

Summary Report

Rural, Remote and Northern Women's Health



Policy and Research Directions



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Rural, Remote and Northern Women's Health: Policy and Research Directions Final Summary Report

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Table of Contents

Executive Summary

SECTION A

Introduction

The origins and purpose of the study

SECTION B

Understanding Rural and Remote Women's Health in Canada

A brief description of the context: gender, rurality and health in Canada

SECTION C

Conducting the National Study

A description of how this research was conducted

SECTION D

Annotated Bibliography of the Literature in French

A review of French-language literature on rural, remote and northern women's health in Canada, compiled by Véronique Martin and Christine Dallaire, PhD in August 2002

SECTION E

A Literature Review and Thematic Bibliography

A review of English- and French-language Canadian literature on rural, remote and northern women's health, compiled by Rebecca Sutherns, PhD in February 2003

SECTION F

Results from Francophone Focus Groups with Women in Rural and Remote Communities in Canada

A summary of the methods and findings from seven French-language focus groups involving 30 women across Canada, compiled by Christine Dallaire, PhD and Guylaine Leclerc in April 2003



SECTION G

**Results from Focus Groups Conducted in English with Women Living
in Rural and Remote Communities in Canada**

A summary of the methods and findings from 20 English-language focus groups involving 164 women across Canada, compiled by Ivy Bourgeault, PhD in May 2003

SECTION H

Pauktuutit Inuit Women's Association

A summary of a discussion held at the 2001 Annual General Meeting

SECTION I

The National Consultation

Results of the consultation held with more than 50 women from rural communities and other researchers from across Canada, in Saskatoon in March 2003

SECTION J

Synthesis of Themes

A summary of the findings, synthesized from both literature reviews, both focus group reports and the National Consultation Report

SECTION K

Research Priorities

Suggested directions for community-based and academic research on rural, remote and northern women's health based on the project findings

SECTION L

Policy Recommendations

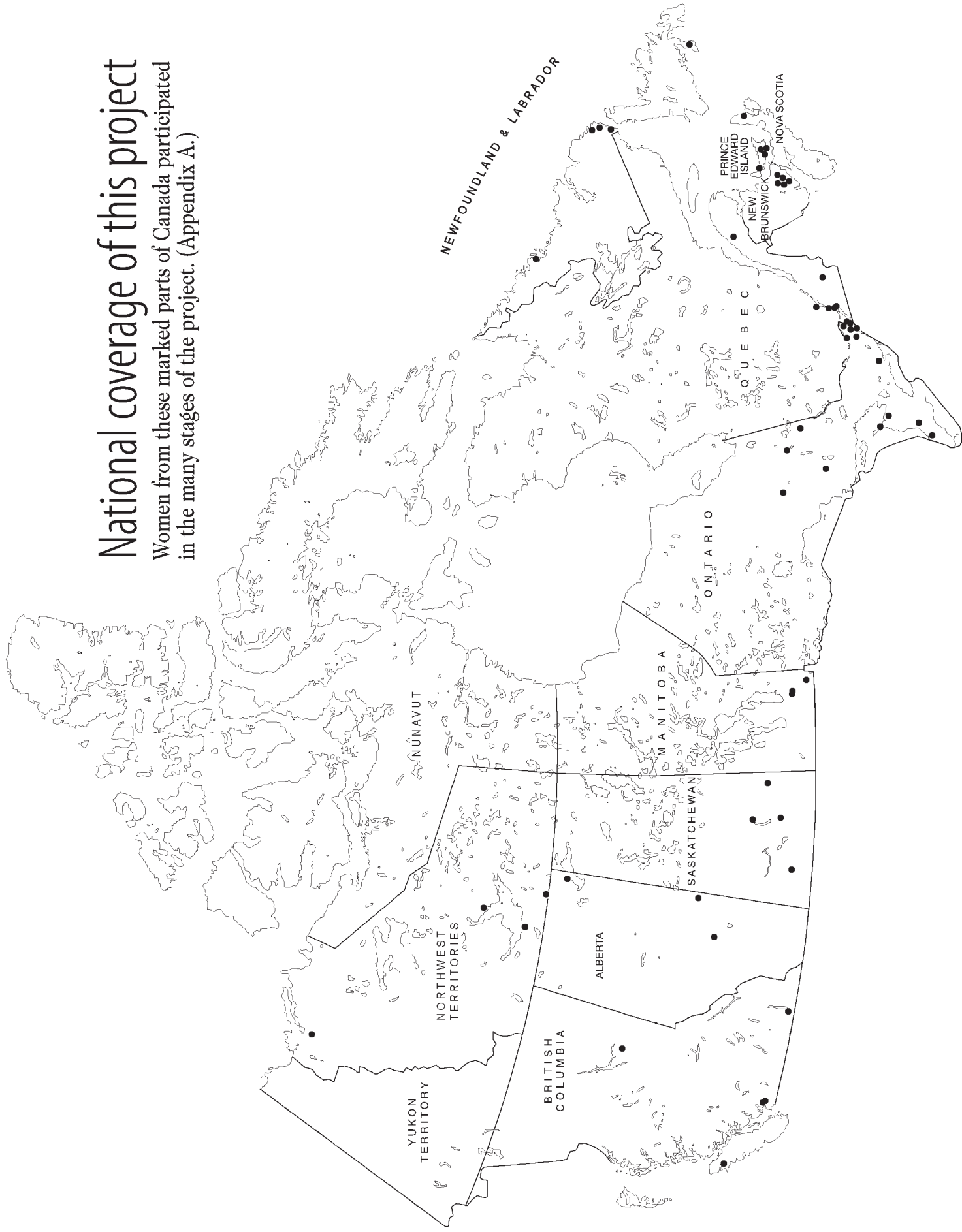
A 27-point agenda for action based on the project findings, targeting policy-makers at various levels

SECTION M

Appendices

National coverage of this project

Women from these marked parts of Canada participated in the many stages of the project. (Appendix A.)



Rural, Remote and Northern Women's Health:
Policy and Research Directions

Executive Summary

Table of Contents

Background	3
The Research Process	4
Findings	5
Research Priorities	6
Policy Recommendations	8
Implementation	11
Next Steps	11



Executive Summary

Background

In response to widespread interest in the health issues of rural, remote and northern populations in Canada, calls for more systematic and applied rural health research and the virtual invisibility of gender analysis in current rural health policy and research, the Centres of Excellence for Women's Health (CEWH) developed a national study entitled *Rural and Remote and Northern Women's Health: Policy and Research Directions*. Its purpose was to combine the knowledge of women living in rural and remote areas of Canada with that of community organizations and researchers to develop a policy framework and research agenda on rural and remote women's health in Canada. The results of the study reported here reflect investment in a highly consultative process

to produce clear, achievable goals for change, based on the knowledge of women who have built their lives in rural, remote and northern Canada.

This two-year initiative (2001-2003) was undertaken by the four Centres of Excellence for Women's Health and was funded by the Women's Health Bureau of Health Canada, with assistance from the Office of Rural Health and the Institute for Gender and Health of the Canadian Institutes for Health Research. Executive Directors of the Centres worked closely with the director of the CEWH program at Health Canada and seven other academic and community-based researchers who formed the National Research Steering Committee (NRSC) for the project.

Administrative support was provided by the existing infrastructure of the Centres.

This Final Report is a compendium that describes the research process, contains the

products of the various phases of that research, and synthesizes those products into themes, recommendations for further research and implications for policy.

The Research Process

From the outset, the Centres wished to hear from women themselves about the variety of circumstances in which they live rurally, and how those circumstances affect their health. Including rural women's voices to research and policy agendas was critical for four reasons:

1. Rural women have knowledge essential to formulating effective policies and programs that will maintain and improve their well-being in their communities and will not perpetuate inequalities for women;
2. Rural women must be *involved* in research and programming in order for those efforts to be maximally effective;
3. Women's participation and expertise are key to the development of further research at the Centres related to improving health care quality and access for women living in rural and remote areas of Canada; and
4. Policy recommendations made by the Centres must be supported by findings from research conducted in accordance with the principles of citizen engagement.

A broadly consultative process was therefore used to gather data for this project. It occurred in several overlapping phases, beginning with a roundtable discussion involving rural residents and health researchers in October 2001. This was followed by thorough reviews of the

published literature on rural, remote and northern health in Canada in both English and French. From November 2001 to January 2003, over 200 women were involved in 28 English, French and Inuit focus groups, videoconferences and teleconferences coast to coast to coast. Health policy makers contributed their expertise through a roundtable in November 2002. These efforts culminated in a National Consultation in March 2003, to which over 50 researchers, facilitators, focus group participants, policy makers and managers from all parts of Canada, including the high Arctic and isolated coastal communities, came to respond to the question, "What are the challenges and opportunities for ensuring the best state of women's health in your community?"

Various members of the NRSC took responsibility for the analysis and reporting of the data at these different stages, with the assistance of numerous research associates.

Conducting a project of this magnitude in this way involved significant complexity, organization and flexibility, as well as commitment from many women throughout the country. The use of qualitative methods and the intentional inclusion of community, academic and government voices gave breadth and depth to the project's understanding. From the women who participated, there was widespread affirmation of the decision to use a consultative approach; as one said, "I felt honoured to be heard."

According to another, “I have the impression that I’ve more effectively contributed

this way than if I had filled out a mail survey and sent it in.”

Findings

Eight interrelated messages provide the backdrop for the research priorities and policy recommendations generated by the project:

1. *Rurality is a powerful determinant of women’s health, as both a geographic and sociocultural influence.*

Rural living affects women’s health, not only because of geographic isolation or limited access to health services, but often due to sociocultural characteristics that influence health-seeking behaviours. Considerations of rural health must therefore take both place and culture into account.

2. *Rural Canada is not homogeneous.*

There is considerable debate over appropriate definitions of the terms “rural”, “remote” and “northern”, yet participants had a clear sense of what rurality meant to them. Throughout the country, women consistently described a rural culture, although its characteristics varied. On the surface, for every observation made, there seemed to be another that contradicted it. Yet these tensions point to the diversity of rural Canada. Rurality does have an iden-

tifiable culture, but that culture varies according to its context. Rural culture must therefore always be taken into account, but at local levels so that its distinctive characteristics can inform appropriate policy. As one participant said, when it comes to rural research and policy making in Canada, “one size clearly does not fit all.”

3. *Consistent rural health priorities are discernable in the face of diversity.*

Despite enormous diversity in location, livelihood and life experience, the priorities highlighted by participants in this study were remarkably similar. Regardless of how or where the information was gathered, the consistency in the salient health issues for rural, remote and northern Canadian women was striking.¹

4. *Rural women are largely invisible to policy makers.*

Participants felt ignored and misunderstood by policy makers who are used to operating in urban contexts. Similarly, research on rural women in Canada is scarce in the literature.



5. *The health care system is perceived as underfunded and deteriorating.*

Women around the country described the health care system as strained, vulnerable, unreliable and insufficient to meet their needs, paralleling a similar preoccupation in the literature with poor rural access to health services.

6. *Efforts to restructure that system have exacerbated rather than improved an already vulnerable situation.*

According to participants and the literature, cutbacks in services inherent in health reform have led to more travel, more stress, and less personalized care for rural and northern residents.

7. *Poverty and financial insecurity, primarily as a result of unemployment, job insecurity, low wages or seasonal work, is a key determinant of health for rural women and their families.*

Many rural places are single industry

towns or rely heavily on seasonal primary resource production such as farming and fishing. Income streams are frequently limited or inconsistent, and the implications on health are far reaching.

Participants saw poverty as the most important determinant of rural women's health.

8. *Health is perceived as being synonymous with, and distinct from, health care.*

Women understand that health is more than health care, yet the two are often used synonymously. Rural health care was viewed overwhelmingly negatively, particularly in terms of access to services, but maintaining health in rural areas was presented positively. Women considered it important to offer a balanced presentation of both the positive and negative aspects of rural life.

Research Priorities

Based on data from all of the sources, eleven priorities for future research emerged:

1. *Anything about rural women in Canada*

Rural women in Canada have been largely invisible to researchers and policy makers. Most health research tends to ignore women, or rural realities, or both. Where rural populations are addressed at all in Canadian research, their input is rarely separately analyzed, and gender analysis is rarely conducted. Virtually any aspect of rural women's health in Canada that explicitly analyzes the importance of place, culture and gender would therefore be a suitable topic for additional research.

2. *Creative models of rural health service provision*

Participants were interested in "thinking outside the box" to solve problems of access to health services in rural areas. They were also committed to rural-specific solutions to health care challenges. They therefore affirmed any research aimed at developing models of health care delivery with rural populations clearly in mind.

3. *Impacts of isolation on health*

Geographic and social isolation are common features of rural life in Canada, and they have powerful effects on personal and community health. Currently the

specific positive and negative influences of place on health are undervalued and underrepresented in the literature.

4. *Importance of cultural values for health*

With the possible recent exception of Aboriginal health issues, research into the characteristics of diverse Canadian rural cultures is rare. More specifically, the ways in which cultural values enhance or undermine good health and models of delivering culturally appropriate health care in rural contexts warrant further investigation.

5. *Factors influencing the impact of rurality on health*

This project has made clear that rurality is an influential determinant of health, often in contradictory ways. Further research is needed to explore why living rurally operates simultaneously as a positive and negative determinant of health, and how rurality interacts with other health determinants.

6. *Moving from information to action*

Participants were passionate about the need to get beyond information to action, both in terms of putting policy research into practice and translating health knowledge into changed personal behaviour.

7. *Health issues across the life course*

More research is needed into women's health experiences at particular stages of their lives, and how those experiences related to ones they had or will have at different ages. Research about children, adolescents and young women in rural contexts is especially scarce.

8. *Health issues relating to specific rural populations*

There are obvious gaps in current research aimed to address the health concerns of specific sub-groups of rural

women. These include but are not limited to: young women, immigrants, coastal women, Métis, Inuit and First Nations women, Mennonite or Hutterite women, women with addictions and women experiencing violence. Research about rural health practitioners who are not doctors or nurses is also very limited.

9. *Getting beyond reports of satisfaction*

When asked, most participants said they were satisfied with their health care. The interactive methods chosen for this project, however, allowed women to continue their comments, and most added, "but..." Understanding this phenomenon of "Satisfied, but..." would be a fruitful research area in rural health. Similarly, the links between reported satisfaction, care quality and expectations of care in rural contexts need further exploration.

10. *Rural definitions and depictions*

In the existing literature, rurality is not defined, defined inconsistently, or defined but not analyzed. Rurality is frequently treated as a homogeneous, straightforward, usually negative influence on health. Similarly, participants expressed concern about the negative, stereotypical ways in which rural people and rural life are portrayed in the media and other areas of popular culture. There is a lack of attention to the diversity that characterizes rural Canada, and a need for more careful analysis of the impacts of that diversity on healthy living.

11. *Rural occupational health and safety*

Rural-specific occupations held by women, especially outside of farming and fishing, have not been well researched in Canada. The experiences of women juggling multiple roles, including those of caregiver, parent and paid worker, also warrant further attention.

Perhaps even more important than research topics, however, are the assertions women made regarding research designs and applications. They spoke passionately of the need for research to be applied, useful and effectively communicated to diverse populations. Participants affirmed the need for research designs that allow women's voices to be clearly heard and that offer women opportunities to be engaged, to work together and to hear one another's perspectives as part of

the research process. As one participant said, "When group consultations are done, the question of one person or the response of another will encourage someone else...It creates consciousness raising in the community." Women also underscored the need for research to be conducted in ways that take the whole of women's lives into account, rather than exploring one small dimension in isolation.

Policy Recommendations

Recommendations for policy makers are clustered under three policy priorities, with eleven accompanying actions:

1. Factor Gender, Place and Culture into All Health Policy

One way of ensuring that gender, place and culture are taken into consideration is to use specific "lenses" or "filters", to take gender, culture and place systematically into account when considering policy alternatives.

Gender-based analysis helps to identify and give priority to those areas where gender-sensitive interventions will lead to improved health. A rural lens offers a way of viewing issues through the eyes of Canadians living in rural, remote and northern areas. Both lenses should be systematically applied to any health-related policies to examine the impacts on rural, remote and northern women.

Actions:

- Use gender/place/culture lenses in policy development, health planning and programming, at federal, provincial and municipal levels, so that the impacts of policy outcomes are systematically considered and more accurately assessed for effectiveness.

- Involve women in rural, remote or northern Canada in gender/place/culture based analyses as a primary means of more accurately assessing impact and effectiveness of policies and practices designed to increase social and economic capital in these regions.

2. Define Health Policy as More than Health Care Services

Despite clear evidence otherwise, health care services still dominate thinking, media coverage, decision making and budgeting for health. Women's experiences of healthy living extend far beyond visits to health care providers, just as barriers to good health often have little to do with the provision of health care services. Many women praised the health benefits derived from the social capital in their communities, including service clubs, community spirit, proximity to family and supportive interpersonal relationships. Yet many others reported poor access to supports such as transportation, recreation and childcare. They spoke of experiencing poor mental health due to social and geographic isolation. They talked about being limited by traditional role expectations for women in small communities. Women were clear that many of the policies

outside the “healthcare silo,” including finance, labour, social services and transportation, can have as much influence on health and health status as those deliberately targeting health.

Actions:

- Invest in women’s health and community health through the Rural Health Access Fund and other sources to provide stable, longer term operational funding for community-based organizations to catalyse women’s engagement in and coordination of economic, political and social services in rural, remote and northern communities.
- Implement federal, provincial and territorial policies that will stabilize household incomes and reduce the stress of women’s lives in rural, remote or northern communities.

3. *Improve Health by Improving Access*

There are four types of access that affect health care utilization: access to information, services, appropriate care and decision-making.

a) Access to Information

In order to be able to access health care services, rural women must be aware of what services are available, particularly in contexts where that availability is frequently changing. Currently, information points are limited and poorly coordinated.

Actions:

- Create and support a Centre of Excellence for Women’s Health that conducts women’s health policy research in the Yukon, Northwest and Nunavut Territories, and increase resources of the existing Centres of Excellence for Women’s Health so that women’s community organizations in rural, remote and northern Canada are engaged in the

Centres’ research, development and dissemination of locally appropriate information and education and advocacy materials.

- Reduce professional and jurisdictional boundaries that impede women’s access to health care and information by coordinating health information access points for rural, remote and northern users throughout Canada, for example through local libraries, telephone information lines, interactive websites, or community health centres.

b) Access to Health Care Services

One of the “Directions for Change” cited in Romanow’s “Building on Values: The Future of Health Care in Canada” includes funding “to support new approaches for delivering health care services and improve the health of people in rural and remote communities.”² The community leaders, residents and rural health specialists involved in this study contributed many such new approaches.

Actions:

- Expand coverage for health services currently excluded from most provincial and territorial health insurance plans, such as prescription drugs and complementary therapies, and include coverage of all costs related to travelling away from home for necessary care.
- Coordinate the supply of physicians and other practitioners to ensure a balanced distribution of services and practitioners well-suited to meeting the needs of diverse rural populations.
- Establish education and training program incentives for students in all the health professions to specialize in appropriate health services directed at under-served rural, remote and northern populations,

particularly Aboriginal and other historically disadvantaged groups.

c) Access to Appropriate Care

Participants reported overall shortages in rural health care services, but even more dire scarcity of what they would consider “appropriate care,” including female practitioners, complementary practitioners, or those trained in cross-cultural care provision.

Actions:

- Implement strategies to increase the recruitment and retention of primary care physicians, medical specialists and non-medical health practitioners in rural, remote and northern areas, such as a) acceleration of accreditation for foreign-trained practitioners and, b) facilitation of health professionals’ involvement in integrated community health centres with mobile service delivery capabilities.

d) Access to Decision-making

Family well-being remains the responsibility of women, while political power over resource allocation still rests largely in male hands. Women’s previous attempts at “political inputs” as stakeholders have seldom been successful in producing “policy outputs” readily accessible to women in rural, remote or northern Canada. Women

as a group seldom fit the description of an acknowledged “policy community,” yet to be effective, policy needs to look at differences between genders and differences within each gender. Only by making it possible for rural women to be engaged directly and actively in the policy-making process can such differences be fully brought to light.

Action:

- Create a “GPA–Gender Place Analysis” policy change network of collaborative, equitable, mutually respectful partnerships between Canadian women in rural, remote and northern Canada and policy makers, at every level of government. Achieve this priority through increased funding to build upon the social capital of women community leaders in rural, remote and northern Canada, including funding leadership training, travel, networking, proposal writing, honoraria and childcare, as well as ongoing liaison with the Centres for Excellence in Women’s Health, the Canadian Women’s Health Network and other supportive partners.



Implementation

Policy-making is about the allocation of scarce resources among competing priorities. The needs of rural women should figure prominently in that process. As slightly more than half of the population, women are far more than a “special interest group.” They are the majority of voters, health care providers and caregivers. Nearly one-third of Canadians live in rural and remote areas, where health care services are sorely inadequate. Women in rural, remote and northern areas of Canada often experience triple disadvantage, because of their gender, their location, and the interactions between the two. Their voices are rarely given an opportunity to be heard. For Aboriginal women, and women facing additional barriers of racism, economics, language, culture or

education, the negative health effects can be multiplied further.

These three policies and 11 related actions do not represent many new tasks, but suggest new ways of doing old tasks. They highlight the need to take gender, place and culture systematically into account in health policy making, which needs to extend far beyond traditional health care services. They demonstrate the multifaceted nature of health care access in these highly diverse communities, and call for a renewed commitment to ensuring it. They point to the need for greater transparency and accessibility within health policy making. Taken together, these recommendations comprise a transformative process that will strengthen the health of our country as a whole.

Next Steps

Two initiatives are already underway that will expand upon the findings outlined here. A second phase of this project, funded by Status of Women Canada, looks more specifically at the health effects of restructuring on rural women. It will intentionally target particular subgroups of rural women who remain underrepresented or missing in this first phase. These include young women, non-white women, women from the territories, Prince Edward Island and Quebec, women with disabilities, and women not affiliated with or known by existing community organizations.

Another missing element in Canadian rural health literature is national statistical or epidemiological studies on rural health

status, as well as longitudinal work. That gap will be filled in part by an ongoing national research program entitled “Canada’s Rural Communities: Understanding Rural Health and its Determinants,” a multidisciplinary partnership between Health Canada, the Canadian Population Health Initiative of the Canadian Institute for Health Information, and the Centre for Rural and Northern Health Research at Laurentian University.

The research and policy agendas generated by this initial exploratory phase of research point to many other fruitful areas of inquiry and application. They should be undertaken ardently and without delay, for the benefit of all women living in rural, remote or northern areas throughout this country.

Endnotes

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- 1 Where important differences did emerge, usually between women's experiences and what is reported in published literature, they are noted in the Report.
 - 2 Romanow, R. (2002) Building on Values: The Future of Health Care in Canada, Ottawa: Government of Canada, p. 159.



Rural, Remote and Northern Women's Health:
Policy and Research Directions

Introduction

**By Rebecca Sutherns, PhD
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Project #1 of the National Rural and Remote
Women's Health Study

Table of Contents

Towards a New Policy and Research Agenda for the Health of Women in Rural, Northern and Remote Canada	A3
Centres of Excellence for Women's Health	A4
Principles	A5
Structure of the Report	A6



Introduction

Health care and health issues have been discussed at great length in Canada for the last 10 years. The media is full of stories of the struggles some Canadians have in getting appropriate and adequate care, personal stories of hallway medicine and long waiting lists, and essays and commentaries about the future of universal health care.

As seen in the recent Report from the Royal Commission on Health Care¹, Canadians have a great deal to say about what they value in the national health care system, and what needs to be changed. The health and health issues of Canadians who live in rural and remote Canada merit special attention because of the geography, history, and makeup of the people who live here.

Towards a New Policy and Research Agenda for the Health of Women in Rural, Northern and Remote Canada

The purpose of this study was to combine the knowledge of women living in rural and remote areas of Canada with that of community organizations and researchers to develop a policy framework and research agenda on rural and remote women's health in Canada.

Those who live in rural Canada contend with health care which is less accessible and which frequently lacks continuity or comprehensiveness. Death rates and infant mortality rates are higher than in urban areas, but birth rates are also higher, and

with young adults moving to cities there is a resulting demographic of young children and older adults.

This study emerged in response to a call from a Rural Health Research Summit in October 1999 to address the need for more systematic rural health research and for the application of a rural lens to health programs and policies in Canada². The Final Report of the Commission on the Future of Health Care has since echoed this need to strengthen applied research into rural and remote health at a national level:

Policies and strategies for improving health and health care in smaller communities have not been based on solid evidence or research. Until recently, Canadian research on rural health issues has been piecemeal in nature and limited to small scale projects... Furthermore, as with health research in general, there is little connection between decision makers and researchers³.

Similarly, the Canadian Health Institutes of Research, the largest funding agency for health research in Canada, released a Rural Health Strategy in early 2002, in recognition of the emerging interests in the particular health disparities or health issues for rural Canada.

Gender, and the health of women, do not have a clear or decisive place in the planning and definition of rural and remote health strategies or research. There is scant research about what determines and influences health for women, access to appropriate health services, experience of quality of care,

environmental exposures, and socio-economic factors particular to rural and remote regions of Canada. For example Kubik and Moore (2001)⁴ found that farm women believe policy makers and health professionals lack any meaningful understanding of the issues women are facing today on the farm. In another study, women who give informal (unpaid) care in their homes in rural Nova Scotia have stated that the rural

communities and small towns where they live have been especially hard hit by health reform, and that significant health resource inequities exist between urban and rural areas of Nova Scotia⁵. In a country as vast as Canada there are undoubtedly areas of commonality among women and their health issues, but there will also be very distinct, regional and circumstantial differences.

