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Abstract

Rural healthcare workers are experiencing barriers to accessing supports for their own mental health and well-being. Findings from an online survey during the initial stages of the COVID-19 health pandemic reveal that healthcare workers (*N*=137) in rural and non-metropolitan Manitoba, Canada, are increasingly stressed by fluctuating COVID-19 protocols and policies and face challenges such as lack of anonymity and stigma about their mental health concerns. The health pandemic has amplified existing challenges to healthcare in rural places and has created extended periods of stress and isolation for healthcare workers. Implications to policies and practices relevant to providing essential mental health supports to reduce the likelihood of long-term negative health outcomes are discussed. Rural healthcare workers' experiences emphasize the importance for place-specific research and practice.

Keywords: healthcare workers, Manitoba, COVID-19, mental health, barriers interest

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Expériences et besoins des travailleurs de la santé en milieu rural lors des premières étapes de la COVID-19

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Résumé

Les travailleurs de la santé en milieu rural rencontrent des obstacles pour accéder à des soutiens pour leur propre santé mentale et leur bien-être. Les résultats d'un sondage en ligne au cours des premières étapes de la pandémie de COVID-19 révèlent que les travailleurs de la santé (N = 137) dans les régions rurales et non métropolitaines du Manitoba, au Canada, sont de plus en plus stressés par la fluctuation des protocoles et des politiques de la COVID-19 et font face à des défis tels que le manque d'anonymat et la stigmatisation de leurs problèmes de santé mentale. La pandémie sanitaire a amplifié les défis existants en matière de soins de santé dans les zones rurales et a créé de longues périodes de stress et d'isolement pour les travailleurs de la santé. Les implications sur les politiques et les pratiques pertinentes à la prestation de soutien essentiel en santé mentale afin de réduire la probabilité de résultats négatifs à long terme pour la santé sont discutées. Les expériences des travailleurs de la santé en milieu soulignent l'importance de la recherche et de la pratique spécifiques au lieu.

Mots-clés: les travailleurs de la santé, le Manitoba, la COVID-19, la santé mentale, barrières d'intérêt

1.0 Introduction

Healthcare workers have garnered significant public attention throughout the COVID-19 health pandemic. The media and government officials in Canada where this study took place have referred to workers as 'healthcare heroes' and as part of a 'frontline' fight against the pandemic (Torres, 2020). Healthcare workers are simultaneously a strength in the pandemic response as well as a vulnerable group in terms of their exposure to COVID-19, stressful work environments, and negative mental health consequences. For example, as of July 23, 2020—around the time this research was conducted—there were 21,842 COVID-19 cases among healthcare workers in Canada and 112,672 cases in the total population (Canadian Institute for Health Information, n.d.; Public Health Agency of Canada, 2020). In addition, research on previous pandemics and early COVID-19 research has shown significant mental health impacts in relation to pandemics, particularly among healthcare workers, including doctor suicides (Gulati & Kelly, 2020).

During previous pandemics of a much smaller scale, such as the outbreak of severe acute respiratory syndrome (SARS) in 2003, healthcare workers in Toronto, Canada, expressed a variety of negative mental health outcomes resulting from treating patients during the outbreak, including but not limited to, symptoms of post-traumatic stress and depression (Maunder et al., 2003; Styra et al., 2008). Results from other countries showed a similar trajectory of mental health problems among healthcare workers in regions impacted by the SARS pandemic (Lin et al., 2007; Tam et al., 2004; Infection Prevention and Control Canada, n. d.). The Middle East Respiratory Syndrome Coronavirus (MERS) in 2015 produced symptoms related to post-traumatic stress among healthcare workers in Seoul, Korea (Lee et al., 2018). SARS and MERS were contained much quicker, spread was limited more effectively, and the mortality response was well below the mortality rates that we have observed with COVID-19. With this knowledge, researchers and mental healthcare professionals started flagging the need for mental health supports for frontline healthcare workers early in the COVID-19 pandemic (Wu et al., 2020).

The place of healthcare work plays a critical role in the mental health experiences because it affects resources and values, yet much less attention has been paid to the role of place in research on healthcare workers during pandemics. Rural places have been particularly neglected (Kulig & Williams, 2012). This may be, in part, because the hierarchical spread of infectious diseases such as SARS and MERS have centered on major urban centers (i.e., global cities). However, as the COVID-19 pandemic continues, rural areas continue to see an increasing number of cases. In addition, it is important to recognize the longstanding challenges associated with delivering rural health services, such as lack of human resources, recruitment and retention issues, isolation in and out of work, and limited infrastructure and amenities (Kulig & Williams, 2012; MacLeod et al., 2017). Although recent research has cautioned against a deficit framing of rural places, which focuses only on what they are lacking (Malatzky & Bourke, 2016), rural places generally have different place-based resources with which to respond to COVID-19. As such, it is critical to look at the experiences and valued resources of rural healthcare workers with attention to the role of place. In this article, we focus on the experiences of being a rural healthcare worker and the mental health effect during the initial stages of the health pandemic in Manitoba, Canada, using an ecological systems approach. Specifically, we examined how healthcare workers described their own mental health, the conditions influencing their mental health, and the suggested resources

needed to improve their well-being and mental health during this stressful time. Rural healthcare workers' values and ability to adapt are tied to place-based resources in the workplace, community and region.

