health and disease are largely a consequence of how we learn, live and work". The study assessed 172 health indicators, finding that health status in rural areas is generally worse than in urban areas; rural residents tend to be poorer, with lower educational attainment, and involved with economic activities associated with higher risk (farming, mining, logging....). At the same time, there is less access to services for prevention, early detection, treatment and support compounding the health concerns. The earlier Romanow report *"Building on Values: The Future of Health Care in Canada"* (2002) had also observed this "inverse care law": people in rural communities have poorer health status and greater needs, yet have difficulty accessing required health services (cited by Whaley, 2006).

In Canada, health is a shared responsibility between the federal, provincial and regional

levels of government. While 20-25% of the province of Ontario's population live in rural communities, only 10% of the province's health care professionals choose to work there (Whaley, 2006). The South West Ontario Local Health Integration Network (LHIN), where the Canadian part of this study is located, is one of the largest in southern Ontario, encompassing almost 22,000 square kilometres, with a population of 920,000 people (7.5% of the total population in Ontario). This area includes a significant rural population as well as five First Nations Reserves (Whaley, 2006). The regionalization of health services through these LHINs is still in the early stages, but already questions are being asked about the status of rural communities in relation to the services, and whether these will ultimately be consolidated in the nearest cities, much as they have been in the case of school board amalgamations (Varpalotai, 2003). Restructuring has differential impacts on urban and rural communities, often reproducing and exacerbating existing inequities. Yet, emerging from these gaps in service have been some innovative rural initiatives, including school-based partnerships to facilitate health promotion, prevention, and care with direct delivery and access for youth. One of these partnerships is the subject of the case study described below.

## A STUDY ON RURAL HEALTH SUPPORT FOR RURAL YOUTH

### Perceptions of stakeholders within rural communities in Wales

Health promotion specialists at county level confirmed the general outcomes of the *Pictures of Health in Wales* report (Wales Centre for Health, 2006a) that:

> [r]ural communities have a greater level of health and well being than non rural communities with equivalent levels of the determinants of health. So you know, poverty, deprivation, unemployment appears to have less of an impact in a rural area on well being than it does in an urban area, as if there's almost substitute compensating factors I think in a rural area. (Rural Public Health Promoter)

Many interview respondents tended to define the term 'rural' in terms of population density and access to services but in one particular case rural within the context of community was considered to be 'based around individuals, individuals working together, sustaining activity to the point where you have certain individuals which are relied on in a community' (Rural educator - Development Manager of *Dysgu Gydai'n Gilydd*) . In this case the respondent emphasized the need for people to develop their own initiatives and activities which respond to their own community needs in order to overcome accessibility concerns. Whereas most other respondents focused on health issues directly, this person approached the issue from the context of enhancing lifelong learning opportunities within a bilingual rural community. As the Development Manager of a rural community-based initiative *Dysgu Gydai'n Gilydd* (Learning Together) project, he saw this opportunity as enabling people to acquire key skills, self-confidence, and self-esteem within the community bond of overseeing the educational programmes themselves. Due to this 'ownership' these programmes have become inclusive of people across all ages and languages. As a further example of inclusiveness the same project is targeting the involvement of a group of Romany travellers, aged between 16 to 25 years old, who are hard to reach people 'who the local community might develop a negative attitude to but you can turn that into a positive and get them to engage in activities that are worthwhile to them as individuals and for the community'. The programme coordinators are also endeavouring to be proactive in overcoming obstacles, such as accessibility to child care. In furthering the scope of the programme,

the initiative has developed in conjunction with the Healthy Schools award scheme in getting health messages out to the community. This has already happened in the case of promoting healthy eating in the community and in doing so reinforces the actions as promoted by the *'Ceredigion Food and Well Being Strategy Action Plan'* (Ceredigion Local Health Board, 2005).

The Healthy Schools award scheme (The National Assembly for Wales, 1999) was recognized at both local authority and national levels as being a success despite challenges particularly within a rural authority. Being a national framework certain procedures for accreditation have to be in place, but there is sufficient flexibility for the scheme to be developed to meet the needs at a local level as exemplified by the following interview response *'*we have a steering group which sees how different key partners own that in the schools, the local education authority, local public health and school nursing, police' (Healthy Schools Coordinator). This demonstrates the fact that health and education professionals are working together to provide a coordinated approach to ensure schools attain and sustain the principles of the Healthy Schools award, as advocated by several researchers in the field (St Leger & Nutbeam, 2000; Lee, et al., 2003; Leurs, et al., 2005; Thomas & Weng, 2007). One of the challenges faced in coordinating such a scheme within a large rural authority such as Powys was to organize steering group meetings. They set up cluster meetings in the north and south of the county, but according to the Healthy Schools Coordinator *'*even a cluster meeting is quite a big area to travel to. So you might have a cluster meeting that might start at 4:00 and they're still coming late'.