There is scant research about what determines and influences health for women.

Centres of Excellence for Women's Health

The Centres of Excellence for Women's Health (CEWH) are funded by Health Canada, through the Women's Health Bureau. Since 1996, the Centres have supported and conducted community-based research on the social determinants of health⁶ which will lead to policy change to improve the health and health status of

women. Because health care delivery and policies relating to health influencing factors are at a local or provincial level, the Centres have supported many small-scale projects which address local issues. In many cases, the results of the Centre-supported work have led directly to changes in health care delivery⁷.

The Centres also have demonstrated expertise in gender-based analysis. GBA examines research data and policy (recommendations or actual) to assess the implications for women and men differentially. GBA is a tool to discern who benefits from policy and who may be disadvantaged. Questions are raised about where there may be discrepancies in power and access to services or results. Gender-based analysis is an accepted tool in Canadian international work, and is, in fact, officially required in national policy. However GBA has not yet been implemented regularly in day-to-day

operations by policy makers in most departments, in most levels of government. Furthermore, gender-based analysis has been virtually absent from rural health research policy in Canada.

Therefore in 2001 the Centres were funded by the Women's Health Bureau of Health Canada to oversee this project to illustrate and record examples of health care issues for women in rural and remote communities, and to bring the issues of women's health to the discussions in research and policy arenas.

Principles

As seen in Section B, clinical and social health researchers have long grappled with useable definitions of what rural means to Canadians. From the outset the Centres wished to hear from women themselves about the variety of circumstances in which they live rurally, and how those circumstances affect their health. We spoke with women from the interior of British Columbia, Inuit women of the high arctic, Métis women from Southern Manitoba and Northern Alberta, farm women in Saskatchewan and Ontario, women in isolated Francophone communities and women from the eastern and western coastal regions.

Specifically, the Centres were interested in including women's voices to the research agendas because:

1. Women living in rural and remote areas of Canada have knowledge essential to formulate effective policies and programs that will maintain and improve their



well-being in their communities and will not perpetuate inequalities for women;

2. Women living in rural and remote areas of Canada must be *involved* in research and formulating effective policies and programs that maintain and

improve their well-being in their communities;

3. Women's participation and expertise are a priority for the Centres and key to the development of further research at the Centres' related to improving access to and the quality of health services for women living in rural and remote areas of Canada; and

4. Policy recommendations made by the Centres must be supported by findings from research conducted in accordance with the principles of engagement stated above.

The work, infrastructure and communication networks already established by the CEWH Program provide an excellent opportunity

for meeting women from across the country, to involve and consult on the widest possible basis, and to discuss the overall issues as well as those that are circumstantial and more local. Thus health care policy and health system performance measures can be

developed to meaningfully reflect the full range of women's experiences with the health system, as consumers, health care providers and members of the general public.

Structure of the Report

The Final Report is a compendium of the first four phases of the National Project entitled "Rural, Remote and Northern Women's Health: Policy and Research Directions," undertaken by the Centres of Excellence for Women's Health. It describes and analyzes the research process, contains the products

of the various phases of that research, and synthesizes those products into themes, recommendations for further research and implications for policy. Several sections of the Final Report could stand alone, but also form part of the larger whole.



Endnotes

- 1 Romanow, R. J. (2002). Building on Values: The Future of Health Care in Canada - Final Report. Commission on the Future of Health Care in Canada.
- 2 Watanabe, M. and A. Casebeer (2000). Rural, Remote and Northern Health Research: The Quest for Equitable Health Status for All Canadians. Report of the Rural Health Research Summit, October 1999.
- 3 Romanow (2002). Pg 164-165.
- 4 Kubik, W., and Moore, R. (2001). Women's Diverse Roles in the Farm Economy and the Consequences for their Health, Well-being and Quality of Life. University of Regina unpublished report.
- 5 Campbell, J., G. Bruhm and S. Lilley (1998). Caregivers' Support Needs: Insights from the Experiences of Women Providing Care in Rural Nova Scotia. Maritime Centre of Excellence for Women's Health.
- 6 Health Canada currently recognizes 12 determinants of health as part of a population health model. They are: income and social status, social support networks, education, employment and working conditions, social environments, physical environments, biology and genetic endowment, personal health practices and coping skills, health child development, health services, gender, and culture. There is on-going discussion among social researchers and community groups that race, migration experience and rural living can also be considered determinants of health.
- 7 For contact information for the individual Centres of Excellence for Women's Health see Appendix C.



Rural, Remote and Northern Women's Health:
Policy and Research Directions

Understanding Rural and Remote Women's Health in Canada

By Rebecca Sutherns, PhD

Table of Contents

Introduction	B3
Rural Canada	B3
Rural Health in Canada.....	B4
The Health of Rural Women in Canada	B5
Summary	B6



Understanding Women's Health in Rural, Remote and Northern Canada

"I believe that...the success of our health care system as a whole will be judged not by the quality of service available in the best of urban facilities, but by the equality of service Canada can provide to its remote and Northern communities."

– Jose Amaujaq Kusugak, Inuit Tapiriit Kanatami,
Presentation to the Commission on the Future of Health Care in Canada, 2002

Introduction

This section offers a brief synopsis of the context for this national study. It outlines the features of rural Canada, what is known about rural health in Canada and more

specifically rural women's health. Although far from comprehensive, it provides some background against which the findings of this study can be better seen and understood.

Rural Canada

Rural Canada occupies 9.5 million square kilometres, or more than 95 percent of Canada's territory. Health Canada defines

rural and remote communities as those with populations of less than 10,000 and removed from many urban services and resources.

According to that definition, almost nine million Canadians—about 30 percent of Canada’s population and 20% of its paid work force—live in rural and remote areas of the country.¹ Rural Canada is growing in population at a half percent annually, and this will accelerate as baby boomers retire to the country where many of them have their roots.² Furthermore in some regions the rural population of Aboriginal people is growing particularly quickly.³

The distribution of rural populations varies from region to region: for example, 15% of the population in British Columbia and Ontario live in rural areas, compared with 46% in Atlantic Canada, nearly 50% in Saskatchewan and 59% in the territories. These percentages can be deceiving,

Diversity is a characteristic of Canada, and it applies to smaller communities just as it does to the largest cities.

however, because despite the proportion of rural residents being relatively low in a highly populated province such as Ontario, the

actual number of people may be quite high.⁴

Diversity is a characteristic of Canada, and it applies to smaller communities just as it does to the largest cities.

Rural Canada is a highly diverse economy and society, from its coastal regions to its agrarian heartland. Canada’s rural natural resources provide employment, forest products, minerals, oil and gas, food, tax revenue and much of our foreign exchange. Rural Canada is also ethnically diverse, encompassing many Aboriginal cultures alongside those of European descent, as well as immigrants from around the world.

Rural Health in Canada

In rural Canada, as in urban Canada, good health is a major resource for social, economic, community and personal development. Yet low population density and isolation result in unique challenges in delivering health care to rural Canadians.⁵

According to the Society of Rural Physicians of Canada, “Canada’s vast land mass and the tendency of the majority of its peoples to settle in densely populated, highly industrialised, urban centres, huddled along the 49th parallel, has produced a culture of neglect of the needs of rural Canadians.” The Canadian medical system, for example, is organized in a highly centralized manner, better suited to countries with dense populations and short

distances. As a result, while 31 percent of Canadians live in rural areas, only about 17 percent of family physicians and about four percent of specialists practise there.⁶

Just as there are significant shortages of health personnel in rural places, so too is there a paucity of data on specific health assets and vulnerabilities of diverse rural populations in Canada. Information is incomplete and unsystematic, with vulnerable subgroups or social aspects of health being virtually ignored.⁷ Growing literature indicates that rural communities have unique characteristics with respect to health determinants, including factors

related to demographics, economics, social relationships and the physical environment. It is known that rural residents, compared to their urban counterparts, have a lower life expectancy, higher disability rate, and experience more accidents, poisoning and incidents of violence. There appears to be an inverse relationship between the size of a community and its health status, that is, the more remote or northern a community is, the poorer the health status of its residents is likely to be.⁸

As part of addressing this information gap, a multidisciplinary team of researchers is

currently conducting a national research program entitled, “Canada’s Rural Communities: Understanding Rural Health and its Determinants.” Health status, health determinants and health services utilization among rural Canadians are being examined and compared with those living in urban settings. Undertaken by Health Canada, the Canadian Institutes for Health Information and the Centre for Rural and Northern Health Research, this program will lead to a number of more specialized studies, including rural women’s health.

The Health of Rural Women in Canada

Over one in five Canadian women live in a rural area.⁹ Research on their health is extremely limited. What little there is tends to focus on farm women, despite the largest category of rural women living off farm. Research that captures rural women’s health experience, while not masking the diversity of that experience, is rare.¹⁰

Preliminary results from the study by Des Meules et al. (2003) mentioned above show clear disparities in health status

between women living in rural and urban parts of the country. For example, rural women have appreciably lower labour force participation rates, higher fertility rates and a higher likelihood of being poor than their urban counterparts. Canadian women living in rural communities have a higher risk of dying from motor vehicle accidents, poisoning, suicide, diabetes and cancer. They are at a higher risk of violence, economic insecurity, primary industry



occupational hazards and a lack of confidentiality. Certain subgroups, including elderly, Aboriginal or disabled women, are particularly vulnerable.¹¹

Rural research conducted outside of Canada suggests that rural women have greater family and community responsibilities, due to coming from larger families, starting their own family earlier, having more children and playing key roles in family businesses and in community affairs. These multiple roles are usually

Rural women are afforded few choices in terms of their health care.

carried out in contexts of firm and conservative social expectations of women.¹²

Women in rural places have limited access to women-centred care. Many women have to travel much farther to obtain health services, often without easy access to transportation, and are therefore less likely to use them. Even when health services are available, they are frequently inappropriate in meeting the needs of rural women. Rural women are afforded few choices in terms of their health care.¹³

Summary

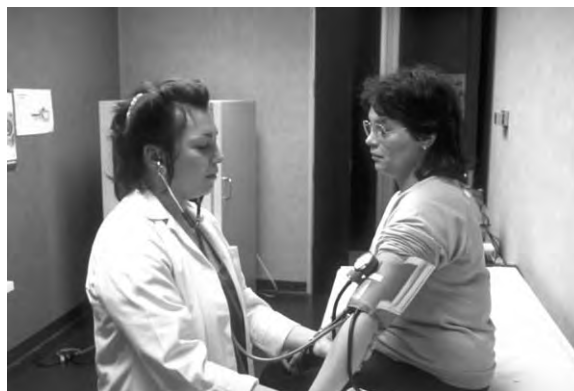
Much more could be said about rural women's health in Canada. More information and sources are provided in the literature reviews. For now, these early

findings clearly support the need for further research and policy initiatives targeted at benefiting rural women in Canada.



Endnotes

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- 1 Office of Rural Health, Health Canada 2003, www.hc-sc.gc.ca/ruralhealth/
 - 2 Society of Rural Physicians of Canada www.srpc.ca
 - 3 See for example, Martens, P. et al. (2002) The Health and Health Care Use of Registered First Nations People Living in Manitoba: A population-based study. Manitoba Centre for Health Policy. www.umanitoba.ca/centres/mchp/reports/reports_02
 - 4 Romanow, R. J. (2002). Building on Values: The Future of Health Care in Canada - Final Report. Commission on the Future of Health Care in Canada Page 160.
 - 5 Ibid.
 - 6 Society of Rural Physicians of Canada www.srpc.ca (specifically the library and statistics sections).
 - 7 Sutherns, R. (2001) Women's Experiences of Maternity Care in Rural Ontario: Do Doctors Matter? University of Guelph PhD Dissertation and; DesMeules, M., C. Lagace, R. Pitblado, R. Bollman and R. Pong. 2003. Assessing rural women's health as part of the national research program "Canada's Rural Communities: Understanding Rural Health and Its Determinants".
 - 8 DesMeules et al. (2003).
 - 9 Ibid.
 - 10 Sutherns, R. (2001).
 - 11 Ibid.
 - 12 Ibid.
 - 13 Ibid.



Rural, Remote and Northern Women's Health:
Policy and Research Directions

Conducting the National Study

**By Rebecca Sutherns, PhD
and Marilou McPhedran**

Table of Contents

Introduction	C3
The Value of Qualitative Research	C3
Project Management	C4
Timeline	C5
Data Collection	C5
Roundtable Meeting, October 2001	C5
Literature Reviews	C6
Focus Groups	C6
Policy Roundtable	C8
National Consultation	C8
Data Analysis	C8
Summary	C9



Conducting the National Study

Introduction

This national study was conducted as a cross-centre initiative of the Centres of Excellence of Women's Health, funded by the Women's Health Bureau and the Rural Health Office, Health Canada, to understand and take action on policy and research needed to improve the health of women living in rural, remote or Northern communities of Canada. It has been important to the women who designed and participated in this project to spend most resources on ways to listen, record and analyze informa-

tion directly from women who live in rural Canada. Thus, a variety of approaches were used to conduct the project.

In this section, the overall research process is described and explained. Details of the methods used for each phase of data collection are provided within the reports on those phases. This section also includes some reflection of how the study progressed, documenting the lessons learned with a view to informing later efforts.

The Value of Qualitative Research

The methods of gathering data significantly influence the kind of data collected, so research results cannot meaningfully be

discussed without first describing the research process itself.¹ Though there are many approaches to gathering information,

not all are equally compatible with the questions at hand or the spirit in which they are asked. This project was interested in engaging women at local levels in a process that would allow them to share their experiences of health in rural places. Qualitative research methods were deemed to be most appropriate to do so for several reasons. First, although the general topic areas were identified ahead of time, qualitative methods allowed women to shape the research agenda and to use their own words to express their opinions. Second, because this was considered an exploratory study, it was especially important to choose an approach that would



enhance understanding of the issues. Qualitative research allows for deeper understanding, which can then inform quantitative work at a later stage. It also accommodates diversity of experience more readily than would a predetermined survey. Third,

qualitative research more readily values various knowers and sites of knowledge; it does not privilege the knowing of the researcher over the researched.²

Listening to women's voices, involving women at community levels in research and engaging in gender-based analysis are strengths of the Centres. This project was therefore designed and conducted to achieve those three objectives.

Project Management

The project was a national effort involving all of the Centres of Excellence for Women's Health (CEWH). It was co-directed by Marilou McPhedran, Executive Coordinator of the National Network on Environments and Women's Health (NNEWH) based at York University, and Margaret Haworth-Brockman, Executive Director of the Prairie Women's Health Centre of Excellence (PWHCE). They led a Management Committee that included the directors of the other two Centres as well as the Manager of the CEWH program from Health Canada. A National Research Steering Committee, comprising members of the Management Committee as well as academic and community-based researchers, oversaw the research

process itself.³ Meetings were conducted primarily by teleconference, and in person on three occasions.⁴ Administrative support and assistance was provided by the existing infrastructure of the Centres.

The project was a national effort involving all of the Centres of Excellence for Women's Health.

It was beneficial to the Centres to gain experience working together on a shared project but having so many Centres involved meant that there were also many people involved, who were juggling numerous other commit-

ments and working under a variety of contractual arrangements. Although these elements probably undermined some of the consistency and timeliness of the project, they also lent a very valuable richness of experience and perspective to the process.

Timeline

August 2001:	Proposal approved by the Women's Health Bureau of Health Canada
October 2001:	National roundtable discussion in Saskatoon, Early draft of English literature review presented
November 2001- January 2003:	Focus groups conducted (194 women in 27 groups around the country)
August 2002:	French-language literature review completed
November 2002:	Consultation with policy makers
February 2003:	Thematic Bibliography and Review of English and French literature completed
March 2003:	National Consultation in Saskatoon
June 2003:	Final report complete

Data Collection

As envisioned in the original proposal of August 2001, the project unfolded in distinct phases. It also involved several layers and opportunities for collaboration with government staff at various levels, women's health

organizations, academic researchers and women living in diverse rural, remote and Northern communities in all provinces and territories.

Roundtable Meeting, October 2001

In the first phase, the Centres had an opportunity to host a roundtable meeting as part of a larger conference on rural health research being held in Saskatoon⁵. The meeting involved approximately twenty-five women; a cross-section of researchers and advocates in rural women's health from different parts of Canada. They provided suggestions to the Steering Committee to refine the design of the study. It was an important opportunity for the Centres to share information and foster partnerships with others interested in rural women's health.

The design and management of the study were influenced by that roundtable discussion in a number of ways. For example:

- The need for clarity and specificity of terminology was discussed. Concepts such as "health" or "rural and northern" are complex and their meanings may be dependent on the circumstances of use.
- Attention to understanding the diversity of women and women's communities was needed, especially considering the health needs of marginalized and isolated women, or those living in the far North. For instance Aboriginal women include Métis, First Nations, Inuit and Dene women, with potentially very different health influences and served by different health care models.
- The project began to liaise with the Strategic Initiative in Rural Health of the

- Canadian Institutes for Health Research (CIHR) to ensure that the findings of the study would be considered by CIHR in the development of their rural health strategy.
- A Listserv group was established and expanded as participation in the study grew.
 - Canada's international treaty obligations relevant to rural women's health were considered.
 - Plans were made to develop explicit recommendations for action needed as a result of the study's findings, to be communicated at various levels not only to civil servants but also to elected officials and senators.

Literature Reviews

The first phase of the project also involved gathering as much information on rural, remote and Northern women's health in Canada as possible. The original plan called for the preparation of a single literature review. An English-language review was prepared in draft form near the start of the project. It incorporated peer-reviewed and community-based research relating to a wide range of topics relevant to the health of rural women. The Research Committee then

decided that a similar review of French-language Canadian research was needed. In the end, a thematic bibliography and review of literature in both English and French were prepared. The documents assess the scope, accessibility, methodology, key messages, tensions and gaps in existing Canadian research, and offer suggestions for research and policy directions based on that body of literature.⁶

Focus Groups

The second phase of the project involved conducting focus groups throughout Canada. Each Centre of Excellence, with assistance from other members of the Research Steering Committee, took responsibility for selecting the locations of the focus groups to be facilitated in their region, with NNEWH overseeing the Francophone groups across the country. Facilitators were separately hired by the Centres in each region; in some cases they were health care providers or active women from the local area, while in other cases they were researchers brought in from outside. Some facilitators were responsible for convening the focus groups, while others facilitated groups that were convened locally by other

women. A common set of guidelines and interview questions was developed to provide some consistency among the groups. Facilitators also distributed demographic questionnaires to all women in the focus groups.

Despite consistent guidelines having been provided to facilitators, there was some variation in contractual arrangements, levels of involvement, identities in communities, recruitment strategies, coding schemes and products delivered to the Management Committee. For example, in some cases facilitators were well known by focus group participants, perhaps even as their health care provider, whereas in other instances the

facilitator was a newcomer to the group. This reflected a project commitment to getting the best information possible, even if that meant deviating from scripted expectations.

The project management team received helpful feedback from the facilitators regarding how the focus group facilitation guidelines, questions and demographic survey could be made more effective in the next phase of the project. New versions of those tools will be modified accordingly and subject to review and validation. In later phases, more opportunities will be created to ensure that the facilitators have more effective guidelines and clear expectations.

The number of focus groups grew as the project progressed, both in response to recognition of the need to incorporate as much diversity and participation as possible, and with newly available funds. The 2001 annual general meeting of Pauktuutit, Inuit Women's Association, was a unique opportunity to gather information from Inuit women from across the high arctic. By the end of the project, 164 women were involved in 20 diverse, English-speaking focus groups and videoconferences, and 30 women participated in seven French-speaking groups and teleconferences. Recruitment strategies for participation in the groups varied. For example, the Francophone focus groups all involved women who were active in women's organizations. Several of those groups met in cities, regardless of where the women actually

lived. The Anglophone groups took place in rural or remote locations and involved women from those communities or their environs. Full reports of the Anglophone and Francophone focus group findings are included in this Final Report⁷. They include maps, detailed descriptions of the methodology used for the groups, participation in the groups, and all related findings.

The demographic information collected from focus group participants was not analyzed as fully as it might have been. Also, because the focus groups were sometimes held centrally, rather than in locations close to where women actually live, it was difficult to construct place-related tables, maps and graphs. Community profiles were created for some locations, but lacked meaning in other cases since the focus group location was not related to the women's places of residence.

Despite having conducted more focus groups than originally planned, particular subgroups of rural women remain underrepresented or were missing altogether. These include young women, First Nations women, women from the territories, Prince Edward Island and Quebec, women with disabilities, and women not affiliated with or known by existing community organizations. Some of these gaps will be filled in a second phase of the project, in part through purposive sampling that will intentionally include rural farm, rural town, remote drive-in and remote fly-in community members.

164 women were involved in 20 diverse, English-speaking focus groups and videoconferences, and 30 women participated in seven French-speaking groups and teleconferences.

Policy Roundtable

During the time focus groups were being held across the country, the project hosted a consultation with policy makers to coincide with a Research Steering Committee meeting in Toronto. This meeting brought six women involved in shaping rural health policy at provincial and federal levels

together with the Research Steering Committee. It was an opportunity for the Centres to keep policy makers informed about the progress of the project, as well as to gather their advice about the most effective ways to package and disseminate the findings⁸.

National Consultation

The third phase of the project involved hosting a National Consultation, which brought together over 50 women: researchers, facilitators, focus group participants, policy makers and managers, most of whom had already been involved in the project. Women came to Saskatoon from all parts of Canada, and all aspects of the event were simultaneously translated between French and English. A summary of the project to date was presented, as were preliminary results from a quantitative research program on rural health, currently being undertaken by Health Canada, Statistics Canada, the Canadian Institutes for Health Information and the Centre of Rural and Northern Health Research⁹. Open Space Facilitation was used to guide participants in addressing the question, “What are the challenges and opportunities for ensuring the best state of women’s health in your community?” Women then ranked the topics that they

considered to be of primary importance.¹⁰ This served as a new opportunity to collect data as well as to check from women, first-hand, the resonance of existing findings. A video production, for which funding had been secured separately, was also filmed at the Consultation. What unfolded at the national consultation did differ from what was originally envisioned. Intended at first to be an opportunity for reflection on existing data, the consultation became more of an opportunity to ask similar questions to the focus groups and thereby gather new data.

It was energizing to have such a variety of women come together to share their insights,...

The national consultation was a highlight of the project because of its commitment to broad participation from around the country. It was energizing to have such a variety of women come together to share their insights, and for many of the women a first opportunity to discuss their concerns in a national forum.

Data Analysis

Various members of the National Research Steering Committee (NRSC) took responsi-

bility for the analysis of the data at different stages, with the assistance of numerous

research associates. Responsibilities included conducting and reviewing the literature reviews, coding focus group data, compiling demographic data, reviewing and writing reports for the Anglophone and Francophone focus groups, planning and participating in the National Consultation

and discussing plans for the final report. Similarly, this final workbook, synthesizing the findings from all three phases, was written by NRSC member, Rebecca Sutherns, in collaboration with other members of the Committee.

Summary

The use of qualitative methods and the value given to community, academic and government voices and expertise gave breadth and deeper understanding to the project. From the women who participated there was widespread affirmation of the decision to use a consultative approach to this research initiative.

Women appreciated being involved and hearing the views of others in the process. As one said, “I felt honoured to be heard.”

Strong efforts were made at each phase to be as inclusive of diversity as possible for an initial project. This commitment to inclusion was especially visible at the National Consultation, which made it possible for women from all over Canada to participate. Although certain groups remained underrepresented (or unrepresented), additional resources were sought to expand the reach of this project, and even more women will be able to have their voices heard in the upcoming second phase.

From a researcher’s point of view, this inclusivity, alongside the complexity of managing a national project involving new terrain,



busy people, many stages and sometimes limited resources posed challenges to maintaining the rigour of the research process. The process of data analysis, for example, was thorough at each stage, but in the end involved summarizing summaries of summaries, presumably at the exclusion of details that may not have been highlighted adequately in the final

product. Similarly, having several different types of data feeding into the final report required making decisions about how to “weight” the observations from each phase.

Conducting a project of this magnitude involved significant complexity, organization and flexibility. Many women from across the country contributed their time, experience, expertise and enthusiasm for the project. The size of the project engendered some complications, but nevertheless the following sections of this Report represent the diverse and varied circumstances and situations of women who live beyond Canadian cities, and who must be recognized and consulted in the debates around “rural health”.

Endnotes

- 1 Kirby, S., and McKenna, K. (1989). *Experience Research Social Change: Methods from the Margins*. Toronto: Garamond Press; Wiebe, N. (1995). *Farm Women: Cultivating Hope and Sowing Change*. In S. Burt and L. Code (Eds.), *Changing Methods: Feminists Transforming Practice*, Peterborough: Broadview Press, pp. 137-162.
- 2 Ironstone-Catterall, P. with P. McDonough, A. Robertson, B. Payne, B. Rahder, F. Shaver and P. Wakewich. (1999). *Feminist Research Methodology and Women's Health: A Review of Literature* (Toronto: National Network on Environments and Women's Health).
- 3 A full list of members of the Management Committee and National Research Steering Committee appears in Appendix A.
- 4 In Saskatoon in October 2001, Toronto in November 2002, and Saskatoon in March 2003.
- 5 Appendix A lists the participants at the National Roundtable in Saskatoon, October 20, 2001. The Roundtable was hosted at the conference, *Health Research in Rural and Remote Canada: Taking the Next Steps*.
- 6 See Sections D and E of this Report. The documents give detailed descriptions of the methods used to compile the literature reviews.
- 7 See Sections F and G of this Report.
- 8 See Appendix A for a full list of participants at the policy meeting, November 2002.
- 9 DesMeules, M., C. Lagace, R. Pitblado, R. Bullman and R. Ponj. (2003). *Assessing rural women's health as part of the national research program "Canada's Rural Communities: Understanding Rural Health and Its Determinant*.
- 10 See Section I for the report from the National Consultation.



