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REVIEW ARTICLE

Understanding Australian rural women's ways of achieving health and wellbeing - a metasynthesis of the literature

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ABSTRACT

Introduction: Although Australian rural women appear to be coping well despite a lack of services, harsh environmental conditions and overall rural health disadvantage, there is little research into the factors which promote good health among them. The aim of this article is to document and analyse current understandings about how rural Australian women maintain health and wellbeing, by conducting a metasynthesis of peer reviewed empirical qualitative research.

Methods: Searches were conducted of CINAHL, MEDLINE, Proquest, Blackwell Synergy, Informit, Infotrac, National Rural Health Alliance and Indigenous Health *Infonet* data bases. A definition of health and wellbeing as a positive concept emphasising social and personal resources as well as physical capacities, provided a framework for the review. Six studies published in rural health, nursing and sociology journals between 2001 and 2006 were selected. Common and recurring themes from the original studies were identified. Reciprocal translation was used to synthesise the findings among the studies, leading to interpretations beyond those identified in the original studies.

Results: Four themes emerged from the metasynthesis: isolation, belonging, coping with adversity, and rural identity. The findings of this study exhibit a tension between a sense of belonging and the experience of social and geographical isolation. The study

findings also reveal tension between adherence to a strong gendered rural identity which fosters a culture of stoicism and self reliance and feelings of resistance to societal expectations of coping with adversity.

Conclusions: Metasynthesis enabled a deeper understanding of the health and wellbeing of rural women in Australia. The social experiences of rural women influence the way they construe their health and wellbeing. Understanding how women maintain health and wellbeing is critical in ensuring that policies and services meet the needs of rural women and do not entrench existing inequalities.

Key words: Australia, health and wellbeing, metasynthesis, qualitative, women.

Introduction

Approaches to addressing rural health disadvantage now focus on strengthening the capacity of rural communities to promote health and remain resilient to adversity, rather than on the delivery of medical services in small rural hospitals[1]. Studies in Australia have shown that rural women consider themselves to be healthy despite the stresses associated with rural living[2]. Understanding the factors that underlie this perception of good health will make an important contribution to policies and services aimed at improving health and resilience in rural communities.

The purpose of this article is to review selected health and social science literature relating to rural women's health and wellbeing by conducting a metasynthesis of selected peer reviewed empirical qualitative research. The aim of the metasynthesis is to develop a deeper understanding of how rural women maintain health and wellbeing. Consistent with Creswell's[3] approach to reporting qualitative research, the literature is used to frame the research problem in the Background section. This is followed by a description of the methodology. The results of the study are the themes emerging from the metasynthesis. In the Discussion, these themes are discussed in relation to the relevant literature.

Background

Despite overall rural health disadvantage, lack of services and harsh social and environmental conditions, studies have shown that rural women rate their overall health positively across the lifespan. The Australian Longitudinal Study on Women's Health (known as Women's Health Australia) is a longitudinal population-based survey of a stratified sample of over 40000 Australian women selected from the Medicare database. The survey is designed to enable comparisons to be made between women living in different geographical areas, based on the widely accepted Rural, Remote & Metropolitan Areas (RRMA) classification system. The first survey, conducted in 1996 found that most women residing in rural and remote areas in the young (18-22 years), mid-age (45-49 years) and older age (70-74 years) cohorts assessed their health as excellent/very good or good[2] .

Studies have shown that there are no significant differences in levels of stress and life satisfaction between women in urban and rural and remote settings[2], even though Australians living outside metropolitan areas may be expected to have a heightened risk of mental health problems and mental disorders, due to a range of factors specifically related to the rural context[4]. These include isolation, economic restructuring, climatic extremes and distance from services[4]. Women's Health Australia found that although women in rural and remote areas experienced a similar number of stressful life events, they were less stressed by them than urban women[2]. In a randomised telephone survey of 394 women in Queensland, Bramston, Rogers-Clark, Hegney and Bishop[5] found no significant difference in levels of emotional distress between urban, rural and remote women.

Curtis and Rees Jones[6] maintain that qualitative research has an important role to play in explaining the findings of quantitative studies that describe health in terms of particular measurable indicators. This article reviews selected qualitative studies relating to the health and wellbeing of rural women in order to obtain a better understanding of accumulated findings that reveal rural women appear to be coping well despite the stresses associated with rural living and overall rural health disadvantage. Qualitative research also increases our understanding of health within the broader context of people's lives[6]. A metasynthesis of qualitative research relating to rural women's health and wellbeing deepens our understanding of the lived experience of rural women, and facilitates the utilisation of these studies in health policy, practice and research.