2.0 Literature Review

Our research draws together literature on rural healthcare, work environments, and uses an ecological systems approach to ground our analysis of healthcare workers' mental health needs in rural places. Medical geographers have traditionally examined rural healthcare quantitatively with a focus on healthcare access, use, and outcomes (Gesler & Ricketts, 1992; Joseph & Phillips, 1984). From an ecological systems approach (e.g., Bronfenbrenner 1992; Bronfenbrenner & Morris, 2006) individual outcomes are the product of interactions between person and the environment within which they are situated. This approach emphasizes the dynamic role of the person, process, context, and time to describe and understand outcomes (Bronfenbrenner & Morris, 2006). Over the past three decades, qualitative health research has shed light on the needs and experiences of people accessing health services in rural communities (Herron & Rosenberg, 2017; Kulig & Williams, 2012; Parr et al., 2004), as well as the impacts of restructuring on rural communities and individuals (Hanlon & Kearns, 2016; Hanlon et al., 2019; Ramsey & Beesley, 2007; Toomey et al., 2013). This work continues to highlight distinct differences between rural and urban settings in terms of distance, access to health services (e.g., Jackson et al., 2011), attitudes toward service use (Halseth & Ryser, 2006; Joseph & Cloutier-Fisher, 2005), models of service delivery (e.g., telehealth), and community assets such as community cohesion, support networks, and attachment to the land (Caxaj, 2016). In sum, the growing body of literature on rural healthcare has emphasized the significance of place in rural healthcare, including the local material context (Phillips et al., 2020), social relations (Park et al., 2021), and meanings people attach to a rural location (Cresswell, 2013; Kulig & Williams, 2012).

Most rural health research in geography, nursing, and the social sciences has focused on healthcare consumption with much less attention to the experiences of healthcare workers (Andrews, 2002, 2016; Andrews & Evans, 2008). Andrews and Evans (2008) called for more attention to how healthcare is reproduced within places; however, over a decade later, there remains a paucity of research focused on the place-based experiences of healthcare workers, especially those in rural settings (Andrews et al., 2021). Where healthcare takes place shapes the character of healthcare work (Andrews & Evans, 2008), this includes the physical, professional, social, and cultural dimensions of a work environment (Andrews, 2016, 2019). Geographic, nursing, and sociological research have contributed to a deeper understanding of the complexity of work environments, including how they support, empower, or imperil workers (Peter et al., 2018). For example, Peter et al. (2004) examined the moral habitability or moral climate of the work environment and emotions within the workplace. Healthcare work often involves managing contested emotions in work relationships and spaces, including practicing detachment, attachment, and containment (Andrews et al., 2021). Shaped by the places in which they work and live, healthcare workers' abilities to express and cope with this emotional work can have an impact on their well-being and mental health. However, these feelings are not just shaped within the work environment and in relation to colleagues and clients. The emotions felt must be situated within a broader context of the community, as well as larger-scale policies and processes influencing both the workplace and the community.

Conceptually, through an ecological systems approach, our understanding of healthcare workers' experiences includes a focus on the interplay of the work environment and the broader forces that shape well-being. This approach situates individual experiences within a network of mutually dependent systems with multiple layers or scales, such as culture, economics, and politics (Ungar, 2021). Each system contains varied resources and processes that interact with other systems in ways that influence the well-being of the individual depending on time and place. Ecological systems approaches are widely used in (a) health geography, (b) public health, (c) health promotion, and (d) health research to explain and understand the relations between individuals, their environments, and their health for decades (Golden & Earp, 2012; McLaren & Hawe, 2005; Richard et al., 2011). Additionally, they are used to shift focus away from the individual and to acknowledge systemic barriers that inhibit health (Henderson et al., 2020; Wharf Higgins et al., 2009; Tanhan & Francisco, 2019). Rather than focusing solely on the responsibilities of individuals to maintain their own health and wellness, research must look to the responsibilities of workplaces, communities, and provincial and federal systems to reduce barriers and support the well-being of rural healthcare providers (Richard et al., 2011). Understanding how material, social, organizational, and community resources differ from one place to the next and, in turn, developing solutions that are appropriate based on an understanding of these differences is especially critical in the context of the COVID-19 pandemic.

3.0 The Manitoba Context

The Province of Manitoba is a prairie province located in western Canada with a population of 1.3 million people (Statistics Canada, 2017). The capital city of Winnipeg accounts for slightly more than half of the total population of Manitoba. The remainder of the population is scattered in smaller cities and towns, with the North being the most sparsely populated (see Table 1). Health care is administered through five health regions (see Table 1, Figure 1). Winnipeg is predominately urban, apart from a special agreement to administer health care in the northern community of Churchill. The remaining regions are predominately rural but include small urban centres (see Table 1). Population, including density, decreases as one travels north.