Rural, Remote and Northern Women's Health:
Policy and Research Directions

Annotated Bibliography of the Literature in French

Research and Summaries by Véronique Martin, Research Assistant
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Prepared for the *Rural and Remote Women's Health: Policy and Research Directions* research project sponsored by the National Network on Environments and Women's Health (NNEWH), in concert with the Centres of Excellence for Women's Health.

August 2002

Project #2 of the National Rural and Remote
Women's Health Study

Table of Contents

Introduction	D3
Summary of the Literature in French	D4
Summary of Topics	D24
Topic 1: Health and Rural Specificity	D24
Topic 2: Women's Health	D26
Topic 3: Rural Women's Health	D28
Bibliography	D31



Annotated Bibliography of the Literature in French

Introduction

The first phase of this review of the literature in French on rural women's health was to do a reference search using the search engines of the Université Laval library system, the CEWH-CESAF website and Google.ca, with the French keywords for: "woman", "girl", "health", "rural", "country-side", "isolated", "rural environment", and "rurality"¹. The combination of the terms "rurality" and "woman" produced the greatest number of results related to the research topic. Generally speaking, the results of these initial searches were rather disappointing and pointed to the great need for research on this subject. However, a few good articles were used to locate new references. It was therefore by going through the bibliographies of these first articles that the

present literature review could be compiled. A second web search using the French keywords for "agriculture", "farming", "mine", "farm", "forest", and "fishing"² was conducted. The keywords "woman" and "agriculture" uncovered new articles on the topic. After the selected articles were photocopied, individual summaries of the texts and their relevant sections were prepared. Next, a synthesis of these summaries helped to identify the similarities and differences between the texts with respect to their treatment of the issue and the following three topics:

- Topic 1: Health and Rural Specificity
- Topic 2: Women's Health
- Topic 3: Rural Women's Health ³

In the opinion of Maria De Koninck (1994), the issues of women's status and social conditions must be addressed before action can be taken regarding their health. Health research must focus on identifying determining social factors for health and ways of acting on them. Moreover, Ms De Koninck feels that the most glaring need for research is in the area of occupational health.

Another area is that of women's contribution as stakeholders in the health field. Both elements are specifically dealt with in this literature review.

Research on rural women's health and work tends very often to be about farm women. Yolande Cohen (1982) points out that at the end of World War I, many [Quebec] women joined farm women's circles (*cercles de fermières*): "[TRANSLATION] From this tumultuous post-war period until the Great Depression of 1929-1931, rural women saw their way of life undergo radical changes. Farm women were keenly aware of the transformations that fast-paced industrialization introduced into the essentially rural French-Canadian society, and became involved in a process of adapting to these changes." What is the situation of rural women today? Do they still have the means to cope with change? Do they have access to the services needed to maintain a good quality of life?

There is also significant focus on the contribution of women in the health sector (both

paid and unpaid). The government is offloading more and more homecare responsibilities onto organizations operating essentially on the volunteer work of women. Several studies underscore the particularly harmful impact of this shift to ambulatory care on women.

The collection "Femmes et développement des régions" [women and regional development] is a series of published documents on the living conditions of women and regional and local development for all the Quebec regions. The following are summaries of a few of these documents, most of which begin with a statement about the existence of data on the status of women, but indicate that these data were not compiled for public release. For certain aspects, including the situation of women according to age group, women living alone or the characteristics of women in business or the community sector, the gendered data were piecemeal, scattered or non-existent. However, the Quebec government, in its *Programme d'action 2000-2003-L'égalité pour toutes les Québécoises* [Action Plan 2000-2003—Equality for All Women of Quebec], reiterated its commitment to implementing gender-based analysis in its practices by integrating mechanisms so that the specific realities of men and women are reflected in the analyses, policies, programs and legislation in all areas of government responsibility.

Summary of the Literature in French

1) Les conditions de vie des femmes et le développement local et régional dans l'Outaouais, Collection "Femmes et développement des régions".⁴ January 2000.

Issues raised related to the rural environment

- The region shows significant deficiencies with respect to perinatal care. Resources in the territory are rare and scattered, and are even more cause for concern in a

region where the road infrastructure is far from adequate (p.68).

- This is the only region where immigrant women are mentioned: There is very little documentation on the situation of these women, who require a mental health approach that is considerate of cultural references and the context of their particular ethnic background (p. 73). Aboriginal women are also mentioned (p. 80).
- Despite its high Cesarean rate, the region seems to be heading toward a shortage in practising obstetricians. The fact that little effort has gone into increasing the practice of midwifery only aggravates the problem (p. 74).
- Teen pregnancy rates are among the highest in Quebec. The region has few resources for pregnant teenagers or young mothers, and these services are concentrated in the Ottawa Urban Community (p. 74).
- The region's five shelters for abused women are scattered randomly throughout the territory and, with an ever-increasing number of cases, must turn away many woman seeking their assistance (e.g., women with alcohol or drug abuse problems) (p. 79).

The shift to ambulatory care

- p. 69 = postnatal follow-up and early release from hospital
- p. 73 = situation of elderly women and women caring for relatives, and the impact of this shift on their mental health

2) Les conditions de vie des femmes et le développement local et régional en Abitibi-Témiscamingue, Collection "Femmes et développement des régions"⁵ July 1999.

Issues raised related to the rural environment

- The very size of the Abitibi-Témiscamingue region brings to bear on the daily life of the population. Unfortunately, there are few data on the situation of rural women. Nevertheless, the accessibility of certain resources, particularly daycare and transportation services, must be taken into consideration, as this greatly affects women's access to the labour market or services. Furthermore, the region's daycare services are much less developed than in the rest of Quebec, and there is the need for another 2,433 spaces (p. 39).
- While it is difficult to know the exact distribution of urban or rural daycare services, the consensus is that most are located in urban areas and are better suited to the reality of this setting. On the other hand, they are often not very compatible with farm women's schedules, for example. Furthermore, the rules governing the opening of daycare centres, especially in schools, are sometimes hard to apply in small rural locations, and this hinders the development of such services (p. 40).
- Rural women, especially elderly ones, find it particularly hard to get around. The absence of public transportation, and the fact that fewer women have a vehicle or even a driver's licence for cultural and economic reasons, makes their day-to-day mobility more onerous. (p. 40).
- Teen pregnancies—It bears mentioning that most of the regions have no specialized school services for pregnant teens or young mothers, and abortion is less frequent (p. 43). It seems surprising that in a region with five hospitals and six facilities with a CLSC [local community service centre] mission, 13.9% women

travel to another region, mainly Montreal, for these services. Is this made necessary due to an absence of resources (elective abortion during the first trimester only), excessive delays or other reasons, such as the desire for confidentiality? (p. 43) (*see article on abortion*)

- Youth migration gives rise to population aging in small communities, and the elderly are migrating to urban centres to be closer to services that meet their needs. The elderly who remain require informal caregivers since there are fewer services available (pp. 47-48).

Decentralization

- The *Conseil du statut de la femme* [Quebec council on the status of women] suggests that the distribution of health and social services programs should be considered an important element in regionalization and decentralization plans, especially if accessibility of these services is to be guaranteed throughout the territory (p. 44).

The shift to ambulatory care

- Ambulatory shift = aging population = greater need for informal caregivers (p. 48)



3) Les conditions de vie des femmes et le développement local et régional en Chaudière-Appalaches, Collection "Femmes et développement des régions"⁶, December 2000.

Issues raised related to the rural environment

- Female students, much more than the males, are concentrated in a few areas of education. These options lead to traditionally female jobs that sometimes have

little to do with regional strategic directions, which exposes them to unemployment or prompts them to migrate out of the region. (p. 68)

- There is significant disparity in terms of income (p. 68) and access to services (p. 70) within the same region.
- The lack or insufficiency of certain services essential to professional or social participation greatly limits women's labour force activity, particularly in rural environments. The situation is aggravated when they live alone, are isolated or have family responsibilities to children or semi-autonomous relatives (p. 71).
- There are minimal urban and suburban public transportation services in the region (p. 72).
- Women must have freedom over their bodies and be able to exercise their maternity rights freely. This is why the

lack of evolution in abortion and family planning services in the region is so deplorable. In 1997, only four of the 867 area women who had an abortion did so in the Chaudière-Appalaches region, which is by far the

lowest retention rate in Quebec (p. 72) (*see article on abortion*).

- Demographics are shifting significantly, and include an aging population, youth migration, family breakdowns... As a result of these trends, there is an increase in the number of people living alone with more economic and socio-psychological problems than the rest of the population. These trends will also likely have a stronger impact in the rural context,

primarily in the devitalized and isolated areas. Furthermore, such demographic changes affect women in particular because 1) there are more women in the age 65+ category and among single-parent households, 2) they tend to live longer, are the biggest consumers of health care services, and will therefore feel health service cuts more keenly...

The shift to ambulatory care

- and 3) in the context of the shift to ambulatory care, women make up the large majority of “natural” caregivers, for family and cultural reasons (p. 74).

4) Les conditions de vie des femmes et le développement local et régional dans le Bas-Saint-Laurent, Collection “Femmes et développement des régions”⁷ January 2002.

Issues raised related to the rural environment

- Current demographic changes must be addressed, given that some of the more rural municipalities have among the highest percentage of people ages 65 and over in Quebec (Basques, de La Mitis and Kamouraska). This trend threatens to reduce the numbers of available volunteers, weaken family support, and increase expectations of family caregivers with respect to the health and social services network. There are more women in the 75 + age group; they tend to live alone and in poverty, and are in poorer health (pp. 81-82).

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- More women need to get involved in community development, especially by entering the labour market. Women from the Bas-St-Laurent region have lower participation and employment rates and a higher unemployment rate. They are paid only 2/3 of the average regional male wage and have less education (many have not gone beyond the high school level), etc. On the other hand, the *Syndicat des agricultrices du Bas-Saint-Laurent* [Bas-Saint-Laurent farm women’s union] lists 693 female farm producers with shares in one of the 1900 farm businesses in the region, a percentage nearly twice that of Quebec. With respect to services, there is only one women’s group involved in labour market integration issues: *Ficelles pour l’accès des femmes au travail*, in Rimouski (pp. 86-87).

- There is a shortage of daycare spaces. Furthermore, the daycare services in place must consider the demand from various areas of the territory, and assess the needs related to different work and study schedules, including those of farm women (p. 87).

- A broader understanding and more effective action are needed with respect to women’s health and in the struggle to eradicate violence against women. Twice as many women as men are underweight; they are dealing with more than one health problem; more have consulted a health care professional during the two weeks leading up to the survey; women take more medication and are affected more by affective and anxiety disorders and depression than men (p. 89).

- There is a need to increase external services and adapt shelters for abused women to the rural reality (p. 90).

5) Les conditions de vie des femmes et le développement local et régional en Gaspésie, Îles-de-la-Madeleine, Collection “Femmes et développement des régions”,⁸ March 2000.

Issues raised related to the rural environment

- Given that the three communities that comprise Quebec’s Micmac nation are located in this region, it is important to mention the significant deficiency of information on the reality of women from these communities (p. 45). The measures proposed on the following page indicate the importance of a deeper knowledge of the economic and social needs of the region’s Aboriginal women living in the various native communities or off the reserves.
- Women must enjoy the conditions necessary to enter the labour market and contribute to the diversification of the regional economy: the unemployment rate of regional women is twice as high as that of all women in Quebec. Most are in the service industry; their average income is 80% of the average of female workers in Quebec; they are over-represented on social assistance rolls; more than one-quarter have less than a Grade 9 education; their educational choices tend to lead to traditionally female occupations, etc. (pp. 56-57).
- The demographic shift is reflected in an aging population, and youth and family migration. Women are affected by current demographic changes because there are more of them among the elderly population, and because youth and family migration causes a breakdown in elderly

women’s natural support network, for the most part comprising their children and grandchildren. These migrations mean that elderly women are no longer able to get around, since there is little organized public transportation (pp. 57 to 59).

- Age and poverty are linked, especially where women are concerned. Evidence now exists of a higher incidence of physical and mental health problems in the economically disadvantaged (p. 60).
- Sexual and reproductive health of women: the region is far from having all of the necessary medical resources. In April 1997, two of the municipalities had 46 general practitioners, while the identified need was for 61 (p. 64). More women in this region who wish to terminate a pregnancy use services located outside the region where they live. Only two hospitals in the region perform abortions, and only up to 11 and 12 weeks. There is also a confidentiality issue since it is difficult for women from the peninsula who do not have access to private transportation (teenagers) to get to Gaspé without anyone finding out (p. 65). The highest percentage of births in the 15-19 age group occurred in the municipality of Avignon, where the territory’s two Micmac reserves are located (p. 66).
- Finally, the issues of mental health and conjugal violence are discussed (as in the previous documents).

6) Les conditions de vie des femmes et le développement local et régional dans Lanaudière, Collection “Femmes et développement des régions”,⁹ June 2001.

Issues raised related to the rural environment

- Socio-professional integration and social participation: Very positive, unlike the

other regions... With a youth ratio (ages 0-14) that is well above the Quebec average, Lanaudière is among the “youngest” regions in Quebec (p. 87). In 1997, 34 up-and-coming farmers were women, or 12.8% of all new farmers for the region (the 674 female farm business owners identified for the Lanaudière region represent one-quarter of farm business owners, a larger percentage than for Quebec as a whole, p. 93). In 1998, young women, who account for most of the university registrations from the Lanaudière region, chose courses in administrative science, education and the humanities. The fertility index is higher here than in the rest of Quebec (p. 88).

- This report draws particular attention to women with disabilities and Aboriginal women, who are more affected by low education levels and unemployment (one of the only reports that addresses women with disabilities, see p. 93).

The shift to ambulatory care

- Not only has the shift to ambulatory care increased the burden of responsibilities for women, but the transformation of mental health services has affected access to the services of which they are frequent users (p. 99). Woman caregivers who live with their care recipients have a less favourable perception of their own health, are more likely to use tranquilizers, and suffer more constraints on their social lives than those who are not caregivers (p. 101).

N.B.: This region is 45-50 minutes away from Montreal, and could therefore be considered to be part of the Greater Montreal metropolitan region. Perhaps this explains why its situation is so positive...

7) Côté, J., Desmartis, M., Caron, M. and Ouellet, L. (1993). *Le point de vue des leaders d'opinion sur la maladie mentale et la réinsertion sociale en milieu rural*¹⁰.

Beauport: Centre de recherche Université Laval Robert-Giffard. Report prepared for the Ministère de la Santé et des Services Sociaux.

N.B.: This study was carried out in the municipality of L'Islet, in the Chaudière-Appalaches region. Half of the towns used for the survey have a population of less than 800 inhabitants and the numbers are dropping.

Perceptions of the living environment (pp. 38-39-40)

- The positive aspects mentioned are the physical environment (healthy, peaceful, etc.) and the solidarity and community caring that exist in “this rural environment where everyone knows each other and about each other.”

- The negative aspects include:

- 1) the isolation: “This is a closed region, far from the major centres. We are remote and to some extent inaccessible...”
- 2) Economic problems, shortage of work, large numbers of welfare recipients: “It is terrible how little work there is here. I would say that one-third of the entire local population is on social assistance.”
- 3) Youth migration and its effect on the age pyramid: the population is not only decreasing, but it is aging as well.
- 4) Alcohol and drug abuse, and violence (there are the young people who get an education and leave, and those who stay behind...)

Perceptions of the region's mental health resources and services (p. 42 and up)

- According to the people polled who live in St-Pamphile or the neighbouring communities, the CLSCs are the only available resources in this area.

Principal problems associated with institutional resources (p. 45)

- Some people perceive their region to be disadvantaged from a medical viewpoint, particularly given the lack of physicians and their inaccessibility at certain times during the day and week. This situation is seen as appalling, especially in emergency situations: “You are at a disadvantage, medically speaking. If you are in a serious accident, the nearest doctor is 30 minutes away. You can’t get immediate assistance. But as far as other resources like the CLSCs go, we are used to them, and arrange to go when they are open.”
- The fact that CLSCs are closed in the evenings and on weekends contributes to a sense of insecurity and isolation, particularly in the elderly or mothers with young children (p. 51).

Attitudes of the population regarding use of services—People still do not seem to know much about the services provided by CLSCs (p. 46)

Alternative and community resources (p. 47)

- The authors note that there seem to be some community resources in this region. Given the population size, the same people often head up these organizations. The authors mention volunteer committees and informal caregivers without indicating whether most of them are women.
- The authors cite the family as the most natural framework for social reintegration in their discussions on informal caregivers.

Problems related to social reintegration and desired improvements (p. 49)

- The people interviewed saw the main problem related to the treatment of mental illness as the transportation to the Montmagny psychiatric services. In fact,

people without a vehicle often waste an entire day just to see their psychiatrist for 15 minutes.

8) Bouchard, N., Gilbert, C. and Tremblay, M. (1999). Des femmes et de soins. L’expérience des aidantes naturelles au Saguenay. 11. Recherches féministes [feminist research],¹²(1): 63-81

Purpose of the study (p. 64)

The study seeks to better understand how caregiving affects the lives of women living with a dependent relative in the Saguenay region. Their experience, while shared by other women in Quebec, relates to a specific geographic and social context, that of a region marked by its isolation from Quebec’s major urban centres. This local study therefore has particular relevance in the global appreciation of women caregivers in a Quebec context.

Method and context (pp. 65-66)

The authors chose to use a bibliographic method and semi-structured interviews. The sample was built on the basis of the type of relationship between caregiver and care recipient: mother, spouse, sister, daughter. The other sample criterion was the demographic context of the caregiving experience. The authors excluded cases that were part of the ambulatory shift, so the study does not address perinatal or day surgery situations. The sample includes women involved in a CLSC “client follow-up” approach.

The women were asked to share their caregiver experiences by addressing four main themes: 1) a description of the caregiving approach that provides factual data on the persons involved as well as a history of the helper-helpee relationship; 2) a description of the type of care required by the recip-

ient's situation, as well as the caregiver's perception of this type of relationship; 3) the impact of caregiving on the various aspects of the caregiver's life, with a particular focus on her motivation to continue; and 4) a look at the support obtained from social and health system institutions and civil society organizations.

The Saguenay region has a distinct profile marked by its remoteness from the major urban centres. Because it borders on urban as well as semi-rural and rural areas, access to health services can vary significantly from one place to the next.

For statistics that show women are the primary homecare providers, see p. 67

Issues raised related to the rural environment

- Women with a less stable socio-economic situation tend to have a negative perception of accessibility or existence of the various services offered by health facilities. This puts a unique slant on the experience of women caregivers in a region like the Saguenay where the socio-economic status of women is lower than that of the men in the same region and Quebec women overall (this caregiver profile would affect their possibilities of asking for and getting institutional support, p. 71).
- Some unique aspects of public health in the Saguenay region may also intensify the caregiving potential. In fact, recent

studies have shown an overall excess mortality of 8% in the Saguenay-Lac-Saint-Jean region compared with Quebec over the past 15 years. This situation requires a considerable investment from the community-based system, and particularly women, who will be the front-line caregivers for family members affected by these difficult conditions (p. 71).

- The authors note that one might expect that the social networks for caregivers would be more present in the Saguenay region than in the major urban centres. The region's reputation for solidarity might lead to the assumption that its informal, community-based systems are easily engaged. The experience of some of the female respondents is otherwise (the authors give an example using a quote from one caregiver who receives no support).
- Living in a small community can sometimes be an additional source of stress that stems from the shame or embarrassment from the marginality caused by a health condition or by a child who is "different". (The authors give two examples, including a quote from a woman caring for her mother, daughter and husband!, p. 73)

The authors' conclusion does not identify anything specific to the rural environment. Rather, they address the significant

...the government is increasingly offloading homecare responsibilities onto organizations operating essentially on the volunteer work of women...

upheavals brought on by caring for someone, and indicate that this can often change the relationships in a couple or family. In some situations involving obvious overload and burn-out, these women caregivers had a negative perception of their own health and felt that the support available for informal caregivers was of a temporary and limited nature (p. 75).

The authors end with a discussion of the role of government (pp. 76-77). Among other things, they mention that the government is increasingly offloading homecare responsibilities onto organizations operating essentially on the volunteer work of women... By targeting the free and invisible work of women to preserve its social coverage, the government can cut costs considerably. The reduction in the share of care provided by the government does not in any way lessen the need for this care: rather, women are compensating this shift by mobilising their personal time and resources.

N.B.: These authors wrote a document (a project brief of sorts) prior to this one, the reference for which is:

Tremblay, M., Bouchard, N. and Gilbert, C. (1997-1998). *Les aidantes naturelles et la prise en charge de personnes en perte d'autonomie: santé des femmes et défi des solidarités familiales et sociales*.¹² Montreal: Centre of Excellence for Women's Health—Université de Montréal Consortium.

9) Bouchard, N., Gilbert, C. and Tremblay, M. (1996). Les solidarités fragiles: Les femmes et la prise en charge de personnes en perte d'autonomie. Under the direction of Camil Ménard and Florent Villeneuve. *Projet de société et lectures chrétiennes*.¹³ 1996 conference

proceedings of the Société canadienne de théologie Quebec: Éditions Fides, 171-186.

This is the same type of research on the experience of women caregivers. The authors compiled the life stories of four women ages 35 to 45, one of whom is from the Saguenay region (however, it is not known whether she was still living there at the time of the interview). The place of residence is not important in this article and no connection is made with the rural setting. The authors highlight some of the ramifications for caregivers: increased burden of tasks that requires reorganizing of schedules; changes in employment or the forced withdrawal from the labour market; strains on marital and family life; less vacation time and respite; stress and burnout, etc.

10) Fontaine, S., Laplante, É. and Rinfret, M. (1988). *La question de l'avortement au Québec*¹⁴. Document adopted by Quebec's Conseil du statut de la femme.

Highlights (p. 7)

- 65 % of abortions are performed in the Montreal region.
- There are significantly more “later” abortions (after week 16) among young women, with 30% of such abortions among teenagers ages 19 and under, and 53% among women ages 20 to 29.

Accessibility: the major issue... (pp. 9-10)

- Accessibility of abortion services continues to vary greatly from one region to another. The data show that nearly seven out of ten abortions are performed in the Greater Montreal region. Furthermore, only two regions of 11 have resources that offer a full range of abortion services—l'Estrie and Montreal—where abortions are available up to week

20 or 22 of gestation. Montreal is the only place where abortions are available to women from other regions after 18 weeks, since the *Centre hospitalier de Sherbrooke* will not take women from outside the region at this stage in the pregnancy.

- Some regions and subregions have no abortion services, including the Témiscamingue, Lanaudière, Nouveau-Québec, Bois-Francs and Beauce regions.

11) Busque, G. (1987). Les besoins et les ressources des femmes dans l'agriculture.¹⁵ In: *Growing Strong: Women in Agriculture*. Document prepared for the Advisory Council on the Status of Women, Ottawa.

This article was written in follow-up to telephone interviews conducted by the author with farm women or women connected to the farming world from Newfoundland to British Columbia. She indicates that it is impossible to present an accurate portrayal of the situation using the documentation available, and that further research is critical (p. 13). The purpose of this article was to reach farm women themselves in their struggle to preserve the quality of farming life. This quality of life is rooted in very concrete elements: daycare, health services, eradicating violence against women, and access to training—all areas of interest to farm women. Furthermore, access to credit and ownership, for example, is at the heart of the economic situation of farm women, which is in turn at the heart of the recognition they are due (p. 14). The author addresses several elements that impact on the health of farm women:

1) Daycare services

Children's security is an increasingly important issue. More and more farm women are

taking employment off the farm, and they are working more hours (financial support necessary for full-time farm work). They continue to have slightly more children than urban women, although the gap is rapidly closing. According to a study in Ontario, 53% of mothers with children under 12 have to bring them along to the fields while they do their farm work. Access to daycare services that reflect these realities is therefore crucial (pp. 16-17). To support this, the author provides the preliminary results of a survey conducted in Quebec by the *Bureau de la répondante à la condition féminine* [office of the status of women coordinator] of the *Ministère de l'Agriculture, des Pêcheries et de l'Alimentation du Québec* [Quebec's department of agriculture, fisheries and food], by way of the *La Terre de Chez-Nous* magazine, showing that 100% of women with children ages 0 to 17 months said they required daycare services (p. 18). It is therefore important that irregular schedules, peak periods, a high percentage of geographic isolation, lack of public transportation, etc. be taken into consideration when seeking to identify daycare solutions. Daycare services could, for example, be provided in the family home. This solution, while less popular in urban areas, is something that farm women seem to favour more (p. 20). Furthermore, cost becomes an issue, since families are all too often financially strapped, and there is little or no money left for daycare services (p. 24).

N.B.: The *La Terre de Chez-Nous* [our land] magazine is put out by the *Cercles des fermières*.

2) Farm health and safety

Farm work has its own class of health disorders and problems. Maintaining quality of life in this environment is closely linked to health promotion. Interest for health and

social services available in rural areas is therefore of utmost importance. Women who live in remote regions suffer from geographical isolation that forces them to travel long distances: the problem becomes a pressing one when specialist services are required, either on an emergency or regular basis. There is a lack of specialized services. There are fewer physicians per person and fewer hospital spaces available than in the urban centres (pp. 25-26).

The absence of gynecologists, pediatricians, services for children with disabilities and the elderly is frequently a source of concern for women. In some regions, no family planning information service is available (even less so for abortion). According to the author, one thing is certain: rural women base their appreciation of health services on their ability to travel the distances that separate them from the centres where they can find such services (p. 26).