Methods

Increased acceptance of evidence-based approaches to addressing health issues has led to interest in ways to synthesise the proliferation of qualitative research studies in health[7]. Metasynthesis is a methodological process for integrating findings from qualitative studies and locating them within a broader interpretive context[8]. It provides a means of analysing and presenting the accumulated understandings from qualitative research beyond the 'little islands of knowledge' of individual studies[8,p367]. The purpose of metasynthesis is to achieve a depth of understanding of a knowledge base and a level of conceptual development beyond that which is achievable by the more conventional narrative literature review[9]. A conventional literature review would have involved describing and summarising empirical studies and the identification of key themes. A metasynthesis of the literature has involved the juxtaposition of studies and the search for connections between them, in order to develop a more sophisticated understanding of health and wellbeing. The more complex concepts which emerge from the metasynthesis are linked to bodies of literature not previously explored in relation to these studies, and lead to new insights that can help explain how rural women maintain health and wellbeing.

While the relationship between gender and rurality has been well documented in the literature[10-15], the impact of gender and rurality on health and wellbeing is an emerging area of inquiry[16]. The paucity of qualitative studies that explore how rural and remote women achieve health and wellbeing makes the process of metasynthesis ideal for documenting and enhancing the current knowledge base in this area.

Search strategy

Interpretations of health vary and in many studies the concept is not defined. My approach to selecting studies and conducting the analysis is informed by my background in social work and health promotion. According to the World Health Organisation definition of health, encapsulated in the Ottawa Charter for Health Promotion, health is not merely the absence of disease. It is a positive concept emphasising social and personal resources, as well as physical capacities[17]. In this study, the inclusive term 'health and wellbeing' is used to encompass this broad definition, which includes both physical and mental health. The review also reflects my previous experience as a health promotion officer with the Royal Flying Doctor Service. One of the challenges in working with each community was how to engage with them in developing broader understandings of health and wellbeing in order to design activities and programs that were relevant and meaningful to their lives[18].

Searches were conducted of the following databases: CINAHL, MEDLINE, Proquest, Blackwell Synergy, Informit, Infotrac and Indigenous Health *Infonet*. Due to the dearth of research in peer reviewed journals, searches were also conducted of peer reviewed conference proceedings from the National Rural Health Alliance database to identify potentially relevant studies not found using key words. Key words searched in multiple combinations were rural, women, health, wellbeing, qualitative methods and Australia. The criteria for including studies were that they described the qualitative methodology, were published in peer reviewed journals, related to how rural women achieve health and wellbeing, and that studies were conducted in Australia. In order to focus on contemporary issues, inclusion was limited

to studies published between 2001 and 2006. Assessment of the quality of qualitative studies for a metasynthesis is contentious[7]. In this metasynthesis, a balance was sought between inclusiveness and the need to limit the sample size so as not impede the depth of analysis[8]. Studies' inclusion was based on the auditability of the methodology and the rich description of the data, which are recognised criteria for assessing qualitative research[19]. Articles considered within the criteria were reviewed for relevance. All articles not reporting empirical research were excluded. The main criteria used for exclusion was that the article was not based on empirical research, did not describe a qualitative methodology or was not published in a peer reviewed journal within the period specified.

Qualitative studies selected

The six articles from six separate studies were published in rural health, nursing and sociology journals. The studies were carried out in Queensland, New South Wales and South Australia. Participants included farm women, women from a non-English speaking background, same-sex attracted women and women from an isolated mining town. The age of participants was not stated in one study. Of the remaining studies, participants were aged between 18 and 87 years. None of the studies identified participants as being of Aboriginal or Torres Strait Islander background, and no studies of Indigenous women that fitted the criteria and were published in peer reviewed journals were located. Details of each of the published articles, based on relevance to the process of metasynthesis, are included in this section.

The studies selected explored the health and wellbeing of socially, culturally and economically diverse groups of women living in environments defined by the authors as rural or remote. One study[20] explicitly sought to examine women's perceptions of health and wellbeing but implicit in all of the studies is an understanding of health that goes beyond the absence of disease to include the social, cultural and environmental context of women's lives. Each of the studies examines how women achieve health and wellbeing in a challenging social and environmental context.