A further challenge facing rural authorities is ensuring the youth and older population have access to health services. Whereas there are post buses operating during the day in certain areas that will enable some people to access services in towns, there are no county-wide systems in place geared to assist the youth. Consequently, the remoteness of areas in mid Wales makes it difficult for the youth to access sexual health clinics; they are unlikely to ask their parents to take them. In response, certain strategies have been considered so that the youth can seek support and advice in confidence. One such scheme involves *'*working with the community pharmacists to introduce a scheme that's happening elsewhere… in order for emergency contraception to be available for young people' (Health Promotion Officer). Another initiative set up to ensure the youth have access to health education is the availability of a bus that visits secondary schools and youth clubs in one area of Powys. Despite the general health information available the bus has been labeled the 'sex bus' due to the information on sexual health and that *'*they can give out condoms'. (Health Promotion Officer)

A separate initiative in Ceredigion is *Ymlaen Ceredigion* (translates as Forward Ceredigion) which uses community organizations to access those who are at risk and disadvantaged in society and proceeds to support and encourage them to undertake activity, in the general sense of the word, which is likely to reduce their risk factors of coronary heart disease. In fact what initially set out to focus on reducing the risk factors of coronary heart disease has now branched out to address the promotion of healthy lifestyles. According to the Community Development Officer, the initiative is now focused on *'*increasing physical activity, 5 portions of fruit and vegetables a day, dealing with stress, not smoking, etc'; more importantly these are the issues identified by the individuals targeted and it is them together with the group leaders who decide on the most appropriate and accessible intervention. Rather than targeting individuals in

isolation, the approach is to target parents and very young children. Because of this approach, *Ymlaen Ceredigion* does not work in schools as that would isolate the young person from their family background.

Engaging rural youth directly in issues affecting them, continues to be a concern and a challenge. The Institute of Rural Health has developed a professional development model to "rural proof" health care professionals, to ensure a sensitivity to rural issues, as well as to enhance recruitment and retention of health care practitioners in rural areas. *Rural proofing* may be a concept worth adopting for all policy-makers and practitioners engaged with rural issues.

**Health care in rural communities: Ontario, Canada**

This section is based, in part, on a case study and interviews with key personnel involved in the partnership between one rural secondary school in southwestern Ontario and a community health centre located in the same community. "Rural" in this case is defined by the Youth Worker as: "connection to agriculture, limited resources for the youth and our most 'at risk' populations – the elderly and young families…. And distance from the nearest city." The Health Promoter, who has been a rural/farm resident all her life, describes rural as: "Living in a farm community - though not everyone here lives on a farm. For me, rural is not 'living without' – it's living in a community where I feel there is more connectedness with people and an opportunity to really make some significant changes in your community."

Health care needs in rural communities have been making headlines in Ontario for years (Southwest Region Health Status Working Group, 2004; Trute et al, 1994; Turner, 2004). Though the Health Centre has funding for 3 physicians, only one (temporary) physician was actually on staff at the time of these interviews (the full complement of physicians has since been recruited). The nearest hospital is on the border of the neighbouring county while government offices are a one-hour drive away.

The Executive Director of the Community Health Centre was a registered nurse with many years of rural health experience and the partnership with the high school was initiated by him. The school's previous and current principals have been highly supportive of these joint ventures. As long-time residents of this rural community, they were well aware of the needs and accessibility issues related to health care. Distance from the nearest urban centre, lack of public transportation, and a resistance to seeking health care, all combined to make this an under-serviced community. The Director had been active in "advocating equity and fairness to access for services and promoting some professional training for rural youth as they're moving forward and getting them interested in some of these fields." He described this community as primarily agricultural, relatively poor, with a population of European immigrants who bring with them some traditional values, particularly as these pertain to family values and gender stereotypes. He notes that often very bright girls are not encouraged to continue their education beyond high school, and sexuality issues are frequently ignored. The demographic is skewed with a population high in seniors and youth, while many young adults were either away at school or elsewhere for jobs.

The Community Health Centre was located here because of its proximity to surrounding smaller communities, and the local elementary and secondary schools. The Centre has a

strong community development and health promotion mandate. Networking with other relevant agencies, partnerships have been formed where combined funds have created greater opportunities and services, including the Wellness Centre at the school. The head of Student Services at the school considers the partnership with the Health Centre a welcome relief. "So when they opened up the health centre uptown, it was just like, oh God, thank you! Here's what I need, and they even came to us and said, what do you need? I said, well, I'll tell you …. We need help with personal counselling with kids, so a social worker, youth worker. We need help with mental health issues. Those are two of the biggest… like any school, we have kids who are dealing with depression, dealing with anxiety, dealing with parental problems, wanting to quit school; we have kids who have survived abuse of different kinds."