Like their husbands, farm women sometimes experience adverse health effects further to the use of insecticides and various chemical products: birth defects, miscarriages, still-born or premature babies, irregular menstrual period, other production types are rapidly absorbed and carried in the bloodstream and sometimes attack the nervous system, allergies, respiratory problems (particularly "farmer's lung" caused by inhaling mouldy spores released when handling hay or wet grain), back pain and hearing loss (due to operating farm equip-

ment) (pp. 26-28). The author indicates that it is still nearly impossible to provide a broad perspective on these issues and therefore limits her discussion to facts that have already been documented (p. 26).

3) *Stress*

The author focuses on the importance of factors related to the financial situation of farmers, both men and women: money problems that induce women to look for work off the farm, and long work weeks of up to 100 hours (pp. 28-29).

4) *Safety*

Farm-related fatalities make farm work one of the most dangerous types of business activity. New technologies are just as affected by increased accident rates (p. 29). Many farm women bring their children along when they work in the field. In its September 1985 issue, *Farm Women's News* suggested that its readers try using child seats in their tractor cabs (p. 30).

5) *Solutions*

Here are a few solutions proposed by the author: That health care decentralization objectives be pursued so that services can be accessed in all regions. In Quebec, the government tried to discourage physicians from setting up their practices in Montreal or Quebec City by reducing the basic fee they are usually paid, and by increasing by up to 120% the fees for physicians who move to centres where there is a shortage of medical services (p. 30). There is a general need for better information, research and further action. For example, information on



family planning must be made accessible. Quebec's *Cercles de fermières* recommended that midwifery be a legally recognized and self-governed profession, and that the required training be available at university (p. 31). The provinces, and particularly Ontario, have adopted safety measures or are developing related initiatives. In Quebec, the regional farm women's committee in Saguenay-Lac-St-Jean requested financial assistance from an insurance company in order to offer a prevention course to children in the 4 to 7, 8 to 11, and 12 to 15 age groups (p. 34).

6) Needs for abused women

According to the author, conjugal violence in farming communities is influenced by the same factors as in other communities (no difference between the rural and urban environments). However, the fact that it is so difficult in rural areas to maintain anonymity makes any call for help that much harder. Furthermore, in rural locations, the means for dealing with this problem are more scattered and fragile. The absence of shelters and transition houses, the lack of appropriate social services, and even occasional adverse weather conditions intensify the isolation by varying degrees and make it more difficult to cope with a situation that already requires a great deal of courage (p. 37). The safe house solution seems to be gaining popularity in Canada, but the author stresses that a rural safe house is rarely anonymous and therefore does not protect women from a determined spouse (pp. 38-39).

7) Training needs

The author summarizes the findings of the study done by Suzanne Dion which identified the training needs of farm women based on the analysis of their situation and the results of a questionnaire distributed to 52,000 Quebec farm women. Farm women

are most interested in receiving training in the two professional areas of: status of women in agriculture (49%) and agricultural economics (48%). Next come self-improvement courses, like handicraft techniques (32 %), couple psychology (32.3 %), assertiveness training (21.8 %), etc. (pp. 40 to 42).

A few initiatives have emerged in recent years with respect to training needs. In Quebec, even if there are adult farm training programs, women's participation is more limited, for a number of reasons. Farm women who take on the most responsibilities and those who are more financially involved in the farm seem to be more motivated. The others cite a lack of time, distance, their spouse's participation which is more important than their own, and sometimes the fact that because of their status, they do not have the same right to register for certain programs (pp. 42-43). Also in Quebec, the *Ministère de l'Agriculture, des Pêcheries et de l'Alimentation*, through the *Bureau de la répondante à la condition féminine*, launched a three-year action plan in 1986 entitled *Du partage des tâches au partage des pouvoirs* [from sharing tasks to sharing power]. Generally speaking, the purpose of this plan is to develop the programs needed to ensure farm women a complete and visible role in farming in Quebec (p. 45).

8) Interesting references

Bureau de la répondante à la condition féminine (1986). *Du partage des tâches au partage des pouvoirs : Plan d'action triennal*. Quebec: Ministère de l'Agriculture, des Pêcheries et de l'Alimentation.

Dion, S. (1985). *Les besoins de la formation professionnelle des agricultrices*. Mémoire de maîtrise, Université de Montréal. [professional training needs of farm women. Master's thesis]

Direction générale de l'éducation des adultes [continuing education directorate] (1984). *Femmes en agriculture*. [women in agriculture] Quebec: Ministère de l'Éducation.

12) Masson, D. (1994). **S'organiser pour s'autodévelopper: Organisations de femmes et développement au Saguenay-Lac-St-Jean.** In: Marie France Labrecque (Dir.) *L'égalité devant soi : Sexes, rapports sociaux et développement international*.¹⁶ Ottawa: International Development Research Centre.

Purpose: This article is intended to shed light on certain dimensions of the actual role played by women's organizations as the starting point for another kind of development, by and for women, in the outlying regions of a developed country. The author notes that due to the shortage of empirical data on today's women's movement organizations in Quebec, particularly regional ones, she limits herself to a description of what these women's organizations are and what they do (p. 65).

Characteristics of the region: Low population density (less than 30,000) and relatively isolated. Many "traditionally male" jobs, well-paid and unionized. On the other hand, women find few jobs, other than in the service industry, which itself is not greatly diversified. Female unemployment is higher than in the other regions and the number of part-time jobs is also higher here (p. 66).

At the end of the 1980s, the directory of women's groups published by the *Conseil du statut de la femme* identified 815 women's organizations in Quebec, not counting the 870 local *Cercles de fermières du Québec* and the 600 circles of the *Association féminine d'éducation et d'action sociale* (AFEAS) [Quebec women's association for education and social

action]. In the Saguenay-Lac-St-Jean region alone, there are 150 organizations with ties of varying degrees to the women's movement (p. 66).

What they are: There are four main types of women's organizations in the territory of interest to us: 1) the so-called traditional organizations, i.e. the *Cercles de fermières* farm women's circles and AFEAS circles; 2) service groups (women's shelters, perinatal assistance groups, etc.); 3) identity-based organizations (businesswomen); and 4) regional groups (free choice coalition) (see descriptions and explanations, pp. 67 to 73).

What they do (pp. 74 to 77): These organizations are involved on two levels: 1) with women themselves (young mothers, female rape victims, etc.); and 2) in society and the social environment in general (farming communities, business world, etc.). The two main areas of focus in the activities of regional women's groups are: 1) women's access to the labour market as entrepreneurs and paid workers, and 2) violence against women. Women's physical and mental health, their financial self-sufficiency, and motherhood could also be included, although the author does not address them in the article. Work is considered to be an essential requirement for women's autonomy, and itself ensures to a large extent their access to personal independence (particularly in a region where women's participation rate is 10% below that of all of Quebec, the average wages are lower, and there is little diversity in women's employment). See p. 76 for information on what each circle or association is doing with respect to employment issues. There is a higher incidence of violence in this region (one in five versus one in seven women for all of Quebec). The author details action taken by women's groups in regard to this issue on p. 77.

Finally, the author speculates as to the meaning of the “collective interest of women” advocated by regional women’s movement organizations. Furthermore, she stresses that, in addition to immediate interests, many special interests are also represented. As an example, she cites the distance and non-communication between the movement—white, francophone—and the Association des femmes montagnaises [Montagnais women’s association] of the region to illustrate how the gender and ethnical divide come into play (p. 81).

13) **Dion, S. (1991). *Les agricultrices québécoises depuis 1981. Under the direction of Black, N., Cuthbert Brandt, G., Rouyer, M.-C. and Guillaume, P. Femmes et vie rurale au Québec et en Aquitaine*¹⁷. Centre d’études canadiennes [European centre for Canadian studies].**

N.B.: This article was written in 1991, but refers to a survey conducted in the spring of 1981, the highlights of which are as follows...

1) *Women’s contribution to agriculture (pp. 24-27)*

- In exchange for their investments (long work hours, multi-tasking, etc.), farm women received little financial compensation and few had property rights.
- These women indicated they like farming because a) of the quality of life it offers and b) it allows them to reconcile their roles as mothers, wives and farmers.
- The primary reasons why women did not attend union meetings were work overload and the fact that they stayed home to allow their husbands to go (husbands only speak for part of women’s interests). The author indicates (p. 26) that the determining factor explaining absenteeism at union meetings for women over 40 is that

they had a very poor self image: they did not feel they were competent and preferred to stay and do what needed to be done at home so that their husbands, whom they felt were more competent, could go to the meetings.

- The author notes (p. 25) that while these were the interests of farm women ten years ago, they are similar to their interests today (what is she basing this on?).
- Many women were able to identify what they wanted: better working conditions, increased financial security and self-sufficiency, the possibility of making choices and having an impact on the future of farming, and training.

14) **Cuthbert Brandt, G. (1991). *Les origines et le développement des cercles de fermières au Québec et des groupements féminins en Gironde*.¹⁸ Under the direction of Black, N., Cuthbert Brandt, G., Rouyer, M.-C. and Guillaume, P. *Femmes et vie rurale au Québec et en Aquitaine* Centre d’études canadiennes.**

N.B.: The author notes, in the first line of the introduction, that there are still very few studies on rural women. She goes on to say that analysts tend to treat farm women like first-rate conservatives in their social and political views. They come to this conclusion because farm women agree with current explanations regarding behavioural differences between men and women in public life (p. 35).

- For a history of the Cercles de fermières (and the role of the Church in founding this type of organization), see pages 36-37-38-39.

Two important elements

- 1) *Cercle* members are increasingly older (average age is 51 and rising). What

remains consistent is rural women's main motivation for joining such circles.

According to the author's analysis, 2/3 of the women who joined in the past 10 years did so primarily to make contacts with other rural women. This same interest in sociability and solidarity with other women is the main reason given by those who have been members for more than 20 years (p. 39).

- 2) The most relevant concerns for farmers' wives are still: what is the status of 'Farmer's Wife'? How can she continue to make an economic contribution to the new production methods introduced by modern technology? How can the transfer of the family farm to the next generation be guaranteed? (p. 43).

15) Black, N. and Cuthbert Brandt, G. (1999). *Feminist Politics on the Farm: Rural Catholic Women in Southern Quebec and Southwestern France*. Montreal and Kingston: McGill-Queen's University Press.

Chapter 3 describes rural women and compares farms in France and Quebec. The authors have chosen to describe four 'exemplars' of rural women, two living in Quebec—Andrée and Brigitte—and two in France. Andrée is a member of the *Cercle de fermières*; she is 59, got as far as high school but never finished, is Catholic and has eight children. Brigitte is not a member of any organization or club; she is 29, also got as far as high school and has three children. These two fictitious characters represent a synopsis of the answers obtained from the questionnaires completed by 196 women in Quebec, working on the farms of 16 different communities south of Montreal near Salaberry de Valleyfield. They provide a

depiction of these farm women in terms of their work environment, age, education, religious practices, legal relationships, on- and off-farm work, and degree of satisfaction.

- 1) Work environment (p. 52) : Farm size differs in France and Quebec. The average size of French farms is 15 hectares, versus 90 hectares in Quebec. The type of farm operation is important. In Quebec, dairy, beef and cash crop farms require a great deal of land. Farms in France are used for wine production, and land is very expensive.
- 2) Age (pp. 53-54): Cercle members are the oldest of the respondents. The average age is 53, compared with 38 for non-members in Quebec. Farm women indicated that their organizations are worried about the absence of younger members (under 40). Some of the newer groups, like the *Association féminine d'éducation et d'action sociale (AFEAS)* identify themselves as more activist and possibly more appealing for the younger generations of Quebec farm women than the *Cercles*. The authors found no evidence to support this.
- 3) Education (p. 55): In Quebec, 18% of non-members only have an elementary school level of education, compared with 38% of *Cercle* members: these variations are a reflection of the different ages in each of these groups (*Cercle* members are older).
- 4) Religious practices (pp. 57 to 59): The *Cercle* members clearly stood apart: virtually 3/4 of respondents attend church once a week, compared with less than half for the Quebec non-members. Again, the age difference between *Cercle* members and non-members explains this discrepancy.

5) Legal relationship (pp. 61 to 63): French women are more likely to invest their own funds in the farm than Quebec women. Sixty-eight percent (68%) of *Groupement féminin* [French women's organization] members and 58% of non-members invested their own money in farms, compared with slightly less than one-third of all the Quebec farm women. There is also the issue of the family farm, where farm and marital property are intertwined; the issue of marriage and inheritance has always been an important one for rural women activists. The authors note that such businesses (farms) can be particularly unfavourable for women, since all of the profits go to the farm operator—almost always the owner/husband. On page 62, the authors explain how the partnership of acquests works with private property and acquests, as well as separation as to property. I will come back to these legal notions with the following article by Michelle Boivin.

But in farming, the work week is much longer: the average for women is 73 1/2 hours: 43 1/2 hours of household duties plus 30 hours of farm work.

6) Farmwork (pp. 64 to 69): In Quebec, women's work is especially linked to work in the fields, animal care, milking the cows, and livestock management. Duties related to secretarial and management work should also be included. The scope of these activities demonstrates women's high level of involvement in the farm business, as do the many hours put in working on the farm. In Canada, a 40-hour work week is considered to be full-time employment. But in farming, the work week is much longer: the average

for women is 73 1/2 hours: 43 1/2 hours of household duties plus 30 hours of farm work. The major difference between France and Quebec is the fluctuation in work hours depending on the season (Quebec winters are very long...).

7) Off-farm work (pp. 72-73): The authors indicate that in Canada, 36% of farm women had jobs off the farm in 1990. However, the percentage of women with off-farm jobs is considerably lower in Quebec and France—22% and 18% respectively.

8) Satisfaction: Most respondents seemed satisfied with their lives, including their farm work and their status as farm women. None of the women indicates she is totally dissatisfied or unhappy.

However, the women in France are less satisfied on the whole than Quebec farm women. French women were twice as likely to report money troubles or shortages. The

level of satisfaction was extremely high, particularly those women who indicated they were "very happy", and the percentage for Quebec women was nearly double the percentage for Canadian women in 1981-82.

16) Boivin, M. (1987). Les agricultrices: Un travail à reconnaître sur les plans juridique et économique.¹⁹ In: *Growing Strong: Women in Agriculture*. Document prepared for the Advisory Council on the Status of Women, Ottawa, 54-71.

Who are farm women?

The issues

- Farm women are the legal or de facto spouses of farmers, and are generally in charge of the household duties and child care. Recognition of domestic work is a crucial issue for all women.
- The recognition of the work done by farm women, as joint farm operators, is part of the larger struggle of women working in family businesses.
- Women with their own farming business have to deal with the most persistent biases in our society: “A woman can’t operate a farm by herself. It’s too difficult!”
- The Murdoch case sensitized Canada to the dilemma of farm women. Ms. Murdoch claimed that she was entitled to part of the property that had been used for a mixed farming operation, and the Supreme Court of Canada refused to award her this share because her actions were “just about what the ordinary rancher’s wife does.” (p. 57).

Hence the continued relevance of certain claims aimed at ensuring women farmers—and indeed all women working in family businesses—financial self-sufficiency and rights to the farm operation.

The facts

- On a social and political level, the naming of a status of women coordinator in Quebec’s Ministère de l’Agriculture in 1984, and the creation of a status of women office in 1986 also mark an important step toward the recognition of women in agriculture in Quebec (p. 59).
- In Quebec, as in Canada, only 20% of women in agriculture are paid a salary. A 1984 survey conducted in Quebec by the

Association des femmes collaboratrices du Québec [Quebec association of wives in family businesses] shows that farm women’s weekly wages were less than \$100 in 1.7% of cases; 14.8% of them received between \$101 and \$200; and only 1.7% were paid from \$201 to \$300 and up (p. 61).

- Matrimonial regimes (pp. 68 to 71): The *partnership of acquests* governs all couples married on and after July 1st, 1970, unless otherwise provided in a marriage contract. Under this regime, the property of each spouse is divided into two types: private property and acquests. Private property is that owned by each spouse before the marriage, property acquired during the marriage by succession or gifts, and property acquired during the marriage to replace private property (i.e. personal effects). Acquests include all other property, such as the fruits and income of all the property, both private and acquests. The other more familiar matrimonial regimes are the *community of property* and the *separation as to property* regimes (for more information, see page 69). In the most common, the separation as to property regime, each spouse remains the exclusive owner of his or her property. According to the author, some matrimonial regimes, especially that of separation as to property, lead to an unfair distribution of property. And yet, in 1982, 42% of couples chose the separation as to property regime. For farm women, the situation is even more abysmal, since 56.8% of respondents ages 20 to 24 in 1981 were married under the separation as to property regime (p. 70).

17) Couillard, M.-A. and Côté, G. (1997). *Les groupes de femmes de la région de Québec et l'implantation de la région régionale de la santé et des services sociaux*²⁰. Research report presented to the CQRS²¹. Sainte-Foy: Université Laval, centre de recherche sur les services communautaires [community service research centre].

Given that several articles refer to the impact of the shift to ambulatory care on women's health, I selected two texts on the health system. The first text, dealt with here, describes the health and social services system reform with respect to community organizations and women's groups. The second has been commissioned from the women's health bureau and deals with the ambulatory shift in detail.

1) *The Rochon report*

The report of the commission of inquiry on health and social services was tabled in 1988. The mandate of this commission was to examine the objectives, operations, funding and development of the health and social services system. Among the shortcomings identified, we note the discontinuity in services that are also unequal and incomplete depending on the group or region; poor management of unmotivated human resources; the fact that the population's

needs get buried under the priorities advanced by specific interest groups, etc. (pp. 60-61).

The report also highlights regional disparities and notes that the decentralization of government activities provides momentum and breathes new life into the regions by fostering economic activity (p. 62). Among other things, the report recommends further decentralization and recognition of the community sector so that it can take over from a drained government system. Community groups, including women's groups, were very involved in the Rochon Commission consultations, and presented 37.5% of the briefs (p. 63).

2) *The Côté reform*

The recommendations of the Rochon Report were put down in a reform plan entitled *Pour améliorer la santé et le bien-être au Québec : orientations*, [Improving Health and Well-being in Quebec: Orientations] published in 1989 by then Health Minister Lavoie-Roux. This document supports decentralization of services through the creation of regional boards, calling on partnerships with community organizations, an enhanced role for local community service centres (CLSCs), and introducing restrictions to the universality principle (p. 64). In December 1990, the new Liberal Minister of



Health and Social Services, Marc-Yvan Côté, tabled his white paper entitled *Une réforme axée sur le citoyen* [citizen-focussed reform] in which he details the reform objectives and introduces the notions of “*citoyen consommateur, décideur et payeur*” [citizens as consumers, decision-makers and payers]. In keeping with this project, regionalization must reflect regional dynamics, seen as being fuelled by a variable sense of belonging, regional disparities, and the impoverishment of the outlying areas. The Minister’s proposal was presented in Bill 120, which was subsequently translated into a health and well-being policy entitled *La politique de santé et de bien-être* (p. 65).

3) Health policy

The policy outlines 19 objectives to be achieved with respect to specific health and well-being issues and their respective action priorities. The problems targeted were organized into five major areas: social adaptation, physical health, public health, mental health and social integration (pp. 69-70). The section *Voies d’action prioritaires* [priority areas for action] details how the policy intends to recognize community action, including women’s groups (see p. 71 for examples). An analysis of the reform documents reveals that restructuring keeps technocratic functions focused within the ministry, whereas priority and resource operationalization and management are vested to regionally-based boards. In this context, the recognition of community organizations becomes more meaningful (p. 71), and it is therefore as community groups that women’s groups are called to work together with the government in exchange for funding (p. 72).

4) Policy statement on the status of women (1993)

In 1993, the Quebec government’s *Secrétariat à la condition féminine* [status of women secretariat] drafted a new status of women policy, a document that is first and foremost descriptive in nature (p. 72). In fact, it is a brief summary based on a compilation of data that show that Quebec women continue to be subject to numerous social and economic constraints, nine of which are: 1) dead-end educational choices, 2) integration in occupational categories with poorer pay and less advancement potential, 3) unsatisfactory working conditions, 4) the fact that they continue to be largely responsible for child care and household work in spite of their increased professional obligations 5) feminization of poverty, 6) worse physical and psychological health than men, 7) the daily occurrence of violence against women, 8) lack of recognition of their contribution, and 9) limited access to areas of power (p. 73). **N.B.: I find these nine points are often raised in documents in the “Femmes et développement des régions” collection.**

Finally, the policy proposes four main directions in keeping with what the document previously identified as problem areas: 1) economic self-sufficiency (diversified educational choices, easier access to the labour market, etc.), 2) respect for women’s physical and psychological dignity (medication use, sexual and reproductive health), 3) eradicating violence against women and 4) recognition and valorization of their collective contribution to society (female entrepreneurship) (pp. 74-75).

18) (1992). *L'agricultrice, une partenaire professionnelle*. Quebec: Direction des services aux agricultrices²².

- This pamphlet was created in follow-up to a far-reaching consultation process launched in January 1991. The *Direction des services aux agricultrices* [farm women services branch] organized round tables and in total met with nearly 70 people from the financial, media and university fields, as well as members from the farm women's movements and Quebec's *Ministère de l'Agriculture, des Pêcheries et de l'Alimentation*. A telephone survey was also conducted to get personal opinions from 300 farm women. All of this contributed to defining the three-year departmental approaches on the status of women in agriculture for 1992-1995 that reflected farming environment realities in the context of the 90s (p. 3).
- After long being considered as invisible work, the profession of farm woman is now coming into its own. When they marry a farmer, women are often choosing a career as well. In a context where professional and emotional ties overlap, the work women do every day contributes to the growth of the business (p.11)
- The issues: If farm women now have an occupation, they still have to find a sustainable place in managing the business. Over a six-year period, many farm women became landowners (there is an evolution in articles written in 1985 to those from 1992, when farm women were more widely recognized). However, more farm women need to be in positions of power and decision-making. It is still rare for family farms to be left to the female heirs (daughters). Feminization of human resources is therefore required. Along

these lines, the regions that are working on action strategies to foster regional development must seek equitable inclusion of farm women as partners (pp. 13-14).

- The four orientations of the *Ministère de l'Agriculture* are: 1) To ensure recognition of the professional work done by farm women (women's work often goes unpaid, see pp. 15-16), 2) to promote young women in agriculture (in Quebec, it is still rare for daughters to inherit the family farm and the farm woman profession is not widely recognized; see pp. 17-18), 3) to appreciate the value of the "human" side of farm business management (pp. 19-20), and 4) to encourage farm women's participation in rural life (in particular, foster their integration in regional consultative and decision-making bodies, pp. 21-22).
- N.B.: on page 21: While farming is not the only rural activity, it is difficult to imagine the countryside without the presence of farm men and women whose work is essential to all of society. History clearly shows that the creation of rural associations by women is nothing new. From within their groups, women have made a social and economic contribution to church life, as well as education and social services.

19) **Bureau de la répondante à la condition féminine (1985) *Plan d'action triennal***.²³ Quebec: **Ministère de l'agriculture, des pêcheries et de l'alimentation**

- The mechanization of agriculture has lightened women's field and barn chores. This allows them to spend more time at home where new duties have been

created: accounting, researching information, negotiating farm input purchases, planning and management, etc. (p. 1)

- The effect of the economic crisis is strongly emphasized in articles written in the 1980s, such as this one, which points out that the crisis threatened the very survival of many businesses, and made it

necessary for women to work on and off the farm (p. 1).

- Six (6) objectives are listed on page 3, and include promoting women's membership in groups and associations, access, continued training, etc. It should be noted that the status of women coordinator position no longer exists in this department.

Summary of Topics

Topic 1: Health and Rural Specificity

The rural environment has several unique elements related to its remoteness, isolation, and the scarcity of some services. Indeed, the size of the territory brings to bear on the daily life of residents, especially women.

Unfortunately, there are few data on the situation of rural women. The first thing that is clear in articles on the topic is the fact that the scarcity and dispersion of rural resources are even more cause for concern in most of the regions where the road infrastructure is often far from adequate. Accessibility of certain resources, particularly daycare and transportation, must be taken into consideration, as this greatly affects women's access to the labour market or services. Furthermore, rural daycare services are often less developed than in larger urban centres. While it is difficult to know the exact distribution of urban or rural daycare services, the consensus is that most are located in urban areas and are better suited to this setting. On the other hand, they are often not very compatible with farm women's schedules, for example. Furthermore, the rules governing the opening of daycare centres, particularly in schools, are sometimes hard to apply in small rural locations, and this hinders the development of such services. Rural women, especially elderly ones, find it particularly hard to get around. The absence of public

transportation, and the fact that fewer have a vehicle or even a driver's licence for cultural and economic reasons, makes their day-to-day mobility more onerous.

Second, teen pregnancies are even more of a problem in rural areas. It bears mentioning that most of the regions have no specialized school services for pregnant teens or young mothers, and abortion is less frequent.

Furthermore, only two regions of 11 have resources that offer a full range of abortion services—l'Estrie and Montreal—where abortions are available up to week 20 or 22 of gestation. Montreal is the only place where abortion is available to women from other regions after 18 weeks, since the Centre hospitalier de Sherbrooke will not take women from outside the region at this stage in the pregnancy. Some regions and subregions have no abortion service, including the Témiscamingue, Lanaudière, Nouveau-Québec, Bois-Francs and Beauce regions. There are few regional resources for pregnant teens or young mothers. The fact that little effort has gone into increasing the practice of midwifery only aggravates the problem.