In a qualitative study conducted in rural New South Wales in 2001, de la Rue and Coulson[20] explored the meaning of health and wellbeing and the influence of geographic location from the perspective of older rural women. The study participants were five women aged between 73 and 87 years who were either living on a rural property or had done so for most of their lives. Social constructionism and socio-environmentalism were described as providing the philosophical framework for the study. A life history approach informed data collection and analysis. Data were collected through in-depth interviews and review of personal documentation shared with the researcher by the participants. Interviews were transcribed verbatim and data were validated through member checks. Data from each participant were analysed to identify emergent themes following which each participant's life history was compared and contrasted with those of others. Direct quotations from participants were documented to illustrate emergent themes.

Greenwood and Cheers[21] conducted a qualitative study in rural South Australia which explored the health care and life experiences of women on isolated pastoral properties who look after babies and children. Phenomenological inquiry was described as providing the philosophical basis for the study. Data were collected via in-depth interviews with 15 women living on pastoral properties and a focus group of seven women from an isolated mining town. Narrative approaches were described as informing data analysis, and data were validated through member checks. Points of difference or commonality between women on pastoral properties and those from an isolated mining town were not discussed. Quotations included in the study results were selected on the basis that they best reflected and articulated a particular concept.

Rogers-Clark[22] conducted a study involving nine rural women in south west Queensland who were selected on the basis that they were long term survivors of breast cancer and had undergone a mastectomy. Participants were aged between 44

and 75 years. The research question was: *What responses indicating resilience assist rural women who are long term survivors of breast cancer to move on with their lives in the face of this adversity?* (p35). A feminist post-modern narrative methodology involving unstructured in depth interviews with participants was utilised. The methodology sought to allow women the opportunity to tell their own stories and the meanings they drew from those experiences. Research strategies demonstrating rigour were detailed in the article. In focusing on rurality as a factor influencing women's experiences and responses to a significant life event (breast cancer), the study addressed issues relating to change and adaptability to achieve health referred to in the Ottawa Charter.

A qualitative study undertaken by Alston[23] in 2003 explored the social impact of drought on farm families, small businesses and small communities in New South Wales. Semi-structured interviews were conducted with 120 people including 62 farm families (37 women and 25 men). Focus groups were also held with small business members, service providers and community members. Interviews and focus groups were recorded, transcribed and analysed for emergent themes. This article adopted a case study approach which explored women's individual experiences of drought within the larger study. Cases were selected on the basis that they illustrated issues raised by a majority of women in the study. One of the women was 18 years of age and the other two were over 50 years. The article discussed a post-modern feminist approach to understanding women's experiences of drought. One of the case studies specifically explored issues related to health and wellbeing and drought, while the other two case studies also explored issues that fall within the broader understanding of health and wellbeing referred to in the Ottawa Charter. The study was included in the metasynthesis on this basis.

Edwards[24] conducted a qualitative study in South Australia to explore the experiences of same-sex attracted women living in rural areas and how this influences their psycho-social wellbeing. Details of a theoretical framework underpinning the research design were not included but the study design was consistent with critical theory. Interviews were conducted with a non-probability sample of seven same-sex attracted women (recruited to the study through a gay and lesbian counselling and support service) and one service provider. Interviews were recorded, transcribed and analysed for emergent themes. Summaries of interviews were sent to participants for member checks and to enable them to remove any information they considered might identify them.

Kelaher, Potts and Manderson[25] conducted a study of health issues among 90 women born in the Philippines and living in rural and remote Queensland. This cohort was selected for study because issues related to race, gender, socio-economic disadvantage and stigma were expected to exacerbate rural health disadvantage. The study, which is a sub-study of the Australian Longitudinal Study of Women's Health, consisted of both quantitative and qualitative components. Qualitative data were collected through semi-structured interviews and focus groups. Data were coded and analysed using the NUD*IST (QSR Software; Melbourne, VIC, Australia) program to identify emergent themes. The areas of interest explored in the interviews included immigration experience; recognition of qualifications and access to employment and professional development; social support in Australia and the Philippines; relationship issues; perceptions and use of health services; and cultural perspectives on health and staying healthy. Details of the theoretical or philosophical basis for the study design were not included but the study design is consistent with critical theory.