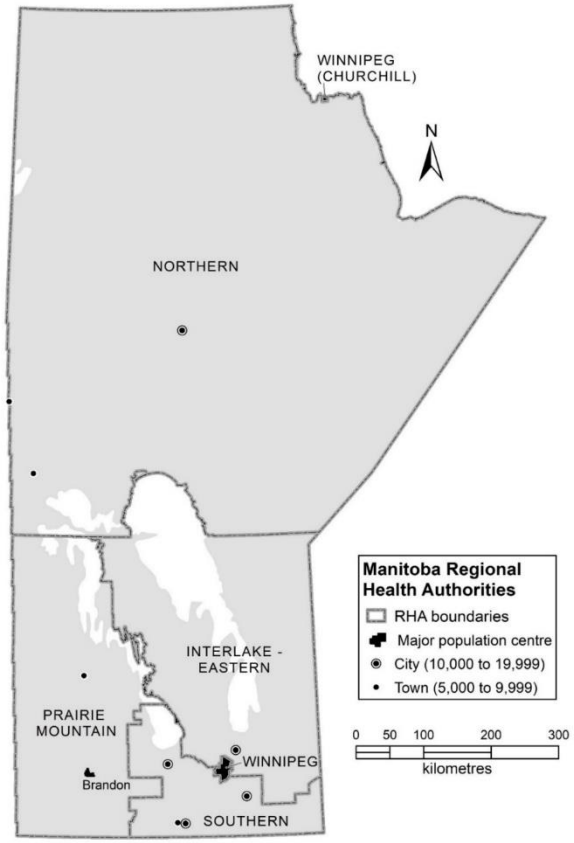
Prior to COVID-19, the health and social care sector in Manitoba and across the Global North has faced decades of restructuring with the primary aim of reducing the costs of healthcare spending (Cloutier-Fisher & Joseph, 2001; Hanlon, 2005). Recently, the conservative provincial government began reforms in 2017 to the health care system in an attempt to further reorganize and consolidate health service in rural regions, this included: (a) converting to a province wide health organization, (b) closing emergency rooms in Winnipeg and shifting these to urgent care units, (c) the closure of intensive care units across the province, (d) closure of rural emergency rooms, and (e) reduced service in rural areas because of physician shortages (Manitoba Health Coalition, n.d.). Advocates were sounding the alarm that there was a shortage of critical care units and high staffing vacancies across the province, but especially in rural areas at the very beginning of the pandemic when there were only 17 positive cases of COVID-19 (Greenslade, 2020). Indeed, both long-term and short-term cycles of healthcare restructuring set the context for the healthcare workers experiences in the present study.

Table 1. *Respondents by Community Size (N=137)*

Community Size	**Respondents**		**Number of Communities in Manitoba with Associated Population Numbers (Community Name)**
	#	**%**	
50,000+	n.a.	n.a.	1 (Winnipeg)
20,000–49,999	26	18.98	1 (Brandon)
10,000–19,999	21	15.33	5 (Steinbach, Portage la Prairie, Thompson, Winkler, Selkirk)
5,000–9,999	28	20.44	4 (Flin Flon, The Pas, Dauphin, Morden)
2,000–4,999	30	21.90	25 (Including, but not limited to, Oakbank, Lorette, Carmen, and Minnedosa)
Under 2,000	32	23.36	43 (Including, but not limited to, Carberry, Roblin, Pinawa, and Rivers)

Source: Authors' survey (2020); Statistics Canada (2017).

Figure 1. Map of Manitoba health regions.

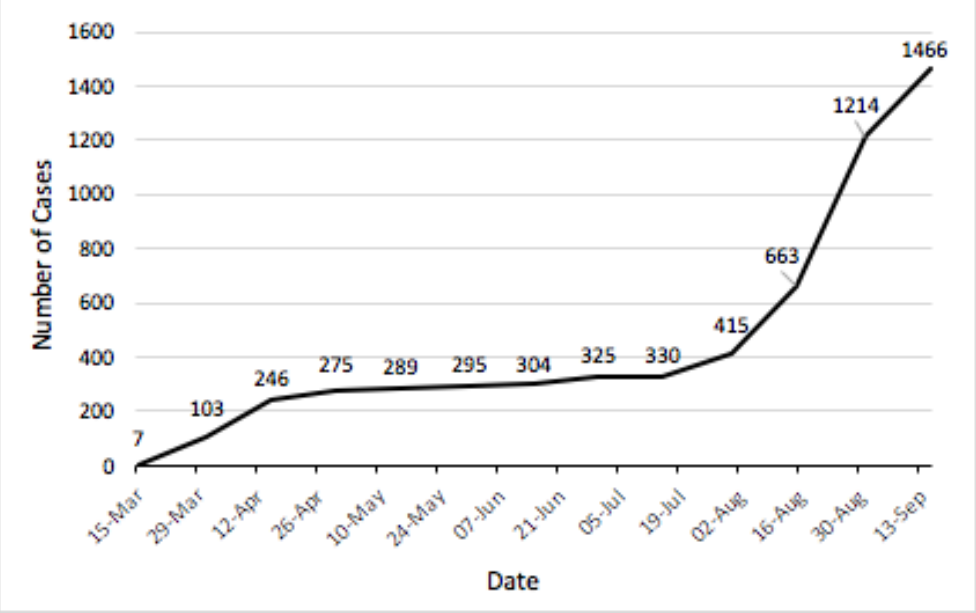


Source: Created by Wenonah vanHeyst, Geography Department, Brandon University.