Demographics are shifting significantly, and include an aging population, youth migration, family breakdowns, and elderly migration to urban centres to be closer to

services that meet their needs. As a result of these trends, there is an increase in the number of people living alone with more economic and socio-psychological problems than the rest of the population. This trend will also likely have a stronger impact in the rural context, primarily in the devitalized and isolated areas. Furthermore, these demographic changes affect women in particular because 1) there are more women in the age 65+ category and among single-parent households, 2) they tend to live longer, are the biggest consumers of health care services, and will therefore feel health service cuts more keenly, and 3) the elderly who remain require informal caregivers since there are fewer services available.

Female students, much more than the males, are concentrated in a few areas of education. These options lead to traditionally female jobs that sometimes have little to do with regional strategic directions, which exposes them to unemployment or prompts them to migrate out of the region. If they are not unemployed or on social assistance, they have part-time employment in the service industry or low-paying jobs. It has furthermore been shown that the prevalence of physical and mental health problems is higher in people who are economically disadvantaged. As a result, girls in a rural environment need more diversified education to access non-traditional careers that give them better recognition and a higher socio-economic status.

When rural residents are asked how they perceive their living environment, the positive aspects they mention include the physical environment (healthy, peaceful etc.) and the solidarity and community caring that exist in *"this rural setting where everyone knows each other and about each other."* The negative aspects include isolation, economic

problems, work shortages, the high numbers of welfare recipients, youth migration which affects the age pyramid (the population is decreasing and aging), alcohol and drug abuse, and violence.

Interest for health and social services available in rural areas is therefore of utmost importance. Women who live in remote regions suffer from geographic isolation that forces them to travel long distances: the problem becomes a pressing one when specialist services are required, either on an emergency or regular basis. There is a lack of specialized services. There are fewer physicians per person and fewer hospital spaces available than in the urban centres. The absence of gynecologists, pediatricians, services for children with disabilities and the elderly is often a source of concern for women. In some regions, no family planning information service is available (even less so for abortion). Very often, the only regional resources available are the CLSCs. Some people perceive their region to be disadvantaged from a medical viewpoint, particularly given the lack of physicians and their inaccessibility at certain times during the day and week. This situation is considered unacceptable, especially in emergency situations: *"You are at a disadvantage, medically speaking. If you are in a serious accident, the nearest doctor is 30 minutes away. You can't get immediate assistance. But as far as other resources, like the CLSCs, go, we are used to them, and try to go when they are open."* The fact that the CLSCs are closed in the evenings and on weekends contributes to a sense of insecurity and isolation, particularly in the elderly or mothers with young children.

In rural areas, there is a need for increased out-patient services and services that are adapted to the rural reality with respect to shelters for abused women. However, the

fact that it is so difficult in rural areas to maintain anonymity makes any call for help that much harder. Furthermore, in rural areas, the means for dealing with this problem are more scattered and fragile. The absence of shelters and transition houses, the lack of appropriate social services, and even occasional adverse weather conditions intensify the isolation by varying degrees and make it more difficult to cope with a situation that already requires a great deal of courage. The safe house solution seems to be gaining popularity in Canada, but it is important to remember that a rural safe house is rarely anonymous and therefore does not protect women from a determined spouse.

Living in a small community can sometimes be a source of incredible support, since the social networks are often more present in rural areas than in urban ones (everyone knows and helps each other). On the other hand, it can be an additional source of stress that stems, for example, from the shame or embarrassment from the marginality caused by a health condition or by a child who is “different”. On a social and political level, the naming of a status of women coordinator in Quebec’s *Ministère de l’Agriculture* in 1984, and the creation of a status of women office in 1986 also mark an important step toward the recognition of farm women in Quebec. The *Conseil du statut de la femme* suggests that the distribution of health and social services programs should be considered an important element in regionalization and decentralization plans, especially if accessibility of these services is to be guaranteed throughout the territory. The 1988 Rochon report highlights the regional disparities and notes that the decentralization of government activities provides momentum and breathes new life into the regions by fostering economic activity. Among other

things, the report recommends further decentralization and recognition of the community sector so that it can take over from a drained government system. Community groups, including women’s groups, were very involved in the Rochon Commission consultations, and presented 37.5% of the briefs.

The recommendations of the Rochon Report were put down in a reform plan entitled *Pour améliorer la santé et le bien-être au Québec: orientations*, [Improving Health and Well-being in Quebec: Orientations] published in 1989 by then Health Minister Lavoie-Roux. This document supports decentralization of services through the creation of regional boards, calling on partnerships with community organizations, an enhanced role for CLSCs, and introducing restrictions to the universality principle.

Topic 2: Women’s Health

In 1993, the Quebec government’s *Secrétariat à la condition féminine* drafted a new status of women policy, a document that is first and foremost descriptive in nature (p. 72). In fact, it is a brief summary based on a compilation of data that show that Quebec women continue to be subject to numerous social and economic constraints. The new policy proposes four main policy directions in keeping with what the document previously identified as problem areas: 1) economic self-sufficiency (diversified educational choices, easier access to the labour market, etc.), 2) respect for women’s physical and psychological dignity (medication use, sexual and reproductive health), 3) eradicating violence against women and 4) recognition and valorization of their collective contribution to society (female entrepreneurship).

The *Plan d'action 1997-2000: santé, bien-être et conditions de vie des femmes* [Action Plan 1997-2000: Women's Health, Well-being and Living Conditions] details the actions to which Quebec's *Ministère de la Santé et des Services sociaux*—MSSS [department of health and social services] commits over these three years, and are organized into three main themes: the struggle against poverty and social inequalities (social economy, food security and recourse to perinatal services), health and well-being (network transformation, midwife services, smoking, adolescent girls' health, well-being and living conditions, other issues), and the struggle against violence. The other health and well-being issues include women's mental health and psychological distress, breast cancer, cervical cancer, family planning, assisted procreation, and HIV/AIDS. The above represent all of the major and crucial issues affecting women's health.

For example, with respect to the transformation of the

network, the document indicates that even if there is consensus to transform and adapt the system, make it more effective and in particular a closer reflection of people's needs and their living environment, this reorganization raises many questions and concerns within the population. In a restrictive budget environment that affects all government functions at the very time this transformation is taking place, Quebec women wonder about the ramifications of the move toward ambulatory care. They fear they will have to bear the burden as workers, users or people

living in close proximity with someone ill (pp. 39-40).

The third part of this plan is devoted to the role of women in regional development. It emphasizes in particular addressing women's interests and realities locally and regionally (p. 89). Despite significant enhancements to their living conditions, Quebec women still have social, economic and cultural experiences that are different from those of men. In fact, on average they live longer than men, but with more disabilities; they are more often part of the disadvantaged class; they have less favourable working conditions; they continue to assume, despite their increased professional obligations, the larger share of family responsibilities and care. Local and regional structures are in the best position to determine, with women's groups, the interests and realities of women in each

This document supports decentralization of services through the creation of regional boards, calling on partnerships with community organizations...

of the Quebec regions, and to come up with appropriate solutions for that population.

The following references may be helpful in getting an accurate

picture of the global issues of women and health:

Colloque régional sur la santé des femmes. (1996). *Virage ambulatoire "Santé-vous concernées!"*, Proceedings of the regional women's health conference in Lévis on October 4, 1996. [on the ambulatory shift]

Bélanger, H, Charbonneau, L. (1994). *La santé des femmes*. Maloine, Fédération des médecins omnipraticiens du Québec [Quebec federation of general practitioners], Édisem inc, 1142 p. [on women's health]

Guyon, L. (1990). *Quand les femmes parlent de leur santé*, Québec: Les Publications du Québec, 185 p. [women on women's health]

Guyon, L. (1996). *Derrière les apparences—Santé et conditions de vie des femmes*, Québec: Les Publications du Québec, 384 p. [women's health and living conditions]

Topic 3: Rural Women's Health

The health profile of women living in rural areas is often less positive than that of women living in the interior regions or near the larger urban centres. When we talk of rural women, we are not talking about a single group; rather this includes girls, elderly women, single-parent mothers, informal caregivers, women's groups, farm women, female entrepreneurs, immigrant women, Aboriginal women, etc. First, information on the reality of **Aboriginal** women in remote regions is glaringly deficient. It is therefore important to have a better understanding of the economic and social needs of Aboriginal women in rural areas, residents of the various Aboriginal communities or living off the reserve. There is also very little documentation on the situation of **immigrant women**, who require a mental health approach that is considerate of cultural references and the context of their particular ethnic background.

The case of **girls, elderly women** and **single-parent mothers** is often mentioned in terms of statistics related to pregnancy and education, isolation and poverty, daycare shortages, and unemployment. First, rural teen pregnancy rates are often higher than in the urban centres. Female students, much more than the males, are concentrated in a few areas of education. These options lead to traditionally female jobs that sometimes have little to do with regional strategic

directions, which exposes them to unemployment or prompts them to migrate out of the region. Second, the rural elderly, especially women, find it particularly hard to get around. The absence of public transportation, and the fact that fewer women have a vehicle or even a driver's licence for cultural and economic reasons, make day-to-day mobility more onerous. There are more women in the 75 and over age group; they tend to live alone and in poverty; and are in poorer health. Third, women are more often the heads of single-parent families, and in most of the regions there is a shortage of daycare spaces. The daycare services in place must reflect the demand from various areas of the territory, and ensure that these services meet the needs related to the different work and study schedules of teenage mothers, single-parent mothers, and farm women.

In the context of the shift to ambulatory care, it becomes important to raise the issue of the role of **informal caregivers**—women who too often have to offset the devolving of government responsibility by assuming care for an ailing spouse or relative. Not only has the shift to ambulatory care increased the burden of responsibilities for women, but the transformation of mental health services has affected access to the services of which they are frequent users. In regional areas where the population is sometimes isolated, it is important to identify professional acts, which must not be entrusted to informal caregivers, and respect the extent to which people are able to take over public services. For informal caregivers, there are significant upheavals brought on by caring for someone else. Often, this changes the relationships in a couple or family. In some situations involving obvious overload and burn-out, these women have a negative perception about their health. Woman caregivers who

live with their care recipients have a less favourable perception of their own health, are more likely to use tranquilizers, and suffer more constraints on their social lives than those who are not caregivers.

Caregivers have an increased burden of tasks that requires reorganizing of schedules, changes in employment or the forced withdrawal from the labour market; strains on marital and family life; less vacation time and respite, stress and burnout, etc.

At the end of the 1980s, the directory of **women's groups**, put out by the Quebec *Conseil du statut de la femme*, identified 815 women's organizations in Quebec, not counting the 870 local *Cercles de fermières du Québec* and the 600 circles of the *Association féminine d'éducation et d'action sociale (AFEAS)*. In the Saguenay-Lac-St-Jean region alone, there are 150 organizations with ties of varying degrees to the women's movement. We know that these women's groups are very involved on a regional level, particularly with respect to occupational health, violence against women, perinatal services, and training that leads to enhanced recognition and status. Violence against women continues to be a priority that seeks fostering of a broader understanding and more effec-

tive action with respect to women's health and in the struggle against this violence.

Twice as many women as men are underweight; they are dealing with more than one health problem; more have consulted a health care professional; they take more medication and are affected more by affective and anxiety disorders and depression than men. The main issues of rural violence against women include a lack of accessible services (shelters, transition houses, etc) and anonymity.

Farm work has its own class of health disorders and problems. Maintaining quality of life in this environment is closely linked to health promotion. First, in exchange for these investments (long work hours, multitasking, etc.), **farm women** receive little financial compensation and few have property rights. Many women can identify what they want: better working conditions, increased financial security and self-sufficiency, the possibility of making choices and having an impact on the future of farming, and training.

In Quebec, women's work is especially linked to work in the fields, animal care, milking the cows, and livestock



management. Duties related to secretarial and management work should also be included. The scope of these activities demonstrates women's high level of involvement in the farm business, as do the many hours put in working on the farm. In Canada, a 40-hour work week is considered to be full-time employment. But in farming, the work week is much longer: the average for women is 73 1/2 hours: 43 1/2 hours of household duties plus 30 hours of farm work. What is more, many farm women have off-farm employment to make ends meet.

As a general rule, farm women lack recognition: they become farm women by getting married and the husband remains the landowner. Some matrimonial regimes, particularly separation as to property, lead to an unfair distribution of property.

However, in 1982, 42% of couples chose the separation as to property regime. For farm women, the situation is even more abysmal, since 56.8% of the respondents ages 20 to 24 in 1981 were married under the separation as to property regime.

Like their husbands, farm women sometimes experience adverse health effects further to the use of insecticides and various chemical products: birth defects, miscarriages, stillborn or premature babies, irregular menstrual period, other production types are rapidly absorbed and carried by the bloodstream and sometimes attack the nervous system, allergies, respiratory problems (particularly "farmer's lung" caused by inhaling mouldy spores released when handling hay or wet grain), back pain and hearing loss (due to operating farm equipment).



Bibliography²⁴

- Bélanger, H, Charbonneau, L. (1994). *La santé des femmes*. Maloine, Fédération des médecins omnipraticiens du Québec, Édisem inc, 1142 p.
- Black, N. and Cuthbert Brandt, G. (1999). *Feminist Politics on the Farm: Rural Catholic Women in Southern Quebec and Southwestern France*. Montreal and Kingston: McGill-Queen's University Press.
- Boivin, M. (1987). Les agricultrices: Un travail à reconnaître sur les plans juridique et économique. In: *Growing Strong: Canadian Women in Agriculture*. Document prepared for the Canadian Advisory Council on the Status of Women, Ottawa, 54-71.
- Bouchard, N., Gilbert, C. and Tremblay, M. (1996). Les solidarités fragiles: Les femmes et la prise en charge de personnes en perte d'autonomie. Under the direction of Camil Ménard and Florent Villeneuve. *Projet de société et lectures chrétiennes*. Proceedings of the 1996 Conference of the Société canadienne de théologie. Quebec: Éditions Fides, 171-186.
- Bouchard, N., Gilbert, C. and Tremblay, M. (1999). Des femmes et de soins. L'expérience des aidantes naturelles au Saguenay. *Recherches féministes*, 12(1): 63-81.
- Bureau de la répondante à la condition féminine (1985) *Plan d'action triennal*. Quebec: Ministère de l'agriculture, des pêcheries et de l'alimentation.
- Busque, G. (1987). Les besoins et les ressources des femmes dans l'agriculture. In: *Growing Strong: Canadian Women in Agriculture*. Document prepared for the Canadian Advisory Council on the Status of Women, Ottawa.
- Colloque régional sur la santé des femmes. (1996). *Virage ambulatoire "Santé-vous concernées!"*, Proceedings of the conference held on October 4, 1996 in Levis.
- Cohen, Y. (1982). Des paysannes aux fermières : L'association des cercles des fermières canadiennes françaises. *Penelope*, 7 (Fall): 87-93.
- Conseil du statut de la femme (1999). Les conditions de vie des femmes et le développement local et régional en Abitibi-Témiscamingue, Collection "Femmes et développement des regions", July 1999.
- Conseil du statut de la femme (2000). Les conditions de vie des femmes et le développement local et régional dans l'Outaouais, Collection "Femmes et développement des regions", January 2000.
- Conseil du statut de la femme (2000). Les conditions de vie des femmes et le développement local et régional en Gaspésie, Îles-de-la-Madeleine, Collection "Femmes et développement des regions", March 2000.
- Conseil du statut de la femme (2000). Les conditions de vie des femmes et le développement local et régional en Chaudière-Appalaches, Collection "Femmes et développement des regions", December 2000.
- Conseil du statut de la femme (2001). Les conditions de vie des femmes et le développement local et régional dans Lanaudière, Collection "Femmes et développement des regions", June 2001.
- Conseil du statut de la femme (2002). Les conditions de vie des femmes et le développement local et régional dans le Bas-Saint-Laurent, Collection "Femmes et développement des regions", January 2002.
- Côté, J., Desmartis, M., Caron, M. and Ouellet, L. (1993). *Le point de vue des leaders d'opinion sur la maladie mentale et la réinsertion sociale en milieu rural*. Beauport: Centre de recherche Université Laval Robert-Giffard. Report prepared for the Ministère de la Santé et des Services Sociaux.

- Couillard, M.-A. and Côté, G. (1997). *Les groupes de femmes de la région de Québec et l'implantation de la régie régionale de la santé et des services sociaux*. Research report presented to the CQRS. Sainte-Foy: Université Laval, centre de recherche sur les services communautaires.
- Cuthbert Brandt, G. (1991). Les origines et le développement des cercles de fermières au Québec et des groupements féminins en Gironde. Under the direction of Black, N., Cuthbert Brandt, G., Rouyer, M.-C. and Guillaume, P. *Femmes et vie rurale au Québec et en Aquitaine*, Centre d'études canadiennes.
- De Koninck, M. (1994). Femmes et santé: La pertinence de recherches féministes. Dans : Marie France Labrecque (Dir.) *L'égalité devant soi : Sexes, rapports sociaux et développement international*. Ottawa: International Development Research Centre, 126-142.
- Dion, S. (1991). Les agricultrices québécoises depuis 1981. Under the direction of Black, N., Cuthbert Brandt, G., Rouyer, M.-C. and Guillaume, P. *Femmes et vie rurale au Québec et en Aquitaine*, Centre d'études canadiennes.
- Éthier, I., Guy, L., Martel Parisé, J. Simard, A. and Therrien, S. (1992). *L'agricultrice, une partenaire professionnelle*. Quebec: Direction des services aux agricultrices.
- Fontaine, S., Laplante, É. and Rinfret, M. (1988). *La question de l'avortement au Québec*. Document adopted by the Conseil du statut de la femme.
- Fortin, C, Leclerc, M. (1998). *Plan d'action 1997-2000: santé, bien-être et conditions de vie des femmes*. Quebec: Ministère de la santé et des services sociaux.
- Guyon, L. (1990). *Quand les femmes parlent de leur santé*, Quebec: Les Publications du Québec, 185 p.
- Guyon, L. (1996). *Derrière les apparences—Santé et conditions de vie des femmes*, Quebec: Les Publications du Québec, 384 p.
- Masson, D. (1994). S'organiser pour s'autodévelopper: Organisations de femmes et développement au Saguenay—Lac-St-Jean. Dans : Marie France Labrecque (Dir.) *L'égalité devant soi: Sexes, rapports sociaux et développement international*. Ottawa: International Development Research Centre, 64-85.
- Tremblay, M., Bouchard, N. and Gilbert, C. (1997-1998). *Les aidantes naturelles et la prise en charge de personnes en perte d'autonomie: santé des femmes et défi des solidarités familiales et sociales*. Montreal: Centre of Excellence for Women's Health—Université de Montréal Consortium.



Endnotes

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- 1 French terms used in initial search: femme, fille, santé, rural, campagne, isolé, milieu rural, ruralité.
 - 2 French terms used in subsequent search: agriculture, agricole, mine, ferme, forêt, pêche.
 - 3 [Translator's note]: The topic titles listed here are based on the actual topic headings used later in the document (see pages 25-29 herein). There is some discrepancy in the wording of the original French.
 - 4 [Translator's note]: Available in French only. Suggested English: Living conditions of women and local and regional development in the Outaouais region of Quebec. Women and regional development collection.
 - 5 [Translator's note]: Available in French only. Suggested English: Living conditions of women and local and regional development in the Abitibi-Témiscamingue region of Quebec. Women and regional development collection.
 - 6 [Translator's note]: Available in French only. Suggested English: Living conditions of women and local and regional development in the Chaudière-Appalaches region of Quebec. Women and regional development collection.
 - 7 [Translator's note]: Available in French only. Suggested English: Living conditions of women and local and regional development in the Bas-Saint-Laurent region of Quebec. Women and regional development collection.
 - 8 [Translator's note]: Available in French only. Suggested English: Living conditions of women and local and regional development in the Gaspésie and Îles-de-la-Madeleine region of Quebec. Women and regional development collection.
 - 9 [Translator's note]: Available in French only. Suggested English: Living conditions of women and local and regional development in the Lanaudière region of Quebec. Women and regional development collection.
 - 10 [Translator's note]: Available in French only. Suggested English: Viewpoints of opinion leaders on mental illness and social reintegration in rural areas.
 - 11 [Translator's note]: Available in French only. Suggested English: Women and care. The experience of women informal caregivers in the Saguenay region.
 - 12 [Translator's note]: Available in French only. Suggested English: Women who care for semi-autonomous persons: women's health and the challenge of family and social solidarity.
 - 13 [Translator's note]: Available in French only. Suggested English: Fragile solidarities: Women who care for semi-autonomous persons. [...] Society project and Christian readings.
 - 14 [Translator's note]: Available in French only. Suggested English: The abortion issue in Quebec.
 - 15 [Translator's note]: Article available in French only. Suggested English: Farm women's needs and resources.
 - 16 [Translator's note]: Article available in French only. Suggested English: Getting ready to grow: Women's organizations and development in the Saguenay-Lac-St-Jean region. [...] The path to equality: issues relating to gender, social relations and international development.

- 17 [Translator's note]: Article available in French only. Suggested English: Quebec farm women since 1981.[...] Women and rural life in Quebec and the Aquitaine region.
- 18 [Translator's note]: Article available in French only. Suggested English: Origins and development of farm women's circles in Quebec and women's groups in Gironde [...].
- 19 [Translator's note]: Article available in French only. Suggested English: Farm women: work deserving of legal and economic recognition.
- 20 [Translator's note]: Article available in French only. Suggested English: Women's groups in the Quebec region and the establishment of the regional health and social services board.
- 21 CQRS = Conseil québécois de la recherche sociale [Quebec council of social research]
- 22 [Translator's note]: Article available in French only. Suggested English: Farm women: professional partners. Quebec farm women services branch.
- 23 [Translator's note]: Article available in French only. Suggested English: Three-year action plan.
- 24 [Translator's note]: Most of these titles exist only in French. Suggested renderings in English have been made in footnotes throughout the body of this document.



Rural, Remote and Northern Women's Health:
Policy and Research Directions

A Literature Review and Thematic Bibliography

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February 2003

Project #3 of the National Rural and Remote
Women's Health Study

Table of Contents

Index of Themes	E3
Background	E5
Scope of the Review	E6
Introduction to the Literature on Canadian Rural Women’s Health	E6
Thematic Summary of the Literature	E7
Analysis of the Literature	E40
Scope and Sufficiency of the Literature	E40
Accessibility of the Literature	E42
Methodology	E43
Key Messages	E45
Tensions within the Literature	E47
Gaps in Current Research	E49
Research and Policy Directions	E50
Conclusion	E50
Appendix E1 – Literature Review Search Strategy	E51
Appendix E2 – Relevant Reports Published by the Centres of Excellence for Women’s Health	E54

Index of Themes

Aboriginal Women and Cancer	E7
Aboriginal Women and Culture	E8
Aboriginal Women and Diabetes	E9
Aboriginal Women and Health Status	E9
Aboriginal Women and Mental Health and Healing	E9
Aboriginal Women and Nutrition	E10
Aboriginal Women and Sexual Abuse and Violence	E11
Aboriginal Women and Sexually Transmitted Diseases and/or HIV/AIDS	E12
Abortion	E12
Abuse and Violence	E13
Cancer	E14
Caregiving	E16
Elderly Women	E17
Farm Women	E18
Fisheries	E19
Health Care Professionals	E20
Health Reform	E21
Health Status	E22
HIV/AIDS	E23
Housing	E23
Information (Access to Health Information)	E23

Lesbian Health	E24
Mental Health	E24
Midlife Women's Health	E26
Obesity and Body Image	E27
Occupational Health and Safety	E27
Place	E28
Poverty and Economics	E29
Pregnancy, Obstetrics, Childbirth and Breastfeeding	E30
Rural-Urban Comparative Analysis	E32
Substance Abuse	E33
Well-being	E34
Work	E34
Rural Health (Women Implicit)	E36
Rural Women (Health Implicit)	E38
Women's Health (Rural Implicit)	E38
Women's Health (Rural Participants)	E39



Authors' Note: This document expands on two previous ones, an October 2002 English-language literature review compiled by P. Wakewich and B. Parker entitled *Rural and Remote Women's Health in Canada: A Literature Review and Research Inventory*³ and a French-language literature review by C. Dallaire, *Femme, Santé et Milieu Rural au Canada: Bibliographie commentée des écrits de langue française*⁴ (August 2002).



A Literature Review and Thematic Bibliography

Background

The Centres of Excellence for Women's Health (CEWH) are collaborating with the Women's Health Bureau of Health Canada to develop a Policy Framework and Research Agenda on Rural and Remote Women's Health, in order to complement and inform research directions for the Women's Health Contribution Program, the Centres of Excellence and their cross-centre initiatives, as well as research granting agencies such as the CIHR⁵. This literature review is the first of four phases of that project⁶. Regional focus groups have also been conducted in order allow key researchers, service providers and other women in rural and remote communities to highlight issues from their direct experience.

The literature review and focus group report will form the basis of a workshop manual to be used at a National Consultation scheduled for March 17-19 in Saskatoon, Saskatchewan, out of which will come the Policy Framework and Research Agenda. [held, March 2003]

This document begins with an explanation of the scope of the review, and a selected list of useful Canadian references on rural women's health. This is followed by a thematic summary of all of the literature located for this review and an analysis of that literature. The analysis takes into consideration the scope and sufficiency of the research, its accessibility, its choice of questions and its methodology. Gaps in the

current body of research are highlighted. Key messages relating to the effects of

rurality on women's health and research and policy directions are then summarized.

