Introduction

The divide between metro Atlanta and the rest of the state of Georgia has long been recognized by Georgians for many years. The gulf between Atlanta and the area outside the perimeter grew so deep that in October 2000, Governor Roy Barnes created the OneGeorgia Authority. The Authority is intended to help bridge the gap between the two Georgias and provide much needed support to rural communities.

If you ask someone living in rural Georgia to describe the differences between the two, the answer might well be that there are three Georgias (or more). That very question was addressed by the Georgia General Assembly in 1999, and was done as a result of healthcare needs in the state. The Georgia General Assembly passed SB195, the Rural Hospital Authorities Assistance Act, which defines a rural county as being one which has a population of 35,000 or fewer residents. Due to the military base in Liberty County, a special exemption was made to designate that county since the population outside the base is less than 35,000 people.

Rural Georgians certainly consider county population in describing themselves. Due to time and distance, they may refer to "the big city" as Savannah, Macon, Augusta, or Valdosta. A night out to see a movie and dinner in a restaurant with table service may require a drive of 30 miles or more. Rural Georgia may be better defined by the number of homes requiring well water, the closing of schools due to rain soaked dirt roads, and high school football rivalries.

Rural communities have serious challenges. They also provide opportunities to offer help without hesitation. Neighbors know where a misdirected letter should go and will deliver it by hand because it creates a chance to visit. Young men with big pickup trucks look for opportunities to pull someone's car out of mud. A rural person gives directions by pointing out that the driver will, "pass the Veal's house on the left (but the Veal's haven't lived there in 100 years)."

Despite the gulf between urban and rural, Georgians do share common goals in caring for their children. Our children face some steep odds regarding healthcare, health status, education, income, housing, and juvenile delinquency.

Children's health status in Georgia consistently ranks in the bottom tiers of the nation's health statistics. A publication issued by the Robert Wood Johnson Foundation in October 2008 reported that children's health status in Georgia is directly tied to their mother's education and income level. Georgia's infant mortality status was 46th in the nation when the mother's education was considered. In addition to infant mortality rates being higher in Georgia (8.4 births in Georgia per 1000 compared to 6.8 nationally), low birthweight is also higher for Georgia's children (9.6 percent of all births in Georgia compared to 8.3 nationally).

When considering health status in relation to income, Georgia ranked 41st when high income households were compared to low income households. A recent report addressing food shortages

in Georgia reported that 14.3 percent of our state's families live in poverty. Additionally, 19.4 percent of our children live in poverty (Georgia Budget and Policy Institute, Reaching Georgia's Tables, March 2009).

The picture is bleak if one only considers numbers and reports. Anyone who has spent much time with children knows that they are very resilient, and can be extremely resourceful (often frustrating parents, teachers, and other adults) in crafting solutions to problems. Every day they rely on adults to teach, feed, house, and play with them. In many ways they count on adults to be their advocates whether they understand what that means in the course of their childhood.

To better understand children's advocacy in Georgia the Georgia Rural Health Association and Voices for Georgia's Children has undertaken a study to better understand advocacy for children in Georgia. An important part of understanding how we support our children also includes understand the unique challenges of doing that for rural children.

Questions discussed range from defining advocacy to identifying champions for children, to asking how well adults can play together on the playground (i.e. collaborating) and sharing resources (funding). Our conversations included health network CEOs, elected officials, university faculty members, tele-medicine healthcare providers, hospital employees, and health policy experts, and non-profit organizations providing a variety of services to children.

Findings

Our focus group and individual conversations began with a discussion of what advocacy means. Most participants agreed that advocacy involves identifying what a current situation is, what the best situation could be, and actions necessary for improvement. One challenge in working on children's behalf is that the children rarely speak for themselves. Therefore, gaining access to decision makers and reshaping the relationship between institutions and people (i.e. children) affected by their decisions is not done directly by the children.

One response to the definition of advocacy stressed the need for accountability. All participants agreed that identifying problems and a need for change was correct, but adding accountability was raised as well.

"The power of advocacy is in metrics and outcomes. It is about accountability."

While some participants and those in other arenas may not think of themselves as advocates for children, after discussing the working definition it became clear that in fact they are. Their passion for children's health and willingness to find opportunities to speak out on behalf of children identifies them as advocates.