Method of analysis

The technique of reciprocal translation was used to synthesise the studies selected[9]. Each of the articles was read several times. Following Ypinazar[7], key concepts and findings from each study were mapped on a grid with the aim of translating the findings from one study to another. These concepts constituted the data for analysis. Identified concepts from each study were considered against each of the remaining studies, identifying common and recurring themes until all studies were considered[9]. These themes were then considered in relation to each study to preserve their integrity and

subsequently mapped on a grid (Table 1). The final stage of the analysis involved considering the relationship between the themes or concepts that were the outcome of the synthesis, and constructing new interpretations based on the relationship between each of the studies. Hence the claim that metasynthesis extends interpretive possibilities and makes a fresh contribution to the literature[9].

Results

Four themes emerged from the reciprocal translation and synthesis of the studies:

1. Isolation
2. Belonging
3. Coping with adversity
4. Rural identity.

Isolation

Five of the studies reported ways in which isolation impacted on women's health and wellbeing. This related not only to distance from family, health and support services, but also the lack of opportunities to share feelings and experiences with others who had similar personal social and cultural experiences. The rural context presented some unique constraints in seeking out others with whom to share intimacy. These included fear of rejection and ostracism for being different from the dominant rural culture, lack of privacy and confidentiality, lack of driving skills and public transport, and lack of informal opportunities to feel connected with others[22,24,25]. This emotional distance from others was most keenly felt during times of crisis, ill health or changed family circumstances, such as following child birth[21]. These experiences were associated with a range of consequences, including feeling sad, psycho-social distress, and hospitalisation. In one study, the availability of a local and supportive female GP was important in addressing the need for emotional support[21]. For others, it was necessary to seek help outside their community[24].

A sense of isolation persisted despite modern communications. A participant lamented that the telephone meant that people were in touch with the outside world but not each other:

> *...and I did speak with her, the owners actually said that she was very lonely and we arranged to speak and we used to speak every Saturday on the* [VHF] *radio. And that went on for two years, I did eventually meet her but in two years we got the telephone and that was the end of that, but yeah for quite some time I had no idea who she was except that she was a mum with a couple of kids and didn't have anybody to speak with*[21,p6].

Belonging

In two studies, participants referred to an inner peace associated with a spiritual connection to the land[20,22]. This was described in terms of a love of the land, having 'come from the land' and a sense of wholeness derived from a personal connection and sense of intimacy with the land. The connection with the land is described as engendering a healing quality[22] and a sense of personal power[20] which had a positive influence on health and wellbeing. This sense of belonging was associated with women in the mid- or older-age groups who were living on a rural property. Living on the land was described as more than a place to live. It engendered a whole way of life that shaped day-to-day living and personal, family and community relationships. However, for other women on rural properties, the experience of rural living was predominantly one of meeting societal expectations of coping, with little compensation in terms of lifestyle[21,23].

A sense of belonging was also associated with feeling connected to others in the community through expectations of interdependence during times of need[22]. However, for others, a sense of belonging necessitated negotiating cultural differences and adopting rural social norms in order to gain acceptance[25].

Coping with adversity

Coping with adversity was a central theme in all of the studies. Participants regarded adversity as an inevitable part of rural life, and being able to cope with whatever comes along was expected. For some women, this entailed adding to existing farm and family income by doing off-farm paid work, compromising their own health in the process[23]. In the study of older rural women, rural living was conceptualised as a resource and a 'shield' for coping with the 'other life' around you[20,p5]. Contrary to expectations of support in times of crisis, women who felt that they didn't fit in with rural social and cultural norms were constrained from seeking help by a lack of acceptance and confidentiality[24].

In other studies, women felt that while family and friends offered practical support, they were in a sense coping alone for a range of reasons. These included sparing others, financial constraints, embarrassment at their situation or lack of practical alternatives and support[21-23]. In two studies participants did express resistance, almost exasperation with the dominant discourse of self-reliance and coping by expressing a desire to escape and have a different life by 'getting in the car and just going'[21,p5], or to 'get in my car and just go north and leave the whole lot behind'[23,p163]. Despite this, the women continued to fulfil what they believed to be their caring and support role in the family and the community.