4.0 Research Design

To examine frontline healthcare workers' experiences during the initial stages of the pandemic, an online survey of 'frontline' healthcare workers was administered between May 15, 2020, and June 15, 2020. The survey period took place after the initial surge and lockdown measures had eased slightly. The survey period was characterized by a declining number of COVID-19 cases in the province and the initial stages of "Restoring Safe Services Pandemic Response" (CTV News, 2020) (see Figure 2). The survey instrument was developed collaboratively by an interdisciplinary research team, including a practicing registered psychiatric nurse and certified clinical counsellor. Prior to respondent recruitment, approval for the survey was obtained by the researchers' institutional research ethic committee, Brandon University Research Ethics Certificate # 22654.

Figure 2. The number of lab-confirmed and probable COVID-19 cases in Manitoba.



Source: CTV News, 2020.

Respondents were recruited through advertisements on professional listservs and social media as well as through press releases in newspapers, television, and radio stations. Healthcare workers in all but the Winnipeg Health Region were eligible to participate. All other health regions in Manitoba are non-metropolitan and have significant rural service delivery requirements, including Prairie Mountain, which includes the City of Brandon, the second-largest city in Manitoba with a 2016 population of approximately 50,000.

4.1 Participants

A total of 137 people responded to the online survey during the one-month data collection period. The majority of respondents (70%) worked as nurses—registered psychiatric nurses, registered nurses, and licensed practical nurses—and the remaining 30% of respondents included healthcare aides, physicians, paramedics, social workers, counsellors, and other healthcare professionals. Most respondents identified as female (90%) and over 60% of respondents worked in communities

with a population of 10,000 or less. All respondents worked in non-metropolitan areas (populations of 50,000 or less) outside the City of Winnipeg. Note that to help maintain anonymity, participants were not asked to name their specific town or community but to indicate the approximate number of people living in their community (see Table 1). Respondents worked in inpatient care (40%) or community health (32%), with 23% of respondents working in two or more care environments. Sixty percent of respondents had worked in health care for less than ten years.

4.2 Survey

The questionnaire included a series of closed-ended background questions about respondents' individual characteristics (e.g., gender), work environment, and work experience, including occupation, the size of community in which they worked, the populations they worked with, type of care environment, and years of experience. Respondents were also asked a series of closed questions about their mental health during and prior to COVID-19: who they talked with about their mental health, current barriers they faced to accessing mental health support, and current coping strategies. The survey also included the GAD-7 questionnaire, a standardized measure for generalized anxiety (Spitzer et al., 2006). Correlation and regression analysis looked at the associations between community size, type of employment and the GAD-7 scores. These findings are reported on elsewhere (Rauch et al., 2020). The key findings are summarized from this analysis in this paper. The closed-ended section of the questionnaire was followed by two open-ended questions which allowed respondents the opportunity to detail their experiences as frontline healthcare workers during the survey period: "What mental health supports do you need as a frontline healthcare worker during COVID-19" and "What else do you think we should know about mental health experiences and needs of rural frontline care workers during COVID-19?" The open-ended questions were generated with the purpose of allowing respondents to share as much as they wanted about their experiences and needs when they had time. Open-ended responses ranged in word count from two words to 574 words.

4.2.1 Analysis of the open-ended questions. A team of four researchers independently coded responses using an inductive thematic approach (Saldana, 2016), which focused on what resources respondents identified needing as well as how respondents characterized their experiences during COVID-19. Team members came from different disciplinary backgrounds, including health geography, rural geography, psychology, and psychiatric nursing. Using NVivo software, the initial process of open coding conducted by the team identified 19 distinct themes and 39 subthemes from the open-ended questions. The themes were organized into individual, community, workplace, and provincial categories following an ecological systems approach (Tanhan & Francisco, 2019). There was a significant repetition of the themes and the responses within the themes showing the dynamic interaction of themes across scales. Axial coding (Saldana, 2016) was then used to categorize the overarching thematic categories that cut across different settings, including (a) mental health experiences in the pandemic, (b) lack of resources in rural settings, (c) difficulties with anonymity, (d) lack of information and leadership, and (e) protocol not consistent with rural experiences. These themes and respondent narratives reveal the interactions between individual experiences and resources within workplaces, communities, regions, and time.