Scope of the Review

This document contains a *review of recent Canadian literature relating to the health of women in rural, remote and Northern areas.*⁷

The review is therefore limited to literature that discusses all three of the core interests, “health”, “women” and “rural”. Some exceptions have been made as follows:

- where two of the three core interests are thoroughly addressed and the third is implicit in the material. For example, within the theme entitled “Women’s Health (Rural Implicit)”, issues that have a clear rural relevance are addressed, such as access to women’s shelters or the insecurity of women’s work, despite rurality not being discussed explicitly;
- where rurality is not explicitly analyzed but the research has deliberately included rural participants, or has been conducted in an area that serves a predominantly rural population, such as Prince George, British Columbia or St. John’s, Newfoundland;
- where Aboriginal women’s health is addressed, without being explicit about whether those Aboriginal women are living in a rural context or not.

Despite being limited by the three core interests, those three terms were defined as broadly as was reasonably possible in the search strategies employed. (See Appendix E1 for full details of how the literature searches were conducted). For example, “health” is understood in terms of all of its social and biological determinants, so keywords such as ‘housing’, ‘well-being’ and ‘literacy’ were also searched. Similarly, “women” included searches of terms such as ‘gender’, ‘adolescent’ and ‘mother.’ “Rural” included such terms as ‘farm’, ‘northern’, ‘remote’ and ‘countryside’.⁸

This review reflects and values the existence of knowledge in many sectors by encompassing peer-reviewed academic publications in biomedical and social sciences, government documents, working papers, community-based research, conference presentations and any other relevant materials available. It therefore attempts to provide a balance often missing when only peer-reviewed materials are considered.

Although this document has been written in English, literature in both French and English has been incorporated in the review.⁹

Introduction to the Literature on Canadian Rural Women’s Health

Prior to beginning a thematic review of the full body of relevant literature, this section provides a suggested reading list of sources that offer a particularly useful and/or thorough treatment of general issues relating to rural women’s health in Canada. Although

not quite a “Top Ten List”, these articles provide a helpful introduction to the field for those looking for an overview of key issues. More specifically, they describe the determinants of health most relevant to women living in rural, remote and Northern environments.

- Dion Stout, M., Kipling, G., and Stout, R. (2001, May). *Aboriginal Women's Health Research: Synthesis Report*, Centres of Excellence for Women's Health. ISBN 0-9689285-0-1.
- Gucciardi, E., and Biernie-Lefcovithc, A. (2002). Rural and Northern Women. In D. E. Stewart, A. M. Cheung, L. E. Ferris, I. Hyman, M. M. Cohen and J. I. Williams (Eds.), *Ontario Women's Health Status Report*, (Tech. Rep. No. ISBN 0-7794-3614-8, pp. 374-386).
- Hutten-Czapski, P. (2002, June). The State of Rural Health Care. *Canadian Journal of Rural Medicine*, presentation to the Standing Senate Committee on Social Affairs, Science and Technology, May 31, 2002.
- Jennissen, T. (1992). *Health Issues in Rural Canada*, (Canadian Library of Parliament. Research Branch), Ottawa: Library of Parliament, Research Branch.
- Leipert, B., and Reutter, L. (1998, Nov-Dec). Women's Health and Community Health Nursing Practice in Geographically Isolated Settings: A Canadian Perspective. *Health Care for Women International*, 19(6), pp. 575-588.
- Northern Secretariat of the B.C. Centre of Excellence for Women's Health. *The Determinants of Women's Health in Northern Rural and Remote Regions: Examples and Recommendations from Northern B.C.* B.C. Centre of Excellence for Women's Health, University of Northern British Columbia, Prince George.
- Prairie Women's Health Centre of Excellence. (2001). *Action Plan for Women's Health in Manitoba and Saskatchewan: Key Priorities and Strategies*.
- Reutter, L., Neufeld, A., and Harrison, M. (2000, June). A Review of the Research on the Health of Low-Income Canadian Women, *Canadian Journal of Nursing Research*, 32(1), pp. 75-97.
- Rosenberg, M., W., and Wilson, K. (2000, July). Gender, Poverty and Location: How Much Difference do They Make in the Geography of Health Inequalities? *Social Science & Medicine*, 51(2), 275-287.

Thematic Summary of the Literature

In this section, the Canadian literature on rural women's health is clustered into thematic groupings, organized alphabetically by topic. Analysis of the overall adequacy of the literature, the approaches to research reflected within it and its key messages are provided on page E40 in the section "Analysis of the Literature".

Aboriginal Women and Cancer

- Clarke, H., Joseph, R., Deschamps, M., Hislop, T., Band, P., and Atleo, R. (1998, March). Reducing Cervical Cancer among First Nations Women, *Canadian Nurse*, 94(3), pp. 36-41.
- Deschamps, M., Band, P., Hislop, T., Clarke, H., Smith, J., Ng, V., and Math, M. (1992). Barriers to Cervical Cytology Screening in Native Women in British Columbia. *Cancer Detection and Prevention*, 16(5,6), pp. 337-339.
- Healey S.M., Aronson K.J., Mao Y., Schlect N.F., Mery L.S., Ferenczy A., and Franco E.L. (2001, December). Oncogenic Human Papillomavirus Infection and Cervical Lesions in Aboriginal Women of Nunavut, Canada, *Sexually Transmitted Diseases*, 28(12), pp. 694-700.

- Hislop, T., Deschamps, M., Band, P., Smith, J., and Clarke, H. (1992, September-October). Participation of BC Cervical Cytology Screening Program by Native Indian Women, *Canadian Journal of Public Health*, 83(5), pp. 344-345.
- Roos, L., Traverse, D., and Turner, D. (1999, June). Delivering Prevention: The role of public programs in delivering care to high risk populations, *Medical Care*, 37(6 - Supplement).
- Woods, S. (2001, October 18-21). *Cervical Cancer Screening in Northern Saskatchewan First Nations*, presented at the Health Research in Rural and Remote Canada: Taking the Next Steps Conference, Saskatoon, Saskatchewan.
- Young, K. T., Kliwer, E., Blanchard, J., and Mayer, T. (2000). Monitoring Disease Burden and Preventative Behaviour with Data Linkage: Cervical Cancer among Aboriginal People in Manitoba, Canada, *American Journal of Public Health*, 90(9), pp. 1466-1468.

Aboriginal Women and Culture

- Adelson, N. (1998). Health Beliefs and the Politics of Cree Well-Being, *Health*, 2(1), pp. 5-22.
- Austin, W. R., Gallop, E., McCay, T., Peternelj, C., and Bayer, M. (1999, February). Culturally Competent Care for Psychiatry Clients Who Have a History of Sexual Abuse, including commentary by Baume P., *Clinical Nursing Research*, 8(1), pp. 5-25.
- Barker-Collo, S. L. (1999). Reported Symptomology of Native Canadian and Caucasian Females Sexually Abused in Childhood, *Journal of Interpersonal Violence*, 14(7), pp. 747-760.
- Benoit, C., and Carroll, D. (2001, Spring). Aboriginal Midwifery in Canada: Blending Ancient Traditions and Emerging Forms, *Network Magazine*, 4(3).
- Browne, A., and Fiske, J. (2001). First Nations Women's Encounters with Mainstream Health Care Services, *Western Journal of Nursing Research*, 23(2), pp. 126-147.
- Browne, A., and Smye, V. (2002). A Post-colonial Analysis of Health Care: Discourses Addressing Aboriginal Women, *Nurse Research*, 9(3), pp. 28-41.
- Browne, A. (1998). *Improving Health Care Services for First Nations Women: A Community Case Study*, WCC98-2, funded by the British Columbia Centre of Excellence for Women's Health.
- Browne, A., Fiske, J., and Thomas, G. (1997). *Northern First Nations Women's Interactions with the Mainstream Health System*, WCC97-3, British Columbia Centre of Excellence for Women's Health.
- Deiter, C., and Otway, L. (2001). *Sharing Our Stories on Promoting Health and Community Healing: An Aboriginal Women's Health Project*, Prairie Women's Health Centre of Excellence.
- Herbert, E., and McCannell, K. (1997, Fall). Talking Back: Six First Nations Women's Stories of Recovery from Childhood Sexual Abuse and Addictions, *Canadian Journal of Community Mental Health*, 16(2), pp. 51-68.
- Pauktuutit Inuit Women's Association of Canada. (2001/2002, Fall/Winter). Inuit Women's Health: A Call for Commitment, *The Network Magazine*, 4/5(4/1).
- Pauktuutit Inuit Women's Association. *A Community Perspective on Health Promotion and Substance Abuse*, (Pauktuutit Inuit Women's Association).
- Pauktuutit Inuit Women's Association. *Community Programs for Healthy Inuit Babies: Guidelines*, (Pauktuutit Inuit Women's Association).
- Restoule, B., Marilyn. (2000, May). Healing in Ojibwa First Nation Communities: Investigating the Relationship among Acculturation, Health and Identity, *Dissertation Abstracts International: Section B: The Sciences & Engineering*, 60(10-B), 5251.

Wawanoloath, C. S. (2001, Winter). The Four Insights from Mali Pili Kizos, *Healing Words*, 3(2), pp. 14-22.

Aboriginal Women and Diabetes

- Daniel, M., and Gamble, D. (1995). Diabetes and Canada's Aboriginal Peoples: The Need for Primary Prevention, *International Journal of Nursing Studies*, 32(3), pp. 243-259.
- Harris, S. B., Caulfield, L. E., Sugamori, M. E., Whalen, E. A., and Henning, B. (1997). The Epidemiology of Diabetes in Pregnant Native Canadians, *Diabetes Care*, 20(9), 1422-1425.
- Hegele, R., Cao, H., Harris, S., Zinman, B., Hanley, A., and Anderson, C. (2000). Gender, Obesity, Hepatic Nuclear Factor-1alpha G319S and the Age of Onset of Type 2 Diabetes in Canadian Oji-Cree, *International Journal of Obesity Related Metabolic Disorder*, 24(8), pp. 1062-1064.
- Hegele, R., Cao, H., Harris, S., Zinman, B., Hanley, A., and Anderson, C. (2000), Peroxisome Proliferator-Activated Receptor- γ 2P12A and Type 2 Diabetes in Canadian Oji-Cree, *The Journal of Clinical Endocrinology & Metabolism*, 85(2), pp. 2014-2019.
- Wein, E., Basualdo, T., Johnson, P., and Basu, T. (1996, Winter). Nutrient Intakes of a Sample of First Nations Adults with and without Diabetes Mellitus in Central Alberta, *Journal of the Canadian Diabetic Association*, 57(4), pp. 153-161.

Aboriginal Women and Health Status

- Armstrong, R. P. (2001). *The Geographical Patterns of Socio-economic Well-Being of First Nations Communities*, Agriculture and Rural Working paper Series, Ottawa: Statistics Canada.
- Government of Canada. (2002). The Health of Aboriginal Women. In Women's Health Bureau. Available: www.hc-sc.gc.ca
- McBride, C., and Bobet, E. (1990). *Health of Indian Women*, Ottawa: Indian and Northern Affairs Canada, p. 32.
- Muckle, G., Ayotte, P., Dewailly, E., Jacogson, S. W., and Jacobson, J. L. (2001). Prenatal Exposure of Northern Quebec Inuit Infants to Environmental Contaminants. *Environmental Health Perspectives—New Series*, 109(12), pp. 1291-1301.

Aboriginal Women and Mental Health and Healing

- Fillmore, C., Dell, C., Anne, and the Elizabeth Fry Society of Manitoba. (2000). *Prairie Women, Violence and Self-Harm*, Prairie Women's Health Centre of Excellence.
- Herbert, E., and McCannell, K. (1997, Fall). Talking Back: Six First Nations Women's Stories of Recovery from Childhood Sexual Abuse and Addictions, *Canadian Journal of Community Mental Health*, 16(2), pp. 51-68.
- Kirmayer, L., Brass, G., and Tait, C. (2000). The Mental Health of Aboriginal Peoples: Transformation of Identity and Community, *Canadian Journal of Psychiatry*, 45(7), pp. 607-616.
- Kirmayer, L. J., Boothroyd, L. J., Tanner, A., Adelson, N., and Robinson, E. (2000, March 1). Psychological Distress Among the Cree of James Bay, *Transcultural Psychiatry*, 37(1).

- Leenars, A. A. (2000, Fall). Suicide Prevention in Canada: A History of a Community Approach, *Canadian Journal of Community Mental Health—Special Issue*, 19(2), pp. 57-73.
- Maclean, L. M. (1991). *The Experience of Depression for Chipewyan and Euro-canadian Northern Women (Canada)*, unpublished doctoral dissertation, University of Saskatchewan, Saskatoon p. 395.
- Mill, J. (1997, August). HIV Risk Behaviors Become Survival Techniques for Aboriginal Women, *Western Journal of Nursing Research*, 19(4), pp. 466-489.
- Paproski, D. (1997, Fall). Healing Experiences of British Columbia First Nations Women, *Canadian Journal of Community Mental Health*, 16(2), pp. 69-89.
- Quebec Native Women Report. (1993). *Assessment of Violence and Mental Health Conditions Among Native Women in Quebec*, Quebec Native Women.
- Restoule, B., Marilyn. (2000, May). Healing in Ojibwa First Nation Communities: Investigating the Relationship among Acculturation, Health and Identity, *Dissertation Abstracts International: Section B: The Sciences & Engineering*, 60(10-B), 5251.
- Wawanoloath, C. S. (2001, Winter). The Four Insights from Mali Pili Kizos, *Healing Words*, 3(2), pp. 14-22.
- Willms, D., Lange, P., Bayfield, D., Beardy, M., Lindsay, E., Cole, D., and Johnson, N. (1992, September to October). A Lament by Women for the People, the Land [Nishnawbi-Aski Nation]: An Experience of Loss, *Canadian Journal of Public Health*, 83(5), pp. 331-334.

Aboriginal Women and Nutrition

- Cuniffe, D. P. (2000). *Eating Disorders in Northwestern Ontario*, Family Medicine North Residency Program, Health Sciences North, McMaster University, Thunder Bay, Ontario.
- Farkas, C. (1986, June). Ethno-specific Communication Patterns: Implications for Nutrition, *Journal of Nutrition Education*, 18(3), pp. 99-103.
- Johnston J., and Schneider, L. (1998, Fall). Effects of a One-month Nutrition and Exercise Program in Blackfoot Women Elders, *Journal of the Canadian Dietetic Association*, 49(4), pp. 249-253.



- Kuhnlein, H., Soueida, R., and Receuver, O. (1995, Winter). Baffin Inuit Food Use by Age, Gender and Season, *Journal of the Canadian Dietetic Association*, 56(4), pp. 175-183.
- Kuhnlein, H., Soueida, R., and Receuver, O. (1996, February). Dietary Nutrient Profiles of Canadian Baffin Island Inuit Differ by Food Source, Season and Age, *Journal of the Canadian Dietetic Association*, 96(2), pp. 155-162.
- Lawn, J., and Harvey, D. (2001). *Change in Nutrition and Food Security in Two Inuit Communities, 1992-97*, Ottawa: Indian and Northern Affairs Canada, p. 124.
- Sevenhuysen, G., and Bogert-O'Brien, L. (1987, Spring). Nutrient Intake of Women and School Children in Northern Manitoba Native Communities. *Journal of the Canadian Dietetic Association*, 48(2), pp. 89-93.
- Verrall, Tanya. (2001, 18-21 October). *Understanding and Preventing Iron Deficiency Anemia in Cree Infants*, presented at the Health Research in Rural and Remote Canada: Taking the Next Steps, Saskatoon, Saskatchewan.
- Wein, E. (1986, Winter). Nutrition of Northern Native Canadians, *Canadian Home Economics Journal*, 36(1), pp. 25-25.
- Wein, E., Basualdo, T., Johnson, P., and Basu, T. (1996, Winter). Nutrient Intakes of a Sample of First Nations Adults With and Without Diabetes Mellitus in Central Alberta. *Journal of the Canadian Diabetic Association*, 57(4), pp. 153-161.

Aboriginal Women and Sexual Abuse and Violence

- Austin, W. R., Gallop, E., McCay, T., Peternelj, C., and Bayer, M. (1999, February). Culturally Competent Care for Psychiatry Clients Who Have a History of Sexual Abuse including commentary by Baume P., *Clinical Nursing Research*, 8(1), pp. 5-25.
- Barker-Collo, S., L. (1999). Reported Symptomology of Native Canadian and Caucasian Females Sexually Abused in Childhood, *Journal of Interpersonal Violence*, 14(7), pp. 747-760.
- Dion Stout, M., Kipling, G., and Stout, R. (2001, May). *Aboriginal Women's Health Research: Synthesis Report*, Centres of Excellence for Women's Health.
- Frank, S. (1996). *A Needs Assessment for an Aboriginal Women's Transition House*, available: www.hppb/family.ed_inventory/english/section_1.htm
- Graveline, M., J. (1986). *Northern Native Wife Abuse Prevention Demonstration Project*, (Canada. First Nations and Inuit Health Programs Directorate, Health Programs Support Division; Thompson Crisis Centre, p. 57), Thompson, MB: Thompson Crisis Centre.
- Green, K. (1996). *Family Violence in Aboriginal Communities: An Aboriginal Perspective*. Ottawa: National Clearinghouse on Family Violence.
- Herbert, E., and McCannell, K. (1997, Fall). Talking Back: Six First Nations Women's Stories of Recovery from Childhood Sexual Abuse and Addictions, *Canadian Journal of Community Mental Health*, 16(2), pp. 51-68.
- McGillivray, A. (1997). Intimate Violence, Aboriginal Women and Justice System Response: An Annotated Bibliography, available: www.hc-sc.gc.ca/hppb/family.ed_inventory/english/section_1.htm
- McKeown, I., Reid, S., Turner, S. and Orr, P. (2002). *Social Risk Factors Involved in the Acquisition of HIV Among Women in Manitoba*, Prairie Women's Health Centre of Excellence.
- Ontario Native Women's Association. (1989, December). *Breaking Free: A Proposal for Change to Aboriginal Family Violence*, Thunder Bay, Ontario.

- Prairie Women's Health Centre of Excellence. (2001). *Action Plan for Women's Health in Manitoba and Saskatchewan: Key Priorities and Strategies*.
- Quebec Native Women Report. (1993). *Assessment of Violence and Mental Health Conditions Among Native Women in Quebec*, Quebec Native Women.
- Quebec Native Women Report. (1995). *Beyond Violence*, Quebec Native Women.
- Strategic Design and Production. (1993). *Family Violence in First Nations Communities: A Study of Attitudes and Awareness of Family Violence Issues*, Health and Welfare Canada, Medical Services Branch, Indian and Northern Health Services, Addictions and Community Funded Programs, Ottawa, p. 66.
- Wawanoloath, C. S. (2001, Winter). The Four Insights from Mali Pili Kizos, *Healing Words*, 3(2), pp. 14-22.

Aboriginal Women and Sexually Transmitted Diseases and/or HIV/AIDS

- Cardwell, M. (1998, May 26). Drug Use a Threat to Canadian Natives, *Medical Post*, 34(20), pp. 32-33.
- Gilmore, A., and Ross, M. (1993). *HIV/AIDS and the Impact on Aboriginal Women in Canada*, Aboriginal Nurses Association of Canada.
- Healey S. M., Aronson K. J., Mao Y., Schlect N. F., Mery L. S., Ferenczy A., and Franco E. L. (2001, December). Oncogenic Human Papillomavirus Infection and Cervical Lesions in Aboriginal Women of Nunavut, Canada, *Sexually Transmitted Diseases*, 28(12), pp. 694-700.
- Hislop, T., Deschamps, M., Band, P., Smith, J., and Clarke, H. (1992, September-October). Participation of B.C. Cervical Cytology Screening Program by Native Indian Women, *Canadian Journal of Public Health*, 83(5), pp. 344-345.
- Hodgins, S., Peeling, R., Dery, S., Bernier, F., LaBrecque, A., Proulx, J., Joly, J., Alary, M., and Mabey, D. (2002, April). The Value of Mass Screening for Chlamydia Control in High Prevalence Communities, *Sexually Transmitted Diseases*, 78 (Supplement 1), pp. 64-68.
- McKeown, I., Reid, S., Turner, S. and Orr, P. (2002). *Social Risk Factors Involved in the Acquisition of HIV Among Women in Manitoba*, Prairie Women's Health Centre of Excellence.
- Mill, J. (1997, August). HIV Risk Behaviors Become Survival Techniques for Aboriginal Women, *Western Journal of Nursing Research*, 19(4), pp. 466-489.
- Mill, J. (2000, October). Describing an Explanatory Model of HIV Illness among Aboriginal Women. *Holistic Nursing Practice*, 15(1), pp. 42-56.

Abortion

- Eggertson, L. (2001, March 20). Abortion Services in Canada, *Canadian Medical Association Journal*, 164(6), pp. 847-849.
- Fontaine, S., Laplante, É. and Rinfret, M. (1988). *La Question de l'avortement au Québec*, (Document adopté par le Conseil du statut de la femme).

Abuse and Violence

- Austin, W. R., Gallop, E., McCay, T., Peternelj, C., and Bayer, M. (1999, February). Culturally Competent Care for Psychiatry Clients Who Have a History of Sexual Abuse, including commentary by Baume P., *Clinical Nursing Research*, 8(1), pp. 5-25.
- Barker-Collo, S. L. (1999). Reported Symptomology of Native Canadian and Caucasian Females Sexually Abused in Childhood, *Journal of Interpersonal Violence*, 14(7), pp. 747-760.
- Dempster, H. (1995). *The North Island Network to Resist and Heal from Violence* [www.hc-sc.gc.ca/hppb/family.ed_inventory/english/section_1.htm], Abstract Woman Abuse/Violence Against Women, Health Canada.
- Denham, D., and Gillespie, J. (1992). *Wife Abuse: A Workplace Issue*, Family Violence Program: Canadian Council on Social Development, Health Canada.
- Denham, D., and Gillespie, J. (1994). Work Place Learnings about Women Abuse: A Guide for Change II, Family Violence Prevention Division, Health Canada.
- deVink, S., and Doherty, D. (1995). *Family Violence on the Farm and in Rural Communities*. Available: www.hc-sc.gc.ca/hppb/family.ed_inventory/english/section_1.htm
- Dion Stout, M., Kipling, G., and Stout, R. (2001, May). *Aboriginal Women's Health Research: Synthesis Report*, Centres of Excellence for Women's Health.
- Forsdick Martz, D. J., and Sarauer, D. B. (2001). Policy From the Ground Up: Rural Services for Survivors of Woman Abuse, *Centres of Excellence for Women's Health Research Bulletin*, 2(1); Summer, pp. 14-16.
- Frank, S. (1996). *A Needs Assessment for an Aboriginal Women's Transition House*, available: www.hc-sc.gc.ca/hppb/family.ed_inventory/english/section_1.htm
- Galway, C. (1997). *Should We Ask Our Patients About Domestic Violence: A Patient Survey*, Family Medicine North Residency Program, Health Sciences North, McMaster University, Thunder Bay, Ontario.
- Graveline, M., J. (1986). *Northern Native Wife Abuse Prevention Demonstration Project*, Canada. First Nations and Inuit Health Programs Directorate, Health Programs Support Division; Thompson Crisis Centre, Thompson, MB: Thompson Crisis Centre, p. 57.
- Green, K. (1996). *Family Violence in Aboriginal Communities: An Aboriginal Perspective*, Ottawa: National Clearinghouse on Family Violence.
- Health and Welfare Canada. (1993). *Family Violence in First Nations Communities : A Study of Attitudes and Awareness of Family Violence Issues*, Medical Services Branch, Indian and Northern Health Services, Addictions and Community Funded Programs, Ottawa, p. 66.
- Herbert, E., and McCannell, K. (1997, Fall). Talking Back: Six First Nations Women's Stories of Recovery from Childhood Sexual Abuse and Addictions, *Canadian Journal of Community Mental Health*, 16(2), pp. 51-68.
- Hornosty, J. (1995). Wife Abuse in Rural Regions: Structural Problems in Leaving Abusive Relationships (a case study in Canada), available: www.hc-sc.gc.ca/hppb/family.ed_inventory/english/section_1.htm
- Janovicek, N. (2000). *Confronting Violence Against Women: Organizing Services in the Kootenay, B.C. and Northwestern Ontario, 1965-1985*, thesis.
- MacLeod, L. (1989). *Wife Battering and the Web of Hope: Progress, Dilemmas, and Visions of Prevention: A Discussion paper*, Ottawa: National Health and Welfare Canada, Family Violence Prevention Division, p. 516.
- MacLeod, L., and Kinnon, D. (2000). *Taking the Next Step to Stop Women Abuse: From Violence Prevention to Individual, Family, Community and Societal Health*, Health Canada.