Rural identity

All of the studies explored the construct of a gendered rural identity. Consistent with the literature[5,12], participants articulated and valued an identity as rural women. This involved being responsible, self-reliant, organised, physically and mentally strong, positive, competent, caring and supportive. It also involved being able to fulfil multiple roles in the family, paid work force and the community. In two studies, being a 'woman of the land' was found to go beyond lifestyle and personal character traits to encompass a spiritual connection with the land from which women derived strength and an inner peace[20,22]. These findings imply a homogeneity among rural women that was not shared by women in some studies.

While the sense that 'everybody knows everybody' can facilitate a sense of belonging, the visibility of daily life, and conformity to an accepted rural identity, can marginalise and exclude women who do not share this persona. Same sex-attraction carried with it a fear of exposure and harassment. Denial and conformity to achieve acceptance resulted in personal distress[24]. Some women also experienced stigma and alienation as a result of ethnic identity[25].

Discussion

The study findings highlight the impact on health and wellbeing of the diverse social and cultural experiences of rural women. The social experiences of rural women varied according to their age, socio-economic status, sexuality, ethnicity and whether they lived on rural properties. The heterogeneity of rural women is often overlooked in the literature. In a review of scholarly literature and mass media in Australia, Grace and Lennie[26] noted a tendency to overlook varied lifestyles and equate 'rural women' with farming women. Sharma and Rees[27] found that, despite indicators that they experience significant mental distress, the mental health and wellbeing of women living in remote mining towns had been virtually overlooked in the literature. Indigenous Australians make up a large proportion of the population in remote areas[28], yet this review found that there are few published studies relating to the health and wellbeing of Indigenous women. Marginalised groups, such as same-sex attracted women, Indigenous women and those from culturally and linguistically diverse backgrounds, may experience aspects of rurality that are detrimental to their health and wellbeing[29-30]. Studies that portray rural women as a homogeneous, satisfied and healthy group obscure the way in which geographical location intersects with social, cultural and economic factors to influence the health and wellbeing of rural women.

Table 1: Key themes derived from reciprocal translation of original studies[20-22]

Theme	Article content		
	de la Rue and Coulson, 2003[20]	**Greenwood & Cheers, 2003**[21]	**Rogers-Clark, 2002-2003**[22]
Isolation	–	Not being able to participate in farm activities. Separated from loved ones. Not being able to share experiences. Loneliness. In touch with the 'outside world' but not each other. Lack of intimacy. Dealing with danger. Communicating with others. Missing the company of other women. Family separation.	Geographical isolation from professional support services. Lack of privacy and confidentiality constrain sharing of experiences and feelings. Feeling physically different.
Belonging	Spiritual underpinning to life Inner peace.	–	Inner peace. Spiritual connection to the land. A sense of intimacy with others.
Coping with adversity	Land and rural lifestyle as protector. Health a resource for living. Learn to live with whatever comes along.	Coping alone. Financial constraints. No relief. Meeting expectations of coping. Compromising own health. Resistance – escape. Reaching a crisis. Finding help elsewhere. Inevitability of coping. Feeling unprepared. Responsibility for others.	Financial constraints. Lack of options for choice of professional support. Practical support from family and friends a 'given' in rural areas. Learning to live with adversity. Coping alone.
Rural identity	'Woman of the land' as positive identity.	Being able to cope. Being organized. Being responsible.	Being physically and mentally strong. Being self reliant. Fulfilling expected roles. Being positive.
	Alston, 2006[23]	**Edwards, 2005**[24]	**Kelaher, Potts and Manderson, 2001**[25]
Isolation	Geographical isolation from professional support. Not being able to share feelings.	Feeling different. Lack of social networks. Concealing difference. Isolation enforced by fear of rejection and ostracism. Lack of intimacy. Distance from support services.	Lack of contact with family overseas. Lack of local support Networks. Physical and social isolation due to lack of driving skills.
Belonging	–	Feeling comfortable with where you live. Having a public persona that conforms to social norms.	Need to negotiate different cultural norms. Concerns about negative public perceptions of Filipina culture.