4.3 Key Findings: Mental Health Context, Barriers, and Responses

4.3.1 Mental Health Experiences. Almost half of the respondents (48%) sought mental health support prior to the pandemic, a percentage that increased in the initial stages (55%) when the survey was conducted. This provided context for the issues raised by respondents. Almost 60% of respondents reported some level of anxiety and one quarter reported moderate or severe anxiety using a standardized anxiety scale (GAD-7), which assesses clinical levels of anxiety over their past week. High coping levels were also expressed, with only 17% of respondents indicating that their anxiety caused concerns in their work or home life.

The majority of participants (n= 104) identified 231 barriers cumulatively, to accessing mental health supports. Most barriers related to a lack of support services, inappropriate support services, and lack of managerial support or direction. While these feelings are likely a reflection of the survey taking place during the early stages of the pandemic, they provide context to the frustrations in respondents' work environments. This is further reflected in the fact that respondents reported more than double (471) the number of coping strategies during this time, including different types of self-care, ranging from practicing yoga and seeking spiritual advice to medications and increased substance use.

When describing their mental health experiences, respondents identified demands on their time as well as sources of fatigue. One respondent wrote,

> it's a constant battle of putting your mental health first to ensure you can take care of others mental health, but not having the time to take care of your mental health because you're busy ensuring others mental health are taken care of first. I came into this profession because I love what I do, I love helping others, but the strain of the pandemic has been felt. There has been lots of change and unfortunately, in this area of work, you just keep going because it's essential. Support is needed. (Participant # 12)

The need to support others while simultaneously maintaining their own mental health was a struggle for some respondents. Another respondent wrote,

> I feel as though I have put my own mental health on the back burner and am simply trying to focus all my attention and effort on my patients as a distraction from my own struggles. It's hard for me to articulate how my own mental health has declined however, I do not live with a mental illness nor am I on any prescribed medication and part of me feels guilty for voicing that I am struggling because I am 'better off' than a lot of other individuals—in particular the acutely ill individuals I am working with…There just does not seem to be a safe, non-judgmental place for frontline workers to talk about their day to day struggles and receive encouragement and support that is easily and readily accessible - it seems

> like in order to receive help you need to be admitted to an acute mental health ward yourself. (Participant #122)

Both respondents above highlight the role of professional and workplace cultures in producing fatigue as well as feelings of guilt. They also suggest that there is a lack of space to talk about their mental health concerns in their workplace and community, a point we will elaborate on further.

4.3.2 Lack of resources in rural settings. Respondents expressed a need for healthcare workers to have the supports available so that they can care for themselves. Respondents associated the lack of support with their rural location, and they compared their work environment to urban centers. For example, one respondent stated, "rural is a unique situation and we should not be compared to larger centers like [Winnipeg]. We do not get the same supports!" (Participant # 73) Another indicated, "rural workers feel forgotten and less protected compared to city nurses" (Participant #28). There was a connection made between feelings of isolation in their rural environments and the impact this has on healthcare workers. For example, one respondent wrote, "working in a small hospital with minimal staff makes one feel very alone, isolated, unsupported especially on nights and weekends when there is no one around, just the minimal staff." (Participant # 58) Other respondents commented on the impact of isolation on mental health more directly saying, "isolation is very detrimental to our mental health, especially in a rural community." (Participant # 107)

Respondents reported the supports that they require within their workplace settings to assist with coping through the pandemic. Some suggestions were adequate time-off, breaks, extra staffing, and appropriate reimbursement for time at work. For instance, respondents wrote, "Paid mental health days :) (*sic*) in all seriousness it was difficult to get up and function like a person." (Participant # 14) and "We also need to be paid for all the extra time we put in to discuss the pandemic. As nurses, we stay late to inform each other of updates and are not paid for the overtime" (Participant # 47). Another suggested strategies to accommodate breaks within the workplace:

> Maybe longer breaks in safe spaces away from the unit to refresh and relax before heading back to units. Maybe sleep/nap/mindfulness areas where people can feel safe enough to fall asleep and get a quick nap in when they're feeling exhausted (Participant # 102).

The lack of resources and staff in healthcare settings, especially rural settings, may require individuals to skip days off or work through breaks. Ensuring there are adequate resources in place to alleviate the burden on individual healthcare professionals is warranted.

When discussing their mental health needs, rural healthcare workers highlighted the difficulties of accessing supports in smaller rural communities:

> Having resources available in Winnipeg is beyond useless for people with families and other obligations outside of work. If a plan does not involve

> putting someone in the community/region at least part-time, then it is a complete waste of time and resources. (Participant # 115)

Another indicated, "access to affordable, local and highly qualified supports is limited, and often provided by colleagues if at all." (Participant # 112) Additionally, respondents indicated that they needed access to professional mental health support (n=43) and peer support (n=28). One respondent wrote, "support groups/discussion groups, it would be helpful to know that not only are other frontline workers struggling but to know what they are doing to cope and to hear from other professions in a more direct way" (Participant #122).