One of the unique characteristics of living and working in a rural community is that access to local officials and civic/church leaders is not exceedingly difficult. Rural communities don't

offer numerous places to buy groceries, pick up garden supplies, or have lunch. In some cases, the person who repairs the heat and air system in your home may be the chair of the county commission. The opportunity to advocate in a rural community is sometimes part of an ordinary day.

In both rural and urban areas, children's advocates will point to policies such as required childhood immunizations. A challenge in rural communities is having transportation to get children vaccinated as needed, and a medical home for the child so parents are aware of when to have children vaccinated and why it is important. Therein lies the disconnect between policy and program.

For example, if a community has a one person Family Connections program, the staff person there is perceived as the policy and the program in one. If the community is satisfied with that person's work, regardless of whether their work is result of a program or a policy, then it is likely to be considered to be a good one.

Differentiating between policies and programs was a challenge for participants. In particular, differentiating between policy and programs in terms of delivery of program services in rural communities was a challenge. If the office staff is very small, then the ability to maneuver around an ineffective staffer is limited, there again identifying the program as a poor one.

In defining the difference between policy and programs, it is also important to identify some terms which are commonly used in healthcare but have very different meanings when used in rural and urban settings. In rural communities access to care usually means transportation to a doctor's office or hospital. Lack of public transportation in rural areas results in appointments missed and prescriptions not filled. Rural residents may live many miles from a provider and walking may not be a realistic option. This often results in the use of ambulances and emergency rooms for primary care. As well, a lack of providers (both family practitioners and pediatricians) and insurance coverage also pose problems for children and their families in rural Georgia.

A challenge for anyone working toward policy or program change is making the need for change unique and urgent. When discussing the commonalities of rural and urban, policy may serve as the point of juncture. A policy requiring childhood immunization is good for all children, regardless of where they live. Developing a program to achieve this goal is where rural and urban may most often diverge. Program development for rural points back to transportation, locations for having children vaccinated, educating parents, and affordability.

This example also points to the problem many rural advocates will readily point out. Policy and program decision makers are too often unfamiliar with rural communities, services, and lifestyles. Rural residents will readily say, many legislators and state agency department directors may know rural Georgia only as a place they drive through on their way to the mountains or the beach. It may look idyllic or quaint, but truly grasping the differences between the two can't be done by stopping at the only traffic signal in a county.

Another challenge in advocating for children's health is differentiating between children's healthcare needs and adults, or rather the family as a whole. Participants addressed insurance coverage, sufficient numbers of providers, transportation, and education within the context of family healthcare instead of focusing only on the child's needs. Insurance coverage is also tangled in this merging of children's healthcare and family/adult healthcare. Most often the concept of universal healthcare coverage was pointed to as a means to provide services to both children and adults.

"What works in Atlanta (or Macon, Augusta, Columbus, Savannah, Thomasville) won't work here."

While differentiating between children and families may be a challenge in some respects, identifying champions and resources for children results in organizations which are focused in both policy and programs on children. With limited resources, often an organization is the champion with local leaders identified in tandem with their group. Commonly named champions and resources include: Family Connections, Boys and Girls Clubs, Public Health Departments, church programs, civic groups such as Rotary, Pilot, Optimist, Recreation Departments, Healthy Mothers Healthy Babies, school nurses, shelters for battered women, Parent-to-Parent, Disease and Syndrome groups (i.e. Parents of Autistic Children, Special Needs, ADD/HDD. etc.) local physicians, elected officials (local, state, and federal), Department of Community Health and Department of Human Resources, Community Health Clinics, DFACS, Head Start, and university/Greek organizations.

School nurses were frequently named as essential to providing services and being readily accessible to children. Often they may be a child's medical home.

The champions frequently serve as the resources within rural communities to promote children's health needs and issues. Christy Mountain, a pediatrician working in Washington County, said that churches providing after school programs keep children physically active and provide supervision. She pointed out that teen pregnancy rates can often be tied to a lack of after school programs. Other programs may be offered by organizations such as Family Connections and Recreation Departments. School athletics and extra-curricular programs such as theatre and music also contribute to addressing children's health issues in the realm of physical activity and adult guidance.