- Martz, D., and Sarauer, D. (2000). *Domestic Violence and the Experiences of Rural Women in East Central Saskatchewan*, Prairie Centre of Excellence in Women's Health.
- McGillivray, A. (1997). *Intimate Violence, Aboriginal Women and Justice System Response: An Annotated Bibliography*, available: www.hc-sc.gc.ca/hppb/family.ed_inventory/english/section_1.htm (accessed 25072001).
- Merriam, B. (1993, Summer). News from the Family Violence Prevention Division, Health and Welfare Canada: Abused Women in Rural and Remote Communities, *Vis-A-Vis*, 11(1), pp. 2-3.
- Merritt-Gray, M., and Wuest, J. (1995). Counteracting Abuse and Breaking Free: The Process of Leaving Revealed through Women's Voices, *Health Care for Women International*, [Online] 16, available: www.hc-sc.gc.ca/hppb/family.ed_inventory/english/section_1.htm
- National Clearinghouse on Family Violence. Woman Abuse/Violence Against Women www.hc-sc.gc.ca/hppb/family.ed_inventory/english/section_1.html *Annotated Bibliography*, (Vol. Health Canada), Health Canada.
- Olimb, D., Brownlee, K., and Tranter, D. *Adolescent Dating Violence in the Rural Context*, Lakehead University, School of Social Work.
- Ontario Native Women's Association. (1989, December). *Breaking Free: A Proposal for Change to Aboriginal Family Violence*, Thunder Bay, Ontario.
- Prairie Women's Health Centre of Excellence. (2001). *Action Plan for Women's Health in Manitoba and Saskatchewan: Key Priorities and Strategies*.
- Quebec Native Women Report. (1993). *Assessment of Violence and Mental Health Conditions Among Native Women in Quebec*, Quebec Native Women.
- Quebec Native Women Report. (1995). *Beyond Violence*, Quebec Native Women.
- Scott, W., and VanDine, C. (1995, March 3). *Family Violence in Rural, Farm, Remote Canada*, The Canadian Farm Women's Network.
- Struthers, M. (1994, Sept. 1). At a Crossroads in the Work to End the Violence: A rural perspective, *Canadian Women's Studies*, 14(4), pp. 15-18.
- Trute, B. (1988). *Medical Response to Wife Abuse in Manitoba: A Survey of Physicians' Attitudes and Practices: A Final Report*, University of Manitoba, School of Social Work, Child and Family Research Group, p. 27.
- Tudiver, S., McClure, L., Heinson, T., Scurfield, C., and Kreklewetz, C. (2000). *Women Survivors of Childhood Sexual Abuse: Knowledge and Preparation of Health Care Providers to meet Client Needs*, Prairie Women's Health Centre of Excellence.
- Untinen, L. (1995). Safety For My Sisters: A History of the Shelter Movement in Northwestern Ontario, in L. Timmins (Ed.), *Listening To The Thunder*, Vancouver: Women's Research Centre.
- Wawanoloath, C. S. (2001, Winter). The Four Insights from Mali Pili Kizos, *Healing Words*, 3(2), pp. 14-22.

Cancer

- Ahmad, F., Stewart, D., Cameron, J., and Hyman, I. (2001). Rural Physicians' Perspectives on Cervical and Breast Cancer Screening: A Gender-Based Analysis, *Journal of Women's Health and Gender-Based Medicine*, (Special Issue), 10(2), pp. 201-208.
- Amaratunga, C. (2000). *Breast Cancer Action Nova Scotia*, 99/00-PD2, Maritime Centre of Excellence for Women's Health.

- Black, M. E. A., Stein, K. F., and Loveland-Cherry, C. J. (2001, April). Older Women and Mammography Screening Behavior: Do Possible Selves Contribute? *Health Education and Behavior*, 28(2), pp. 200-216.
- Bryant, H., and Mah, Z. (1992, July). Breast Cancer Screening: Attitudes and Behaviors of Rural and Urban Women, *Preventive Medicine*, 21(4), pp. 405-418.
- Bryant, J., Zumbo, B., Browne, A., and Barton, S. *Access to Health Care: Social Determinants of Preventive Cancer Screening Use in Northern British Columbia*, University of Northern British Columbia (Rural and Remote Health Research Web site).
- Church, J., Curran, V., and Solberg, S. (2000). *Voices and Faces*, Maritime Centre for Excellence in Women's Health.
- Clarke, H., Joseph, R., Deschamps, M., Hislop, T., Band, P., and Atleo, R. (1998, March). Reducing Cervical Cancer among First Nations Women, *Canadian Nurse*, 94(3), pp. 36-41.
- Deschamps, M., Band, P., Hislop, T., Clarke, H., Smith, J., Ng, V., and Math, M. (1992). Barriers to Cervical Cytology Screening in Native Women in British Columbia, *Cancer Detection and Prevention*, 16(5,6), pp. 337-339.
- Healey S. M., Aronson K. J., Mao Y., Schlect N. F., Mery L. S., Ferenczy A., and Franco E. L. (2001, December). Oncogenic Human Papillomavirus Infection and Cervical Lesions in Aboriginal Women of Nunavut, Canada, *Sexually Transmitted Diseases*, 28(12), pp. 694-700.
- Hislop, T., Deschamps, M., Band, P., Smith, J., and Clarke, H. (1992, September-October). Participation of BC Cervical Cytology Screening Program by Native Indian Women, *Canadian Journal of Public Health*, 83(5), pp. 344-345.
- Maxwell, C., Kozak, J., Desjardins-Denault, S., and Parboosingh, J. (1997, September-October). Factors Important in Promoting Mammography Screening Among Canadian Women, *Canadian Journal of Public Health*, 88(5), pp. 346-350.
- Maxwell, C. J., Bancej, C. M., and Snider, J. (2001, February 6). Predictors of Mammography use among Canadian women aged 50-69: Findings from the 1996/97 National Population Health Survey, *Canadian Medical Association Journal*, 164(3), pp. 329-339.
- McKinley, R. (1998, February). Mobile Breast Exam Unit Gets Ready for Rural Visits, *Alberta Sweetgrass*, 5(2), p. 6.
- Minore, B., Hill, M., Kurm, M., and Vergidis, D. (2001). Knowledgeable, Consistent, Competent Care: Meeting the challenges of delivering quality cancer care in remote Northern communities, *Internal Journal of Circumpolar Health*, 60(2), pp. 196-204.
- Roberts, R. (2001, October 18-21). *Pesticide Exposure and Breast Cancer Risk in Canada: A Case Control Study*, presented at the Health Research in Rural and Remote Canada: Taking the Next Steps Conference, Saskatoon, Saskatchewan.
- Roos, L., Traverse, D., and Turner, D. (1999, June). Delivering Prevention: The role of public programs in delivering care to high risk populations, *Medical Care*, 37(6 - Supplement).
- Ross, N., A., Rosenberg, M. W., and Pross, D. C. (1994, Summer). Siting a women's health facility: A location-allocation study of breast cancer screening services in eastern Ontario, *The Canadian Geographer*, 38.
- Woods, S. (2001, October 18-21). *Cervical Cancer Screening in Northern Saskatchewan First Nations*, presented at the Health Research in Rural and Remote Canada: Taking the Next Steps Conference, Saskatoon, Saskatchewan.
- Young, K. T., Kliwer, E., Blanchard, J., and Mayer, T. (2000). Monitoring Disease Burden and Preventative Behaviour with Data Linkage: Cervical Cancer among Aboriginal People in Manitoba, Canada, *American Journal of Public Health*, 90(9), pp. 1466-1468.

Caregiving

- Bouchard, N., Gilbert, C., and Tremblay, M. (1999). Des femmes et de soins. L'expérience des aidantes naturelles au Saguenay, *Recherches féministes (Feminist Research)*, 12(1), pp. 63-81.
- Bouchard, N., Gilbert, C., Tremblay, M., under the direction of Menard, and Villeneuve, F. (1996). *Les Solidarités fragiles : Les Femmes et la prise en charge de personnes en perte d'autonomie (Fragile Solidarity: Women and Assistance for Individuals Lose Autonomy)*, Actes du Congrès 1996 de la Société canadienne de théologie, Projet de société et lectures chrétiennes., Quebec, pp. 171-186.
- Bowd, A., and Loos, C. (1996, May-June). Morale and Coping Strategies of Caregivers for Persons With Alzheimer's Disease in Isolated Communities in Canada, *American Journal of Alzheimer's Disease*, 11(3), pp. 32-39.
- Bruhm, G., and Poirier, L. (1998). *The Caregivers Research Project*, 97/98-SPF2, funded by Maritime Centre of Excellence in Women's Health.
- Campbell, J., Bruhm, G., and Lilley, S. (1998, November). *Caregivers' Support Needs: Insights From the Experiences of Women Providing Care in Rural Nova Scotia*, The Maritime Centre of Excellence for Women's Health/Dalhousie University.
- Fast, J., Eales, J., and Keating, N. (2001, March). Economic Impact of Health, Income Security and Labour Policies on Informal Caregivers of Frail Seniors [www.swc-cfc.gc.ca/publish/resarch/010514-0662564765-e.html], *paper*, Status of Women Canada.
- Fedstein, D. A. (1999). *Barriers to Care for People Living with HIV in Northern Ontario: A Client Centered Survey*, Family Medicine North Residency Program, Health Science North, McMaster University, Thunder Bay, Ontario.
- Forbes, D. (2001, October 18-21). *Closing the Gap between what is Known and Practiced among Rural and Urban Elder Caregivers*, presented at the Health Research in Rural and Remote Canada: Taking the Next Steps, Saskatoon, Saskatchewan.
- Herle, A., McNabb, V., McKay, M., Nokusis, C., and Desnomie, M. (1998). *Effect of Multi-Generational Caring on On-Reserve Women*, 98D-T1-021, funded by the Prairie Centres of Excellence for Women's Health.



- Jaffe, J., and Blakely, B., (1999). *Coping as a Rural Caregiver: The impact of health care reforms on rural women informal caregivers*, Prairie Women's Health Centre of Excellence.
- Payne, B., Grant, K., and Gregory, D. (2001, September 30). *Women's Caring Work in the Context of Manitoba Health Reform*, National Network on Environments and Women's Health.
- Prairie Women's Health Centre of Excellence. (2001). *Action Plan for Women's Health in Manitoba and Saskatchewan: Key Priorities and Strategies*.
- Tudiver, S., and Hall, M. Women and Health Care Delivery in Canada [www.hc-sc.gc.ca/canusa/papers/canada/english/delivery.htm], paper, Health Canada Website (25072001).
- Williams, A., M. (1996). The Development of Ontario's Home Care Program: A Critical Geographical Analysis, *Social Science and Medicine*, 42(6), pp. 937-948.

Elderly Women

- Black, M. E. A., Stein, K. F., and Loveland-Cherry, C. J. (2001, April). Older Women and Mammography Screening Behavior: Do Possible Selves Contribute? *Health Education and Behavior*, 28(2), pp. 200-216.
- Blakely, B. M. (1999). The Impact of Health Care Reforms on Elderly Caregivers in Rural Canada, *Society for the Study of Social Problems Association paper*.
- Botting, I., Neis, B., Kealey, L., and Solberg, S. (2000, July). *Health Care Restructuring and Privatization from Women's Perspectives in Newfoundland and Labrador*, National Network on Environments and Women's Health.
- Fast, J., Eales, J., and Keating, N. (2001, March). Economic Impact of Health, Income Security and Labour Policies on Informal Caregivers of Frail Seniors [www.swc-cfc.gc.ca/publish/resarch/010514-0662564765-e.html], paper, Status of Women Canada.
- Forbes, D. (2001, 18-21 October). *Closing the Gap between what is Known and Practiced among Rural and Urban Elder Caregivers*, presented at the Health Research in Rural and Remote Canada: Taking the Next Steps, Saskatoon, Saskatchewan.
- James, A. M. (1994). *Aging in Urban and Rural Areas: Where are the differences? A study of health care utilization by the elderly population of eastern Ontario*, unpublished doctoral dissertation, Queen's University, Kingston, 309 pages.
- Johnston, J., and Schneider, L. (1998, Fall). Effects of a One-month Nutrition and Exercise Program in Blackfoot Women Elders, *Journal of the Canadian Dietetic Association*, 49(4), pp. 249-253.
- Maxwell, C., Kozak, J., Desjardins-Denault, S., and Parboosingh, J. (1997, September-October). Factors Important in Promoting Mammography Screening Among Canadian Women, *Canadian Journal of Public Health*, 88(5), pp. 346-350.
- Maxwell, C. J., Bancej, C. M., and Snider, J. (2001, February 6). Predictors of Mammography use among Canadian women aged 50-69: Findings from the 1996/97 National Population Health Survey, *Canadian Medical Association Journal*, 164(3), pp. 329-339.
- Mitchell, S. (1991). *Raising the Issues: A Discussion paper on Aging Women in Ontario*, Toronto: Ontario Advisory Council on Women's Issues, 1991, iii, 33, iii, 37, p. 33.
- Neis, B., Drake, A., and Sheir, J. (2001). *We've Talked: Restructuring and Women's Health in Rural Newfoundland*, Final Report to Health Canada Population Health Fund, www.coastsunderstress.ca

- Pittaway, E. (1990). *Leisure Lifestyle and Perceived Social Support of Older Adults in a Rural Environment*, (doctoral dissertation, WLU, 1990), DAI, 52, 4092.
- Prairie Women's Health Centre of Excellence. (2001). *Action Plan for Women's Health in Manitoba and Saskatchewan: Key Priorities and Strategies*.
- Raiwet, C. (1990). *As Long As We Have Health: The experience of age-related physical change for rural elderly couples*, unpublished doctoral dissertation, University of Alberta, Edmonton.
- St. John, P., D., Havens, B., van Ineveld, C. H., and Finlayson, M. (2002). Rural-urban Differences in Health Status of Elderly Manitobans, *Canadian Journal of Rural Medicine*, 7(2), pp. 89-93.

Farm Women

- Black, N., and Cuthbert Brandt, G. (1999). *Feminist Politics on the Farm : Rural Catholic Women in Southern Quebec and Southwestern France*, Montréal and Kingston: McGill-Queen's University Press.
- Boivin, M. (1987). Les agricultrices : Un travail à reconnaître sur les plans juridique et économique, (Farm women: Work that needs to be recognized economically and legally), in *Place aux femmes dans l'agriculture, (Women's Place in Agriculture)*, Conseil consultatif canadien sur la situation de la femme, Ottawa, pp. 54-71.
- Bureau de la répondante à la condition féminine. (1985). *Plan d'Action Triennal*, Ministère de l'agriculture, des pêcheries et de l'alimentation, Québec.
- Busque, G. (1987). Les Besoins et les Ressources des Femmes dans L'Agriculture. In *Place Aux Femmes dans L'Agriculture*, Conseil Consultatif Canadien sur la Situation de la Femme, Ottawa.
- Cuthbert, B. G. (1991). Les origines et le développement des cercles de fermières au Québec et des groupements féminins en Gironde, in N. Black, G. Cuthbert Brandt, M.-C. Rouyer and P. Guillaume (Eds.), *Femmes et vie rurale au Québec et en Aquitaine*, Centre d'études canadiennes.
- deVink, S., and Doherty, D. (1995). *Family Violence on the Farm and in Rural Communities*, available: www.hc-sc.gc.ca/hppb/family.ed_inventory/english/section_1htm (accessed 25072001).
- Dimich-Ward, H., Doerfling, P., Hagel, L., Pickett, W., Rolland, L., Hartling, L., Brison, R., and CAISP Collaborators. (2001, October 18-21). *Who is at Risk of Dying on Canadian Farms?* presented at the Health Research in Rural and Remote Canada: Taking the Next Steps, Saskatoon, Saskatchewan.
- Dion, S. (1991). Les agricultrices québécoises depuis 1981, in N. Black, G. Cuthbert Brandt, M.-C. Rouyer and P. Guillaume (Eds.), *Femmes et vie rurale au Québec et en Aquitaine*, Centre d'études canadiennes.
- Fletcher, S. (1996, Spring). Farm Women Take Action on Mental Health Needs, *Women and Environments*, 38, pp. 25-26.
- Gerrard, N. (2001). Seeking a Seat at the Policy Table: Farm Women and the Impact of Program Cuts (Vol. 2(1) Summer, Centres of Excellence for Women's Health Research Bulletin, pp. 17-18).
- Gerrard, Nikki, and Russell, G. (1999). *An Exploration of Health-Related Impacts of the Erosion of Agriculturally Focused Support Programs for Farm Women in Saskatchewan*, Prairie Women's Health Centre for Excellence.
- Jurifemme. (2000, Summer). Workshop reports: Rural and farm women, *Jurifemme*, 19(3), pp. 12-15.

- Keating, N. (1987, October). Reducing Stress of Farm Men and Women, *Family Relations*, 36(4), pp. 358-63.
- Kubik, W., and Moore, R. (2000). *Women's Diverse Roles in the Farm Economy and the Consequences for their Health, Well-being and Quality of Life*, University of Regina (HTF: SK 321).
- Masley, M., Semchuk, K., Senthilselvan, A., McDuffie, H., Hanke, P., Dosman, J., Cessna, A., Crossley, M., Irvine, D., Rosenberg, A., and Hagel, L. (2000). Health and Environment of Rural Families: Results of a Community Canvass Survey in the Prairie Ecosystem Study (PECOS), *Journal of Agricultural Safety and Health*, 6(2), pp. 103-115.
- Ministere de l'agriculture. (1992). *L'agricultrice, une partenaire professionnelle*, Quebec: Direction des services aux agricultrices.
- Scott, W., and VanDine, C. (1995, March 3). *Family Violence in Rural, Farm, Remote Canada*, The Canadian Farm Women's Network.
- Skillen, L. (2001). *Reflections of Rural Alberta Women: Work, Health and Restructuring*, University of Alberta, funded by the National Network on Environments and Women's Health.
- Thurston, W., and Blundell-Gosselin, H. (2001, October 18-21). *The Farm as a Setting for Health Promotion: Results of a Needs Assessment in South Central Alberta*, presented at the Health Research In Rural and Remote Canada: Taking Next Steps Conference, Saskatoon, Saskatchewan.

Fisheries

- Binkley, M. (2002). *Set Adrift: Fishing Families* [Diss], Toronto: University of Toronto Press.
- Bureau de la répondante à la condition féminine. (1985). *Plan d'Action triennal*, Ministère de l'agriculture, des pêcheries et de l'alimentation, Quebec.
- Grzetic, B. (2002). *Between Life and Death: Women Fish Harvesters in Newfoundland and Labrador*, unpublished master's thesis, Memorial University.
- Hounsell, A., and Neis, B. (2002). Ethical Issues Associated with Occupational Asthma in Single Industry Fishery Villages, in S. Roseman (Ed.), *Identities, Power, and Place on the Atlantic Borders of Two Continents: Proceedings from the International Research Linkages Workshop on Newfoundland and Labrador Studies and Galician Studies*, St. John's, Newfoundland: Memorial University, pp. 144-158.
- Keefe, S. (2002). *Skipper of the Shore Crew: Women and a Fish Plant Closure*, unpublished doctoral dissertation, Wilfred Laurier University, Psychology.
- Lord, S. *Social and Economic Stress and Women's Health in Fishing Communities*, Maritime Centre of Excellence in Women's Health.
- Lord, S., Pahlke, A., and Christiansen-Ruffman, L. (2001, December). *Women's Health and Wellbeing in Six Nova Scotia Fishing Communities*, Canadian Research Institute for the Advancement of Women/Nova Scotia Women's Fishnet.
- Neis, B. (1994). Occupational Health and Safety of Women Working in Fish and Crab Processing in Newfoundland and Labrador, *Chronic Diseases in Canada*, 15(1), pp. 6-11.
- Neis, B., Grzetic, B., and Pigeon, M. (2001, April). *From Fishplant to Nickel Smelter: Health Determinants and the Health of Newfoundland's Women Fish and Shellfish Processors in an Environment of Restructuring*, National Network on Environments and Women's Health/Centres of Excellence for Women's Health, Newfoundland.
- Neis, B., and Williams, S. (1996). "Women and children first: The impacts of fishery collapse on women in Newfoundland and Labrador," *Cultural Survival Quarterly*, Spring, pp. 67-71.

- Neis, B. (1997). Social Effects of One-Industry Fishery Villages, in *Encyclopaedia of Occupational Safety and Health, 4th edition*, Geneva: ILO, pp. 66.13-66.14.
- Williams, S. (1996). *Our Lives are at Stake: Women and the Fishery Crisis in Newfoundland and Labrador*, (Tech. Rep. No. ISER Report no. 11), St. John's, Newfoundland: Institute of Social and Economic Research, Memorial University.

Health Care Professionals

- Ahmad, F., Stewart, D., Cameron, J., and Hyman, I. (2001). Rural Physicians' Perspectives on Cervical and Breast Cancer Screening: A Gender-Based Analysis, *Journal of Women's Health and Gender-Based Medicine* (Special Issue), 10(2), pp. 201-208.
- Benoit, C., and Carroll, D. (2001, Spring, Vol 4, No 3). Aboriginal Midwifery in Canada: Blending Ancient Traditions and Emerging Forms, *Network Magazine*.
- Bilodeau, H. (1986). *Étude des facteurs de stabilité du lieu de pratique des médecins québécois en régions éloignées*, unpublished doctoral dissertation, Université de Montréal.
- Browne, A., and Fiske, J.-A. (2001). First Nations Women's Encounters with Mainstream Health Care Services, *Western Journal of Nursing Research*, 23(2), pp. 126-147.
- Browne, A., Fiske, J.-A., and Thomas, G. (1997). *Northern First Nations Women's Interactions with the Mainstream Health System*, WCC97-3, funded by the British Columbia Centre of Excellence for Women's Health.
- Buske, L. (2000). Availability of Services in Rural Areas, *Canadian Medical Association Journal*, 162, p. 1193.
- Church, J., Curran, V., and Solberg, S. (2000). *Voices and Faces*, Maritime Centre for Excellence in Women's Health.
- Couillard, M.-A., and Côté, G. (1997). *Les groupes de femmes de la région de Québec et l'implantation de la régie régionale de la santé et des services sociaux*, presented at the Rapport de recherche; présenté au CQRS, Sainte-Foy: Université Laval, centre de recherche sur les services communautaires.
- Crump, J. (2001, January 09). Phone Tag: Family doctors in remote settings find they are spending a lot of time on the phone searching for specialists and trying to convince them to see their patients, *Medical Post*, 37(1), p. 37.
- Galway, C. (1997). *Should We Ask Our Patients About Domestic Violence: A Patient Survey*, Family Medicine North Residency Program, Health Sciences North, McMaster University, Thunder Bay, Ontario.
- Hutten-Czapski, P. (1999, August 16). *Rural Midwifery*, Society of Rural Physicians of Canada.
- Jasen, P. (1997, December). Race, Culture and the Colonization of Childbirth in Northern Canada, *Social History of Medicine*, 10(3), pp. 383-400.
- Johnston, M. T. (1998). Goin' to the Country: Challenges for Women's Health Care in Rural Canada, *Canadian Medical Association Journal*, 159, pp. 339-341.
- Klein, M. C., Christilaw J., and Johnston, S. (2002). Loss of Maternity Care: The cascade of unforeseen dangers, *Canadian Journal of Rural Medicine*, 7(2), pp. 120-121.
- Leipert B., and Reutter, L. (1998, Nov-Dec). Women's Health and Community Health Nursing Practice in Geographically Isolated Settings: A Canadian Perspective, *Health Care for Women International*, 19(6), pp. 575-588.
- Leipert, B. (1999, August). Women's Health and the Practice of Public Health Nurses in Northern British Columbia, *Public Health Nursing*, 16(4), pp. 280-290.

- MacLeod, M., Browne, A., and Leipert, B. (1998, May). International Perspective. *Australian Journal of Rural Health*, 6(2), pp. 72-78.
- Meadows, L. M., Thurston, W. E., and Berenson, C. A. (2001, July). Health Promotion and Preventative Measures: Interpreting Messages at Midlife, *Qualitative Health Research*, 11(4), pp. 450-463.
- Ng, E., Wilkins, R., Pole, J., and Adams, O. (1999, March). How Far is the Nearest Physician? *Rural and Small Town Canadian Analysis Bulletin*, 1(5).
- Nowgesic, E. (1995, July). Retaining Nurses in the North: An Opportunity for Human Resources, *Aboriginal Nurse*, 10(1), pp. 3-11.
- Permaul-Woods, J., Carroll, J., Reid, A., Woodward, C., Ryan, G., Domb, S., Arbitman, S., Fallis, B., and Kiltz, J. (1999). Going the Distance: *Canadian Medical Association Journal*, 161(4), pp. 381-385.
- Ross, N. A., Rosenberg, M. W., and Pross, D. C. (1994, Summer). Siting a women's health facility: A location-allocation study of breast cancer screening services in eastern Ontario, *The Canadian Geographer*, 38.
- Rowntree, C., Irvine, H., Thompson, J., Larsen, D., and Morse, J. (1994, December 22). *Rural Physicians' Perspective on Midwifery in Sunde Alberta*, (Society of Rural Physicians of Canada, Rural Medicine Articles, Library).
- Stretch, N., C., and Knight, C., A. (2002). Community Obstetrics: A new look at group obstetrical care in rural communities, *Canadian Journal of Rural Medicine*, 7(3), pp. 183-190.
- Sutherns, R. (2001). *Women's Experiences of Maternity Care in Rural Ontario: Do Doctors Matter?* doctoral dissertation, University of Guelph, 375 pages.
- Trute, B. (1988). *Medical Response to Wife Abuse in Manitoba: A Survey of Physicians' Attitudes and Practices: A Final Report*, University of Manitoba, School of Social Work, Child and Family Research Group, p. 27.

Health Reform

- Blakely, B. M. (1999). The Impact of Health Care Reforms on Elderly Caregivers in Rural Canada, *Society for the Study of Social Problems Association paper*.
- Botting, I., Neis, B., Kealey, L., and Solberg, S. (2000, July). *Health Care Restructuring and Privatization from Women's Perspectives in Newfoundland and Labrador*, National Network on Environments and Women's Health.
- Fast, J., Eales, J., and Keating, N. (2001, March). Economic Impact of Health, Income Security and Labour Policies on Informal Caregivers of Frail Seniors [www.swc-cfc.gc.ca/publish/research/010514-0662564765-e.html], *paper*, Status of Women Canada.
- Fuller, C. (1999). *Reformed or Rerouted? Women and Change in the Health Care System*. Vancouver, British Columbia: British Columbia Centre of Excellence for Women's Health.
- Jaffe, J., and Blakely, B., (1999). *Coping as a Rural Caregiver: The impact of health care reforms on rural women informal caregivers*, Prairie Women's Health Centre of Excellence.
- Lellava, V. (Project Coordinator). (2001, May, 29). *Not Just Desserts: Kitchen Table Discussions*, Northwestern Ontario Women's Decade Council, Thunder Bay, Ontario, pp. 2-20.
- Morton, M., and Loos, C. (1995, Fall). Does Universal Health Care Coverage Mean Universal Accessibility? *Women's Health Issues*, 5(3), pp. 139-142.