Table 1: continued

Theme	Article content		
	Alston, 2006[23]	**Edwards, 2005**[24]	**Kelaher, Potts and Manderson, 2001**[25]
Coping with adversity	Doing paid work to support family. Monitoring and prioritising health of others over self.Compromising own health in order to 'cope'. Coping as an imperative due to lack of alternatives and support. Resistance – escape, seeking independence. Coping with an uncertain future. Opportunities foregone. Strained personal relationships.	Lack of privacy constrains help seeking. Reaching a crisis. Finding help.	Lack of support services for mothers and babies. Strong Filipina cultural networks developed. Taking responsibility for settling in. Lack of confidentiality constrains help seeking.
Rural identity	Self reliance a strength. Self reliance as source of pride. Societal expectations of rural self reliance. Public self reliance/ private embarrassment at social circumstances Multiple family, work roles. Being responsible. Coping despite ill health/injury.	Constrains acknowledging and naming difference. Denial and conformity to achieve acceptance. Meeting community expectations. Constraints of a shared public identity. Fear of exposure and harassment for being different.	Clash between rural Australian and Filipina cultural values.

The metasynthesis has identified ways in which aspects of rural living impact in positive and negative ways on women's health and wellbeing. Some women referred to the important contribution that a sense of connectedness to others and their community made to health and wellbeing[22]. Social support networks can enhance health status by helping people remain resilient to adversity[31]. Leipert and Reutter[32] found that women in geographically isolated areas of northern Canada developed resilience by seeking and receiving social support from others. However, geographical isolation can mean distance from services and support networks, with consequences for emotional wellbeing, particularly during times of adversity or crisis. Isolation can also be experienced as a lack of acceptance by and intimacy with like-minded people with whom women feel comfortable sharing their feelings and concerns. Despite the sense of community and practical support associated with rural life, a lack of privacy and confidentiality can constrain help seeking, compounding a sense of isolation. Nonetheless, some mid-aged and older women from rural properties referred to a spiritual connection with the land which enhanced a sense of wellbeing, despite the challenges. According to Allen[33], people may subscribe to an idealised notion of a healthy rural lifestyle because it gives them a sense of belonging and connectedness. Aspects of rural life that might otherwise be construed as negative are reinterpreted positively to reinforce a sense of belonging.

The study findings also highlight the influence of a socially constructed gendered rural identity on health and wellbeing.

Rural women play a pivotal role in maintaining family and community welfare, particularly during prolonged drought[14]. Patriarchal constructions of rurality focus on women's domestic roles in the home, family and community, and undervalue women's other roles[12]. During times of adversity, women may compromise their own health and wellbeing by assuming an inequitable share of the work of supporting their families and community[34]. However, in finding that women identify self-reliance and the ability to cope with adversity as a strength and source of pride[21-23], this metasynthesis supports assertions that rural women reject portrayals of themselves as disempowered[35] or as victims[26]. Nonetheless, the metasynthesis reveals an underlying resistance by women to conceptualisations of themselves as the saviours of rural Australia.

Further research is needed to understand the way in which health and wellbeing are shaped by societal expectations of the role and responsibilities of rural women and by the rural environment. Stereotypical views of rural women as stoic, used to adversity and self-reliant[36] may be detrimental to their health. The studies in the metasynthesis reveal that women have voiced resistance to expectations that they can cope with whatever comes along without adequate support. However, it is not clear how women negotiate rural identity and the broader social, cultural and physical environment in which they live, in order to achieve health and wellbeing. Research which draws on the voices of women themselves is needed to explicate this further.

Conclusion

In this article, six qualitative empirical studies that explored how rural women achieve health and wellbeing were analysed using the methodological framework of metasynthesis. Reciprocal translation of key themes among studies has expanded the relevance of each study beyond the initial population and setting. It has also added to our depth of understanding of the social experiences of rural women associated with health and wellbeing.

Perceptions that rural women are coping well despite overall rural health disadvantage, lack of services and harsh social and environmental conditions conceal the complex ways in which health and wellbeing are shaped by a range of individual, social, economic, cultural and geographical factors. The findings of this study exhibit a tension between a sense of belonging to a close knit rural community and the experience of social and geographical isolation. The study findings also reveal tension between adherence to a strong gendered rural identity that fosters a culture of stoicism and self-reliance, and feelings of resistance to societal expectations of coping with adversity. Exploring how rural women achieve health and wellbeing is important in developing policies and practices that are meaningful and relevant to women and do not entrench existing inequalities. The findings of this study demonstrate that it is necessary to move beyond stereotypical views of rural women and simplistic notions of rurality to explore the social, cultural, economic and geographical factors which shape women's experiences of health and wellbeing.

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