Students now have access to health professionals *either* at the school's Wellness Centre *or* at the Community Health Centre a few blocks away. Regardless of their choice, their privacy is a high priority. Nurse practitioners, youth workers, social workers, dieticians, and referrals to other services are available at both sites. The use of these services tends to differ along gender lines. According to the Nurse Practitioner, 95% of direct users of the services are the female students. Among the issues of particular relevance to girls (Varpalotai, 2005) have been: counselling related to birth control and pregnancy; weight and body image; continuing education; abuse issues and self-harm (cutting, eating disorders, substance abuse and attempted suicide); relationships with parents; and, grief counselling. Sexuality issues are a major concern, according to the Youth Worker: "Huge, huge, a big issue… STD's (sexually transmitted diseases), pregnancy rate is very high, where real young girls or babies as far as we're concerned, you know, they're 13 or 14 and end up pregnant, it's pretty disruptive to their lives and the baby's life." The Guidance Counsellor adds that in the past, most of these girls left school while they were pregnant, and usually leave the community altogether. Most pregnant teens now choose to keep their babies and remain within their own families; a few try to make it on their own. Girls are the ones who most often seek information about contraception, even for their boyfriends, and sexually transmitted infections are common: "being rural, a lot of times they share partners, you know, over a couple of years or months – so things are getting passed around." (Youth Worker) Everyone has been surprised at the popularity of the dietician's services, especially among teenaged girls who are seeking advice on appropriate weight-loss diets and body image issues, though boys are seeking such guidance also. The Guidance Counsellor notes: "I really didn't think that the dietician would go over very well, and that's probably the [service] that they use the most. They know she's here … mostly young girls who are now 14/15 and not liking the way their body is shaping."

The boys seek health services far less frequently, and mostly when they are in major distress. The most prevalent issues for boys include body image and nutrition counselling, as noted above; mental health issues (particularly depression and suicide); and anger management (referred by school staff). Sexuality issues are addressed indirectly through their girlfriends, as previously mentioned.

A public health nurse and nurse practitioner are also regular visitors to the school, and are available for birth control advice, pregnancy counselling, and other sexuality and health issues. As regional health units have cut back on the public health nurses who used to visit schools regularly (now one nurse may be responsible for 25-30 schools), the local Health Centre provides almost daily access to health care providers in the

school.

Interestingly, none of the educators or health care professionals volunteered information concerning gay, lesbian, bisexual or transgender students. The teachers did not consider this to be a significant issue. When asked, there was awareness of only a handful of individuals who had 'come out' during the past three or four years – all male. As one educator put it: "they generally don't do it, come out, until they're about to leave." While there were no recollections of homophobic incidents and the educators noted that the student population seemed remarkably accepting, it was clear that the broader community was not welcoming of such diversity. And it was also noteworthy that lesbian students in the school were unheard of.

The health care professionals offered a different perspective on this issue: "Yeah, I find that kids are bullied here quite a bit [if someone is 'different']. A girl who has short hair is asked why is her hair so short? Yeah, the differences are picked out quite a bit here … I think they have a lot of presentations on acceptance here – outside presentations – but has it filtered onto the kids? I think in some, but some kids make light of it too – so no, it doesn't feel like a safe place for a gay or lesbian kid to come out, not at all unfortunately."

The Community Health Centre provides groups for at-risk mothers and babies (including teen moms), and youth dealing with anger management issues (also available at the school for students who have been expelled from their classes). Funding has recently been secured for a drop-in centre for after-school activities with a board of directors including a representative group of students. Mental health issues are among the most difficult for small, rural communities. The Health Centre has created additional partnerships with urban-based psychologists and psychiatrists who regularly visit the Centre and are available for consultations with both clients and other health care workers who are trying to create additional "wrap-around" support services for particularly high risk youth and their families.

Despite the popularity of these services, there continues to be resistance from some of the teachers, who view the various health care workers as "outsiders" and "intruders" within the educational environment. Teachers sometimes are reluctant to listen to youth workers who advocate a more flexible approach to dealing with difficult students when personal issues get in the way of their attendance and academic work. The Youth Worker notes: "I think they are afraid of losing total control… my approach is different. My approach is to empower them [students]; let's be more understanding of their issues. Let's let them own more responsibility and let's give them some time, you know, to work on things and they [teachers] were just 'no, just suck it up'. Just suck it up... and I'm saying, you know, you might not realise that this child's mother was just diagnosed with cancer. But this child wouldn't tell this teacher because they don't trust them, because they already have this barrier up and this kid had said to me, 'well when she talks to me, I just go into the toes of my shoes.'" Others are slow to refer students who are in need of counselling or other forms of assistance beyond the classroom. Partnerships take time to develop - mutual respect and co-operation are built slowly. Nonetheless, those most directly involved, and those who stand to benefit from these services are very enthusiastic about working so closely together. "Yeah, there's some resistance although our principal is wonderful… so he's worked to smooth over some of the issues."