The challenges in accessing these programs in rural communities are varied. Some may only serve children who are in a "safety net" situation such as DFACS or a family shelter. Others may only provide services/programs for short periods of time. Yet others revolve around school schedules and sport seasons.

As in accessing healthcare services in rural areas, transportation once again looms as a barrier to using community resources and programs. Children without a way to or from an activity may not be able to participate. As budgets tighten school systems are choosing to eliminate certain after school activities or no longer provide bus services home. The need for adults to conduct the

programs also creates challenges. Volunteer coaches are needed by Rec Departments. Teachers are needed to coach teams or direct fine arts performances.

Another barrier in utilizing community resources is informing parents and schools about what is available. Several participants discussed the use of technology to share information. Web based groups for parents of special needs children were cited as a way for parents to share information, learn what services are available in their area, and to organize services for their children. As noted in both the discussion group and in literature, the parents of special needs children are most often aware of services and likely to use them at some level. However, higher income or well-educated families were more likely to use those services more often

The lack of access to internet service, or having a computer to use at all, was noted as challenges for rural parents to know what is available and have their children participate. In many rural communities, programs such as a Recreation Department may not have the staff skills or funding to maintain a web site to promote their programs and activities. Rural communities usually do not have a local television station or even a local access cable channel. Local radio and weekly newspapers have limited time and space to promote children's programs, and the number of participants they can enroll is often low.

One resource discussed as not being fully maximized for children's healthcare is tele-medicine. This could include specialty care such as behavioral health and weight management, in addition to illnesses children frequently have such as ear infections and allergy problems. Taking advantage of this type of technology can serve as a means to increase access to care by reducing the need for transportation, hours away from work, and reducing the cost of care for the child's family.

> Many rural communities have tele-medicine capacity (30-40 sites across the state) but are not used at capacity to provide services to children.

The question of how public/private/universal health coverage would facilitate improving a child's health status returned to the previously discussed challenges of transportation, provider workforce issues, and cost of care. Insurance coverage will not resolve all these other problems in rural areas. However, the willingness of dentists to accept children covered by Medicaid was cited as a specific limitation in accessing care. In the Waycross area a shortage of dentists was not a problem, but rather having dentists accept Medicaid. This obstacle has been overcome in communities fortunate enough to have volunteer dental services in schools or a local clinic

Funding streams are a challenge in rural areas just as in urban. Much to rural's credit, partnerships and innovative means of applying for funding are found. One group participant wasn't eligible to apply for a grant but through a partnership with their Family Connections office they were able to do so. Rural communities, despite long-standing high school football rivalries, will work together where a regional tie will lend itself to a collaborative effort. That said, geographic distance can still create obstacles for partnering in rural areas.

Knowledge of resources and means to carry out a program create challenges as well. For example, one focus group participant raised the Atlanta Falcons football team as a source for funding a physical activity program for children. A community may have the people and facility to make it feasible, but may not be aware of that funding opportunity.

An importance difference to note between academic research pertaining to rural children's health and the focus group/interview participants was the lack of discussion of race and language barriers.

As in urban areas, rural Georgia continues to see growth in Spanish speaking residents (documented and undocumented). Often these newcomers are underinsured or uninsured, so the challenges for care are no less than English speaking residents, regardless of race.

It is undeniable that race is an important part of life in rural and urban Georgia. The underlying connection to income often correlates to race. That said, conversations (and specifically in the focus group and individual interviews) about children's health tend to focus on how income affects a child's access to care rather than the child's race. The issue of race is more readily delineated in academic studies and grant applications to demonstrate a community's need for funding.

Conclusion

The focus group/interview outcomes and literature indicate that rural children and their families face significant challenges in accessing healthcare. The need for advocacy on their part is real. An important element in this work is to teach those who understand advocacy how to do that work better and to teach those interested in this problem to become advocates. In Georgia, as in other states with significant rural or frontier areas, one of the most pressing challenges is to immerse legislators and government officials in the challenges and benefits of living in a rural community. Without some significant understanding of what rural needs are, our state cannot effectively create policies or programs to improve the healthcare services and status of rural children. Rural communities don't want to spend any more time being the step-child to urban Georgia. It will take a partnership of rural advocates both inside and outside of Atlanta and the Gold Dome to accomplish this. Rural is ready.