Respondents identified a lack of other community resources in rural places as problematic. For instance, one respondent indicated, "different types of issues are in rural. Re. Limited access to childcare, no public transportation, small community and everyone's business is known." (Participant # 97) Another reflected on the pandemic's influence on the resources that they had acquired in their rural environment:

> All the coping mechanisms I had built throughout the year were gone. Yoga class, gone. Counsellor, gone. Pottery class, gone. As a single person living alone, with family across the [Saskatchewan] border it has been very isolating. Then compound my occupation, a very high stress area, it has been awful. (Participant #33)

Respondents identified supplemental resources that were lacking within rural areas such as childcare and public education, as well as resources that were shuttered across urban and rural spaces such as health and recreational activities. One respondent suggested,

> perhaps online help with school age kids and their lessons for front-line workers would help decrease some of that—as well as some kind of assistance for those of us who continued to work and risk self at reduced income would have helped decrease strain too! (Participant #86)

Another highlighted, "we all have 'new' multiple roles to play and fulfilling all of those roles is impossible. Consideration needs to be made for single parent families" (Participant # 129). The comments above highlight the importance of tangible public support in a variety of community settings.

4.3.3. Difficulties with anonymity. Although social cohesion, familiarity, and frequent interaction with others in the community can be an asset in rural places, some respondents highlighted the difficulties that this can cause if you are a professional that is seeking mental health support. For instance,

> …in a rural community it is hard to see the community mental health worker as they are usually based in the hospital and unfortunately there is stigma if you go see them plus you also work with them which may make it more difficult. (Participant # 60)

Respondents identified a lack of anonymity as well as fear of judgement related to seeking mental health support from their peers. This barrier to accessing professional support is heightened in rural communities and the healthcare facilities that support them. Another respondent elaborated,

> there needs to be a better system to access mental health workers or treatments. Being rural makes it hard because you might see the counselor around town or as [healthcare worker] you might have to deal with their family and its uncomfortable when that happens because you have shared issues you have with them and now you have to be the professional that's dealing with them or their family. It's uncomfortable because you feel like you're going to be judged or that they know exactly what your problems are and might think you're not going to do a good job because of them. (Participant # 35)

Importantly, this respondent suggested that stigma in relation to mental health, lack of anonymity, and frequent interaction with other professionals in the community led them to feel unsafe seeking support within the community. They felt they would be judged incompetent in their work because of seeking mental health support, highlighting the complex interplay between personal, work, and community life in rural places.

Public perceptions also influenced how healthcare workers felt that they could move around their communities because they were known as healthcare workers. For instance, one respondent stated,

> people in community (*sic*) see you uptown at the store and are mad; (1) you shouldn't be out because of where you work, or (2) why can't I go see family member if you can be out in public, and (3) tell work[er]s what we should be doing for safety. (Participant # 50)

The respondent highlights the complex role of healthcare workers in rural communities where they provide direct care, advocacy, and leadership. As such, some community members perceive their movements in public spaces as a risk; others see their role as an advocate or leader who may help them access a family member in care or change public health protocols. The respondent also identified a lack of boundaries between their professional and community roles within small towns. Finally, the respondent draws attention to another important issue: clear communication of public health protocols. A lack of information about provincial protocols may have caused the general public to stigmatize healthcare workers in rural spaces.

4.3.4 Lack of information and leadership. Healthcare workers identified a lack of timely and relevant information from the province as a source of stress and anxiety. For instance, one respondent wrote, "info often veiled in secrecy. Silence/lack of information breeds fear & anxiety" (Participant #11). Other respondents corroborated, "often a lack of information and communication can cause feelings of inadequacy and stress" (Participant # 127) and "the impact of a lack of clear information from [Manitoba] Health, which was perceived by many health workers

as being vague and withholding" (Participant # 127). Many workers felt management and Manitoba Health were withholding important information contributing to negative emotions.

The lack of information led some respondents to feel uncared for and unvalued. For instance, one respondent indicated,

> I feel that we are disregarded, unimportant. We are put wherever the [Health Authority] wants us. Not given universal PPE like other staff. Feel like 'we are just to do our jobs and not worry or question anything'. I feel very undervalued. (Participant #76)

In addition to the lack of information provided to healthcare workers, respondents expressed a lack of personal protective equipment (PPE) as an issue. Across Manitoba, leadership had been distributing expired PPE and telling staff to ensure that they were limiting their use of PPE because of the global shortages (Frew, 2020). One respondent highlighted, "not having to worry about being properly protected while exposed is of course, a must—but not the reality many of us rural front-line workers have experienced" (Participant # 86). Another indicated,

> so many unknowns and so much more responsibility dropped on us and we feel like our government, our employers don't care about what we do. To see some appreciation of the battles we have had to challenge through with shifting of staff, shifting of patients and more workload of COVID watch patients it's hard. (Participant # 79)

The lack of timely information also impacted how managerial support was perceived within the workplace. Some felt that more conversations needed to occur to address some of their relevant concerns. For instance,

> there's been very little actual instance-based conversation regarding the topic. It's all memos, how to's (*sic*) and procedure updates. There's been zero 'hey you swabbed those positive patients, how you feeling about it? How are your coworkers feeling about it?' Or 'hey, how are you coping with having to tell patients or residents that their loved ones can't come and see them and that all of their emotional support would be coming from you, a stranger that has their own personal worries about the situation and the potential of taking it home to your own families? (Participant # 61)