There is some resistance from parents also – particularly with regard to sex education. The Community Health Worker, with responsibilities for Parenting Education and Support, has been involved with support groups for young mothers, as well as providing relationship counselling and group sessions for the students. The school has an annual health fair, offering resources and information on a variety of issues, including pregnancy prevention and STDs. "It made the papers – I'm just really happy that I did healthy relationships – it became [labelled] the 'sex fair' and it was just awful! It was all curriculum based; everything met the guidelines with the board of education", but a group of vocal parents protested the sexual aspects of this event, overshadowing the rest. "We also partner with the Parent Advisory Council.... We consult, we have open night for parents, but of course there's always parents that [will say] 'if you give them information, then they're going to go out and have more sex.' No, it won't be any different, you know, if they're going to go and have sex, they're going to have sex but it might be safer sex that's all, you know. So there are some real conservative attitudes but there are others who are very supportive."

The Health Centre's Executive Director credits what he calls 'champion teachers' in every school that make the partnerships possible and successful. Guidance counsellors and principals are often key in coming up with ideas, supporting the partnership, and taking risks. Rural schools are central to enabling the other services to exist. In the face of further rural school closures, this health care provider asserts:

> *"The sustainability of education in these rural communities is essential. I'm sure some schools will have to close but don't close them all! That sustainability is real critical certainly for government, it has to think about a primary care model, working in partnership with one of the most instrumental components of any community involved with children and youth are the schools, the teachers and how to partner and find programs like what we have here – there has to be government support for that." Among the obstacles to further community outreach are rural citizens who better understand a more traditional health care system: physicians and hospitals; and rural elected officials who are more concerned about "sewers, roads and garbage… they don't understand social and health infrastructures…. Somehow your citizens believe that's a waste of money (prevention, promotion, and education)."*

## SUMMARY AND RECOMMENDATIONS

> … Governments are not likely to magically gain a better understanding of what life in rural areas is all about. This can only happen through a process of advocacy and political action coming from the communities themselves. (Smith, in Cullen et al., 1989, p 109)

This paper has provided a brief overview of the policy and practice contexts in each of our two countries, as they pertain to rural schools, communities, and health care services. Among the 'best practices' the most notable were the concept of 'rural proofing' health care practitioners (Wales) and the development of the highly successful 'Wellness Centre' in a rural secondary school (Canada) which partners education staff with locally based community health care practitioners. Both places share similar challenges: access to services is the most significant; followed by resistance to addressing issues pertaining

to sexuality; and finally, creating school-based access to services for rural youth. While Wales has a well-developed Healthy Schools policy, the practice continues to evolve largely due to the Welsh Network of Healthy Schools Scheme particularly so in primary schools but it is unevenly applied in secondary schools. Canada has a less well articulated Healthy Schools policy framework, and the models, as described here, are locally developed and implemented, and isolated to a few schools and school boards.

In summary, while small, rural schools and communities may be challenged by geography, culture, and a relative lack of resources, a close-knit community and dedicated professionals are able to create a "web of supports" as one youth worker put it, to enable all students to complete their schooling, and deal with a wide spectrum of health and personal issues, within easy reach of their home and school. While policies in Canada and Wales may differ in scope and implementation strategies, both countries are increasingly becoming aware of the unique needs of rural communities, and the combination of factors leading to important health concerns. Rural schools may need to work more closely with parents, health professionals, and others within their areas to ensure that their students have access to the services more easily available to urban schools and students. Schools and communities, as well as teachers of various subjects, need to bridge their services and their areas of specialization, in order to provide more comprehensive and effective educational and health service opportunities for all (Varpalotai & Leipert, 2006). As these studies illustrate, working together, through creative leadership and community participation, rather than competing for funding, can lead to positive outcomes. Policymakers, elected officials, and funding agencies need to become more aware of the needs of rural communities, the possibilities of grass-roots community collaborations – and the fact that rural schools are the "cornerstones" of their communities. Further case studies are needed to identify successful strategies, as well as gain a better understanding of the challenges and opportunities within rural communities. International comparative research enables researchers and practitioners to exchange ideas about 'best practices' as well as gain new insights on problems, policy frameworks, and experiences. Healthy School initiatives are increasingly being seen as important sites of early and effective intervention to facilitate healthier lives for rural youth and their communities, and 'rural proofing' health care workers and educators is essential if these partnerships are to flourish.

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