Another respondent reiterated this perceived lack of support, writing,

> I needed a supervisor who took my concerns and personal protection questions and doubts seriously at the beginning of this pandemic. I needed more co-worker input and collaboration in regards to how everyone was doing throughout all the initial changes that were quickly evolving around us. (Participant # 114)

There was also worry over the way in which conversations were occurring between respondents and upper management, for instance, "we are being completely ignored and talked over when we express concern" (Participant # 29). A perceived lack of information, and lack of clear direction led respondents to feel that they were not being supported by their supervisors. One respondent wrote,

> gross mismanagement by managers. Zero support. Told not to visit their office to protect them from exposure while incident reports on our own unnecessary exposures went unanswered. Working grossly short staffed with not one manager showing their face in 2 months. Emails go unanswered or when answered are rude, condescending, or threats of insubordination. Crying every day, witnessing OTHER departments be given education, meetings, protection. Even when requesting the mitigation of controllable stressors, we were denied every time. Mental health is not a priority to our management. (Participant # 36)

There was evidence from one respondent in a management position that they, too, are struggling with the pandemic and all the complexities. They stated, "I feel helpless. I spend my time listening to staff problems and trying to support them. No time to deal with my own feelings and needs" (Participant # 18). Moreover, the comments of both frontline healthcare workers and managers indicate a much larger systemic issue with the way information was relayed within health systems.

4.3.5. Protocol not consistent with rural experience. Many respondents discussed the ever-changing policies and protocols that they were attempting to navigate during the initial stages of the pandemic. Others emphasized that they felt that some of these protocols were out of touch with the realities of working and living in rural environments. One respondent stated, "when changes occur at a provincial level, sometimes it feels like the decision makers don't understand how it will affect rural sites and that feels isolating" (Participant # 74). Another reiterated this sentiment by indicating,

> working rurally is nothing like urban environments and we shouldn't be mandated to implement the same practices. What works in the city isn't always the best rurally. The frontline staff doesn't have a voice in this!!! I fear for my health and the health of my family with every single one of my shifts and the chronic stress of this pandemic has absolutely affected both my emotional and physical health. (Participant #56)

Respondents identified a need for place-sensitive protocols that reflect rural experiences as well as the needs of specific spaces of work and care (e.g., institutional contexts). Respondents expressed the moral distress that they were forced to follow protocols that directly violated normal expectations of care. For example,

> if other long term care workers are like me, they feel like they are abusing their elderly residents by keeping their lonely residents and residents with cognitive impairments who do not understand social distancing/isolation, away from their families. Long term care is a very different area of healthcare than a lot of other departments/branches and should be handled differently than it is being handled. (Participant # 20)

Another respondent reiterated this sentiment by indicating, "the stress is not from dealing with patients sick from it. My biggest stressor is keeping family members away from their loved ones in the hospital. The visiting rules are so strict and family members and patients are suffering because of it" (Participant # 77). For these respondents, the stress of abiding by the rules is yet another source of conflict, highlighting the 'normal' moral and professional principles that govern their workplaces as settings of care. Healthcare workers experienced moral distress because of the conflict between new protocols and their professional and personal principles. Additionally, rural environments create circumstances where patients and family are often more familiar to healthcare workers than in larger urban settings.

5.0 Discussion

In this study, we sought to examine how rural and non-metropolitan healthcare workers described their mental health, the conditions influencing their mental health, and the resources they suggested were needed to improve their mental health during the initial stages of the COVID-19 pandemic, including when case numbers had declined and even levelled off. Respondents revealed the challenges of maintaining their mental health and care practices within their working environment, rural communities, and regional context. Authors in other jurisdictions have warned that COVID-19 will have a negative impact on the mental health of frontline workers (Greenberg et al., 2020; Spoorthy et al., 2020; Tsamakis et al., 2020; Vigo et al., 2020; Walton et al., 2020). Our findings complement and extend these studies and indicate that rural and non-metropolitan workers outside of the epicenter of the pandemic are also experiencing symptoms of anxiety, other mental health concerns, and barriers to accessing support.

Access to appropriate mental health services for healthcare providers can reduce negative mental health outcomes (Greenberg et al., 2020); however, respondents in the study highlighted place-specific challenges to accessing mental health services in rural communities, such as lack of anonymity, stigma and fear of judgement, and limited mental health services. Other researchers studying rural health (Jensen et al., 2020; Smalley et al., 2010) have identified challenges in relation to the availability and accessibility of mental health services prior to COVID-19. COVID-19 has further complicated these existing challenges. For example, fewer respondents spoke with mental health professionals during the first few months of COVID-19 in comparison to the previous year. Respondents identified a lack of time, fatigue, and feelings of guilt in relation to voicing mental health concerns, particularly because they felt a duty to care for others. The latter point illustrates the moral climate and emotions associated with healthcare professions and workplaces (Andrews et al., 2021), which can influence help-seeking. Addressing these barriers to accessing

services requires an ecological systems approach, which recognizes resource disparities between places, time, and the culture of rural communities and particular workplaces.

In addition to disparities in mental health services, respondents identified a lack of community infrastructure such as childcare and recreational activities in their communities. Such social and recreational services are critical to family and self-care and may be overlooked when studies focus on the workplace alone rather than taking a multi-dimensional approach to mental health and resilience. Indeed, respondents revealed specific stressors and strengths of work in rural communities such as closeness with others in the community. While this may be an asset, it can also place additional demands on healthcare workers in rural environments. The lack of anonymity that is often discussed in relation to rural healthcare work (Chipp et al., 2011; Ralph & Buehler, 2006) was amplified during COVID-19. Healthcare workers in rural communities are often known to other residents, which means fear of the virus and disappointment over restrictions may be targeted at healthcare professionals in public settings, as some respondents indicated.

In addition to these community resources and challenges, leadership and communication in the workplace, healthcare system, and province were identified as lacking. Leadership, clear communication, and consistent direction are extremely important in the ever-changing environment that COVID-19 presents (Walton et al., 2020). Researchers that looked at resilience in healthcare workers after the SARS epidemic indicated that, "most people cope very well in their own way and benefit a great deal from a relatively small quotient of shared concern, good information and support" (Maunder et al., 2003, p. 1251). Study respondents highlighted the need to be heard at a larger systems level and have their concerns addressed within their organization.

As recommended by Walton et al. (2020), organizations should reflect on their functioning pre-COVID to determine if they have the resources available to provide practical and tangible support for their frontline workers. This requires that organizational leadership examine what mental health or psychological support they can offer to their employees, while simultaneously critically reflecting on staffing levels, mandatory overtime, shift work rotations and break availability (Walton et al., 2020). Addressing gaps in healthcare systems minimizes the loss of control and increased anxiety that is common in pandemics by ameliorating some of the controllable stressors in the environment (Tsamaki et al., 2020; Walton et al., 2020). However, addressing gaps may pose challenges in the Manitoba context, as—prior to COVID-19—the province was under tight budget restrictions, emergency room closures, intensive care unit bed cuts, job reductions, and mandatory overtime instances among nurses (Manitoba Health Coalition, n.d.). The monitoring and control of COVID–19 in rural areas is "exacerbated by a weakening rural healthcare infrastructure, healthcare provider shortages and closure of rural hospitals" (Melvin et al., 2020, para. 7). Healthcare reform, including changes in policy and protocol that are decided on in larger metropolitan centers without input from rural environments, has detrimental impacts on rural healthcare environments (Hartley, 2004). Therefore, the challenges associated with pre-COVID healthcare service delivery in rural areas adds another layer of complexity that impacts the well-being of the frontline healthcare workers during the pandemic.

Recommendations that come from this study stem from an ecological perspective, meaning that interventions and solutions are required at an individual, family, organizational, community, provincial, and federal level (McLaren & Hawe, 2005).

Respondents indicated that they needed (a) personal mental health supports—not dependent on colleagues (b) time-off, (c) adequate breaks, (d) safe spaces with workplace settings to rest and rejuvenate, (e) input into provincial protocols to ensure that the voice of rural healthcare providers is heard, (f) access to childcare, (g) assistance with educating school-aged children that are at home because of the pandemic, and (h) more understanding and acceptance from society about the stresses of the role and in many cases the inability for the individual healthcare providers to change provincial protocols.

6.0 Limitations

This study reflects on a snapshot in time and was conducted in the initial stages of the health pandemic. It was also a period of uncertainty that may have impacted respondent participation (e.g., fewer medical doctors and managers). Since data collection, the cases of COVID-19 have increased throughout Manitoba, and healthcare workers have continued to respond to changing practices and protocols. Ongoing research is required to understand the long-term impact of COVID-19 on healthcare workers; however, this study provides evidence of early challenges and resource needs that can inform protocols and practices. Additionally, future research should include an in-depth qualitative component to better understand healthcare workers mental health experiences. Given the demands healthcare workers continue to face and restrictions in terms of in-person contact, we chose an online survey that allowed respondents to share as much as they saw fit on their own time. Although we were unable to prompt or clarify what respondents meant, we were able to collect many in-depth responses regarding the pandemic in a short time period and with more depth than we anticipated—speaking to the needs of healthcare workers to have a voice. Finally, the respondents in this study predominantly identified as women and were employed as nurses. Although this demographic is comparable to the workforce within the Manitoba healthcare system, diversity in gender and profession would have provided more depth to the responses.

7.0 Concluding Statement

Overall, this study shows the unique perspective of rural healthcare professionals at the initial stages of the global COVID-19 pandemic. Reflecting on the barriers to mental healthcare support and the stresses that these professionals felt may assist leaders provincially and locally in future pandemic responses. The study also highlights the need to include rural voices to improve access to community and professional supports. Fostering and supporting the tremendous amount of resilience within these communities, to strive and thrive through complexity, depends on the ability of policymakers to understand and address differences in resources and experiences across different settings.

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