- Neis, B., Drake, A., and Sheir, J. (2001). *We've Talked: Restructuring and Women's Health in Rural Newfoundland*, Final Report to Health Canada Population Health Fund, www.coastsunderstress.ca
- Payne, B., Grant, K., and Gregory, D. (2001, September 30). *Women's Caring Work in the Context of Manitoba Health Reform*, National Network on Environments and Women's Health.
- Petrucka, P. M. (2001, October 18-21). *A Preliminary Consideration of Impact of Health Reform/Renewal on Canadian Rural Women*, presented at the Health Research in Rural and Remote Canada: Taking the Next Steps Conference, Saskatoon, Saskatchewan.
- Prairie Women's Health Centre of Excellence. (2001). *Action Plan for Women's Health in Manitoba and Saskatchewan: Key Priorities and Strategies*.
- Scott, C., Horne, T., and Thurston, W. (2000). *The Differential Impact of Health Care Privatization on Women in Alberta*, Prairie Women's Health Centre of Excellence.
- Skillen, L. (2001). *Reflections of Rural Alberta Women: Work, Health and Restructuring*, University of Alberta, funded by the National Network on Environments and Women's Health.
- Willson, K., and Howard, J. (2000). *Missing Links: The Effects of Health Care Privatization on Women in Manitoba and Saskatchewan*, Prairie Women's Health Centre of Excellence.

Health Status

- DesMeules, M., Jones, S., Lagace, C., and Wootton, J. (2001, October 18-21). *Patterns of Health, Disease and Health Services Utilization in Rural and Urban Canada: A mapping project*, presented at the Health Research in Rural and Remote Canada: Taking the Next Steps, Saskatoon, Saskatchewan.
- Dubois-Wing, G. (2001, 11/May). Northern Perspective on Women's Health Issues, Ontario Women's Health Council.
- Government of Canada. (2002). The Health of Aboriginal Women, in Women's Health Bureau [Online], available: www.hc-sc.gc.ca (accessed December 6, 2002).
- Gucciardi, E., and Biernie-Lefcovithc, A. (2002). Rural and Northern Women, D. E. Stewart, A. M. Cheung, L. E. Ferris, I. Hyman, M. M. Cohen and J. I. Williams (Eds.), *Ontario Women's Health Status Report*, Tech. Rep. No. ISBN 0-7794-3614-8, pp. 374-386.
- Manual, D., Goel, B., Williams, J., and Corey, P. (2000). Health-Adjusted Life Expectancy at the Local Level in Ontario, *Chronic Disease Canada*, 21(2), pp. 73-80.
- McBride, C., and Bobet, E. (1990). *Health of Indian Women*, Ottawa: Indian and Northern Affairs Canada, p. 32.
- Muckle, G., Ayotte, P., Dewailly, E., Jacogson, S. W., and Jacobson, J. L. (2001). Prenatal Exposure of Northern Quebec Inuit Infants to Environmental Contaminants. *Environmental Health Perspectives—New Series*, 109(12), pp. 1291-1301.
- St. John, P., D., Havens, B., van Ineveld, C. H., and Finlayson, M. (2002). Rural-urban Differences in Health Status of Elderly Manitobans, *Canadian Journal of Rural Medicine*, 7(2), pp. 89-93.
- Statistics Canada. (1999). *Statistical Report on the Health of Canadians*, Ottawa.

HIV/AIDS

- Cardwell, M. (1998, May 26). Drug Use a Threat to Canadian Natives, *Medical Post*, 34(20), pp. 32-33.
- DeLeeuw, S. (1998). *Young Women's Health Needs in Isolated Northern Communities*, WCC98-7, funded by the British Columbia Centre of Excellence for Women's Health.
- Fedstein, D. A. (1999). *Barriers to Care for People Living with HIV in Northern Ontario: A Client Centered Survey*, Family Medicine North Residency Program, Health Science North, McMaster University, Thunder Bay, Ontario.
- Gilmore, A., and Ross, M. (1993). HIV/AIDS and the Impact on Aboriginal Women in Canada, *Aboriginal Nurses Association of Canada*.
- Graham, J., Brownlee, K., and Ritchie, I. (1996). Aids, Social Work, and the Coming Home Phenomenon, *The Social Worker*, 64(4), pp. 74-84.
- McKeown, I., Reid, S., Turner, S., and Orr, P. (2002). *Social Risk Factors Involved in the Acquisition of HIV Among Women in Manitoba*, Prairie Women's Health Centre of Excellence.
- Mill, J. (1997, August). HIV Risk Behaviors Become Survival Techniques for Aboriginal Women, *Western Journal of Nursing Research*, 19(4), pp. 466-489.
- Mill, J. (2000, October). Describing an Explanatory Model of HIV Illness among Aboriginal Women, *Holistic Nursing Practice*, 15(1), pp. 42-56.
- O'Gorman, K. (2001, Summer/Fall). Northern Women's Health Outreach Project, *Canadian Woman Studies*, 21(2), pp. 113-115.

Housing

- Mavin, R. (1993). *Housing the Rural Elderly: Exploring the Potential for the Abbeyfield Model*, unpublished doctoral dissertation, University of Guelph, p. 153.
- Neis, B., Drake, A., and Sheir, J. (2001). *We've Talked: Restructuring and Women's Health in Rural Newfoundland*, Final Report to Health Canada Population Health Fund, www.coastsunderstress.ca
- Racher, F. E. (1997). *The Challenge of Coping: Frail rural elderly couples identify resources required to maintain their independence*, unpublished doctoral dissertation, University of Manitoba, Winnipeg, p. 141.
- Rathwell, T. (1999). *A Gender Equity Lens for the Health Policy Domain—A Canadian Gender Curriculum Educational Strategy*, 98/99-PF1, Maritime Centre of Excellence for Women's Health.
- Steele, M. (2002, July). *Housing Options for Women Living Alone in Rural Areas—Final Report*, (Canadian Mortgage and Housing Corporation), CMHC, External Research Program, Research Report.

Information (Access to Health Information)

- Bartellas, E., Crane J. M., Daley, M., Bennett, K., and Hutchens, D. (2000, August). Sexuality and Sexual Activity in Pregnancy, *British Journal of Obstetrics & Gynecology*, 107(8), pp. 964-968.
- Bourgeault, I. L., and Sutherns, R. (2001, October 18-21). *Rural Women's Experiences with Health Information and Resources*, presented at the Health Research in the Rural and Remote Canada: Taking the Next Steps. Saskatoon, Saskatchewan.

- Bowd, A., and Loos, C. (1996, May-June). Morale and Coping Strategies of Caregivers for Persons With Alzheimer's Disease in Isolated Communities in Canada, *American Journal of Alzheimer's Disease*, 11(3), pp. 32-39.
- Forsdick Martz, D. J., and Sarauer, D. B. (2001). Policy From the Ground Up: Rural Services For Survivors of Woman Abuse, *Centres of Excellence for Women's Health Research Bulletin*, 2(1); Summer, pp. 14-16.
- Gilmore, A., and Ross, M. (1993). HIV/AIDS and the Impact on Aboriginal Women in Canada, *Aboriginal Nurses Association of Canada*.
- Klassen, D. R., and Schubert, D. P. (1996). *Survey on Adolescent Knowledge of Sexuality*, Family Medicine North Residency Program, Health Sciences North, McMaster University, Thunder Bay, Ontario.
- Meadows, L. M., Thurston, W. E., and Berenson, C. A. (2001, July). Health Promotion and Preventative Measures: Interpreting Messages at Midlife, *Qualitative Health Research*, 11(4), pp. 450-463.
- Parker, B. (2001, May). *Mapping Feminist Praxis and Identity: A Case Study of Women's Health Activism in Northwestern Ontario*, unpublished M.A. thesis, Department of Sociology, Lakehead University.
- Thurston, W., and Blundell-Gosselin, H. (2001, October 18-21). *The Farm as a Setting for Health Promotion: Results of a Needs Assessment in South Central Alberta*, presented at the Health Research In Rural and Remote Canada: Taking Next Steps Conference, Saskatoon, Saskatchewan.
- Williams, R., and Gloster, S. (1999, November). Knowledge of Fetal Alcohol Syndrome (FAS) among Natives in Northern Manitoba, *Journal of Studies on Alcohol*, 60(6), pp. 833-836.

Lesbian Health

- Bella, L. (1999). *Towards Non-Hetero-Sexist Policy and Regulation in Health and Income Security Agencies*, 98/99 PF3, Centres of Excellence for Women's Health.
- Issac, B., Anderson, L., Healy, T., Herringer, B., and Perry, T. (1999). *Out in the Cold: The Context of Lesbian Health in Northern British Columbia*, British Columbia Centre of Excellence for Women's Health.
- Luce, J. (1998). *Assessing Assisted Reproduction: Experiences of Lesbian and Bisexual Women Living in Northern Communities*, WCC98-8, funded by the British Columbia Centre of Excellence for Women's Health.
- Mitchell, J., (1999). *Staying Well Together: Social Support and Well-Being Among Lesbian Couples in Manitoba*, funded by the Prairie Women's Health Centre for Excellence.

Mental Health

- Ali, A. (2001). Medical Psychology in Canada, *Journal of Clinical Psychology in Medical Settings* (Special Issue), 8(1), pp. 15-20.
- Bruhm, G., and Poirier, L. (1998). *The Caregivers Research Project*, 97/98-SPF2, funded by Maritime Centre of Excellence in Women's Health.
- Côté, J., Desmartis, M., Caron, M., and Ouellet, L. (1993). *Le Point de vue des leaders d'opinion sur la maladie mentale et la réinsertion sociale en milieu rural*, rapport conçu pour le Ministère de la Santé et des Services Sociaux, Beauport: Centre de recherche Université Laval Robert-Giffard.

- Côté, J., Ouellet, L., and Caron, M. (1993). *La Réinsertion sociale en milieu rural et urbain : Opinion des citoyens à l'égard des personnes avec une maladie mentale*, Ministère de la santé et des services sociaux, Quebec: Centre de recherche Université Laval Robert-Giffard.
- Fillmore, C., Dell, C., A., and the Elizabeth Fry Society of Manitoba. (2000). *Prairie Women, Violence and Self-Harm*, Prairie Women's Health Centre of Excellence.
- Fletcher, S. (1996, Spring). Farm Women Take Action on Mental Health Needs, *Women & Environments*, 38, pp. 25-26.
- Gillis, A., and Perry, A. (1991, March). The Relationships between Physical Activity and Health-Promoting Behaviors in Mid-life Women, *Journal of Advanced Nursing*, 16(3), pp. 299-310.
- Graveline, M. (1990). Threats to Rural Women's Well-being: A Group Response, in Vanaja Dhruvarajan (Ed.), *Women and Well-Being/Les Femmes et le mieux-être*, Montreal and Queens: Mc-Gill-Queens University Press, pp. 169-179.
- Harris, E. (1990). Well-Being for Rural Women: Empowerment through Nonformal Learning, in Dhruvarajan and Vanaja (Eds.), *Women and Well-Being/Les Femmes et le mieux-être*, pp. Montreal and Kingston: McGill-Queens University Press, pp. 195-200.
- Herbert, E., and McCannell, K. (1997, Fall). Talking Back: Six First Nations Women's Stories of Recovery from Childhood Sexual Abuse and Addictions, *Canadian Journal of Community Mental Health*, 16(2), pp. 51-68.
- Keating, N. (1987, October). Reducing Stress of Farm Men and Women, *Family Relations*, 36(4), pp. 358-63.
- Kirmayer, L., Brass, G., and Tait, C. (2000). The Mental Health of Aboriginal Peoples: Transformation of Identity and Community, *Canadian Journal of Psychiatry*, 45(7), pp. 607-616.
- Kirmayer, L. J., Boothroyd, L. J., Tanner, A., Adelson, N., and Robinson, E. (2000, March 1). Psychological Distress Among the Cree of James Bay, *Transcultural Psychiatry*, 37(1).
- Kubik, W., and Moore, R. (2000). *Women's Diverse Roles in the Farm Economy and the Consequences for their Health, Well-being and Quality of Life*, University of Regina (HTF: SK 321).
- Kyle, J. L. (1985). *Les services de santé mentale en milieu rural de la Colombie-Britannique* (Ministère de la santé nationale et du bien-être social, Ed.), Ottawa.
- Leenars, A. A. (2000, Fall). Suicide Prevention in Canada: A History of a Community Approach, *Canadian Journal of Community Mental Health—Special Issue*, 19(2), pp. 57-73.
- Lord, S. *Social and Economic Stress and Women's Health in Fishing Communities*, Maritime Centre of Excellence in Women's Health.
- Lord, S., Pahlke, A., and Christiansen-Ruffman, L. (2001, December). *Women's Health and Wellbeing in Six Nova Scotia Fishing Communities*, Canadian Research Institute for the Advancement of Women/Nova Scotia Women's Fishnet.
- Maclean, L. M. (1991). *The Experience of Depression for Chipewyan and Euro-canadian Northern Women (Canada)*, unpublished doctoral dissertation, University of Saskatchewan, Saskatoon, p. 395.
- Mill, J. (1997, August). HIV Risk Behaviors Become Survival Techniques for Aboriginal Women, *Western Journal of Nursing Research*, 19(4), pp. 466-489.
- Mitchell, J., Buchner, J., and Huen, D. (97-T3-017). *Staying Well Together: Social Support and Well-Being Among Lesbian Couples in Manitoba*, funded by the Prairie Women's Health Centre for Excellence.
- Morrow, M., and Chappell, M. (1999). *Hearing Women's Voices: Mental Health Care for Women*, Vancouver: British Columbia Centre of Excellence for Women's Health.

- Neis, B., Grzetic, B., and Pigeon, M. (2001, April). *From Fishplant to Nickel Smelter: Health Determinants and the Health of Newfoundland's Women Fish and Shellfish Processors in an Environment of Restructuring*, National Network on Environments and Women's Health/Centres of Excellence for Women's Health, Newfoundland.
- Paproski, D. (1997, Fall). Healing Experiences of British Columbia First Nations Women, *Canadian Journal of Community Mental Health*, 16(2), pp. 69-89.
- Parikha, S. V., Wasylenkia, D., Goeringa, P., and Wonga, J. (1996, April 26). Mood Disorders: Rural/urban differences in prevalence, health care utilization, and disability in Ontario, *Journal of Affective Disorders*, 38(1), pp. 57-65.
- Pittaway, E. (1990). Leisure Lifestyle and Perceived Social Support of Older Adults in Rural Environment, doctoral dissertation, WLU, 1990). *DAI*, 52, 4092-.
- Prairie Women's Health Centre of Excellence. (2001). *Action Plan for Women's Health in Manitoba and Saskatchewan: Key Priorities and Strategies*.
- Quebec Native Women Report. (1993). *Assessment of Violence and Mental Health Conditions Among Native Women in Quebec*, Quebec Native Women.
- Restoule, B., Marilyn. (2000, May). Healing in Ojibwa First Nation Communities: Investigating the Relationship among Acculturation, Health and Identity, *Dissertation Abstracts International: Section B: The Sciences & Engineering*, 60(10-B), p. 5251.
- Robinson, R. (2001, 18-21 October). *Rural-urban Differences in Mental Health Status*, presented at the Health Research in Rural and Remote Canada: Taking the Next Steps, Saskatoon, Saskatchewan.
- Ross, H., and Shirley, M. (1997, February). Life-time Problem Drinking and Psychiatric Co-morbidity among Ontario Women, *Addiction*, 92(2), p. 183.
- Scattolon, Y., and Stoppard, J. (1999, May). "Getting on with Life": Women's Experiences and Ways of Coping with Depression, *Canadian Psychology*, 40(2), pp. 205-219.
- Strass, P. (2002, March 2). Rural Community Health: Postpartum depression support, *Canadian Nurse*, 98(3), pp. 25-28.
- Wawanoloath, C. S. (2001, Winter). The Four Insights from Mali Pili Kizos, *Healing Words*, 3(2), pp. 14-22.
- Willms, D., Lange, P., Bayfield, D., Beardy, M., Lindsay, E., Cole, D., and Johnson, N. (1992, September to October). A Lament by Women for "the People, the Land", [Nishnawbi-Aski Nation], An Experience of Loss, *Canadian Journal of Public Health*, 83(5), pp. 331-334.

Midlife Women's Health

- Black, M. E. A., Stein, K. F., and Loveland-Cherry, C. J. (2001, April). Older Women and Mammography Screening Behavior: Do Possible Selves Contribute? *Health Education and Behavior*, 28(2), pp. 200-216.
- Botting, I., Neis, B., Kealey, L., and Solberg, S. (2000, July). *Health Care Restructuring and Privatization from Women's Perspectives in Newfoundland and Labrador*, National Network on Environments and Women's Health.
- Fast, J., Eales, J., and Keating, N. (2001, March). Economic Impact of Health, Income Security and Labour Policies on Informal Caregivers of Frail Seniors, [www.swc-cfc.gc.ca/publish/resarch/010514-0662564765-e.html], *paper*, Status of Women Canada.
- Gillis, A., and Perry, A. (1991, March). The Relationships between Physical Activity and Health-Promoting Behaviors in Mid-life Women, *Journal of Advanced Nursing*, 16(3), pp. 299-310.



- Maxwell, C., Kozak, J., Desjardins-Denault, S., and Parboosingh, J. (1997, September-October). Factors Important in Promoting Mammography Screening Among Canadian Women, *Canadian Journal of Public Health*, 88(5), pp. 346-350.
- Mitchell, S. (1991). *Raising the Issues: A Discussion paper on Aging Women in Ontario*, Toronto: Ontario Advisory Council on Women's Issues, 1991, iii, 33, iii, 37, p. 33.
- Prairie Women's Health Centre of Excellence. (2001). *Action Plan for Women's Health in Manitoba and Saskatchewan: Key Priorities and Strategies*.
- Steele, M. (2002, July). *Housing Options for Women Living Alone in Rural Areas—Final Report*, Canadian Mortgage and Housing Corporation, CMHC External Research Program, Research Report.

Obesity and Body Image

- Dubois-Wing, G. (2001, May 11). Northern Perspective on Women's Health Issues, Ontario Women's Health Council.
- Katzmarzyk, P., and Malina, R. (1999). Body Size and Physique among Canadians of First Nation and European Ancestry, *American Journal of Physical Anthropology*, 10(2), pp. 161-172.
- Sweet, L. E., Macdonald, S. M., Reeder, B. A., Chen, Y., and Angel, A. (1997, July 1). Regional and Rural-Urban Differences in Obesity in Canada, *Canadian Medical Association Journal*, 157(1), pp. S10-S16.
- Wakewich, P. (2000b). Contours of Everyday Life: Women's Reflections on Embodiment and Health Over Time, in J. M. S. a. V. A. Baukje Miedema (Ed.), *Women's Bodies Women's Lives: Health, Well-Being and Body Image*, pp. 237-253.
- Young, T., and Sevenhuysen, G. (1989, May). Obesity in Northern Canadian Indians: Patterns, determinants, and consequences, *American Journal of Clinical Nutrition*, 49(5), pp. 786-793.

Occupational Health and Safety

- Binkley, M. (2002). *Set Adrift: Fishing Families*, [diss], Toronto: University of Toronto Press.
- Denham, D., and Gillespie, J. (1992). *Wife Abuse: A Workplace Issue*, Family Violence Program: Canadian Council on Social Development, Health Canada.
- Grzetic, B. (2002). *Between Life and Death: Women Fish Harvesters in Newfoundland and Labrador*, unpublished master's thesis, Memorial University.

- Grzetic, B., Shrimpton, M., Skipton, and Sue. (1996). Women, Employment Equity and the Hibernia Construction Project: A study of women's experiences on the Hibernia construction project, St. John's, Newfoundland: WITT Newfoundland and Labrador.
- Hounsell, A., and Neis, B. (2002). Ethical Issues Associated with Occupational Asthma in Single Industry Fishery Villages, in S. Roseman (Ed.), *Identities, Power, and Place on the Atlantic Borders of Two Continents: Proceedings from the International Research Linkages Workshop on Newfoundland and Labrador Studies and Galician Studies*, St. John's, Newfoundland: Memorial University, pp. 144-158.
- Kosny, A. (2000). *Trying to Work It Out: Newfoundland Women's Experiences in Small Workplaces*, National Network on Environments and Women's Health, www.yorku.ca/nnewh.
- Masley, M., Semchuk, K., Senthilselvan, A., McDuffie, H., Hanke, P., Dosman, J., Cessna, A., Crossley, M., Irvine, D., Rosenberg, A., and Hagel, L. (2000). Health and Environment of Rural Families: Results of a Community Canvass Survey in the Prairie Ecosystem Study (PECOS), *Journal of Agricultural Safety and Health*, 6(2), pp. 103-115.
- Messing, K., Neis, B., and Dumais, L. (1995). Can't Get my Breath: Occupational Asthma and Women Snow Crab Processing Workers, in *Invisible: Issues in Women's Occupational Health/La Santé des travailleuses*, Charlottetown: Gynergy Books, pp. 3-28.
- Messing, K., Neis, B., and Dumais, L. (1995). *Invisible: Issues in Women's Occupational Health/La Santé des travailleuses*, Charlottetown: Gynergy Books.
- Neis, B. (1994). Occupational Health and Safety of Women Working in Fish and Crab Processing in Newfoundland and Labrador, *Chronic Diseases in Canada*, 15(1), pp. 6-11.
- Neis, B., Grzetic, B., and Pigeon, M. (2001, April). *From Fishplant to Nickel Smelter: Health Determinants and the Health of Newfoundland's Women Fish and Shellfish Processors in an Environment of Restructuring*, National Network on Environments and Women's Health/Centres of Excellence for Women's Health, Newfoundland.
- Neis, B. (1997). Social Effects of One-Industry Fishery Villages, in *Encyclopaedia of Occupational Safety and Health, 4th edition*, Geneva: ILO, pp. 66.13-66.14.
- Roberts, R. (2001, October 18-21). *Pesticide Exposure and Breast Cancer Risk in Canada: A Case Control Study*, presented at the Health Research in Rural and Remote Canada: Taking the Next Steps Conference, Saskatoon, Saskatchewan.

Place

- Bourne, L., and Rose, D. (2001). The Changing Face of Canada: The uneven geographies of population and social change, *The Canadian Geographer*, 45(1), pp. 105-119.
- Rosenberg, M., W., and Wilson, K. (2000, July). Gender, Poverty and Location: How much Difference do they make in the Geography of Health Inequalities, *Social Science & Medicine*, 51(2), pp. 275-287.
- Thurston, W., and Meadows, L. (2001, October 18-21). *The Role of Place in the Health of Mid-Life Rural Women*, presented at the Health Research In Rural and Remote Canada: Taking Next Steps Conference, Saskatoon, Saskatchewan.
- Williams, A., M. (1996). The Development of Ontario's Home Care Program: A Critical Geographical Analysis, *Social Science and Medicine*, 42(6), pp. 937-948.

Poverty and Economics

- Berthelot, J.-M., Ross, N., and Tremblay, S. (2002). *Regional Socio-economic Context and Health*, Ottawa: Statistics Canada.
- Botting, I., Neis, B., Kealey, L., and Solberg, S. (2000, July). *Health Care Restructuring and Privatization from Women's Perspectives in Newfoundland and Labrador*, National Network on Environments and Women's Health.
- Conseil du Statut de la Femme. (December 2000). *Les conditions de vie des femmes et le développement local et régional en Chaudière-Appalaches*, (Collection "Femmes et développement des régions," Ed.).
- Conseil du Statut de la Femme. (January 2000). *Les conditions de vie des femmes et le développement local et régional dans le Bas-Saint-Laurent*, (Collection "Femmes et développement des régions," Ed.).
- Conseil du Statut de la Femme. (January 2000). *Les conditions de vie des femmes et le développement local et régional dans l'Outaouais*, (Collection "Femmes et développement des régions," Ed.).
- Conseil du Statut de la Femme. (July 1999). *Les conditions de vie des femmes et le développement local et régional en Abitibi-Témiscamingue*, (Collection "Femmes et développement des régions," Ed.).
- Conseil du Statut de la Femme. (June 2001). *Les conditions de vie des femmes et le développement local et régional dans Lanaudière*, (Collection "Femmes et développement des régions," Ed.).
- Conseil du Statut de la Femme. (March 2000). *Les conditions de vie des femmes et le développement local et régional en Gaspésie, Îles-de-la-Madeleine*, (Collection "Femmes et développement des régions," Ed.).
- Donner, L. (2000). *Women, Income and Health in Manitoba: An Overview and Ideas for Action*, Winnipeg, Manitoba: Women's Health Clinic.
- Fast, J., Eales, J., and Keating, N. (2001, March). Economic Impact of Health, Income Security and Labour Policies on Informal Caregivers of Frail Seniors, [www.swc-cfc.gc.ca/publish/research/010514-0662564765-e.html], *paper*, Status of Women Canada.
- Gandy, K. (2001). *Single Parent Women's Experiences Performing the Required Tasks of Health Provider for Their Families*, 00/01-ST1, funded by the Maritime Centre of Excellence for Women's Health.
- Lawn, J., and Harvey, D. (2001). *Change in Nutrition and Food Security in Two Inuit Communities, 1992-97*, Ottawa: Indian and Northern Affairs Canada, p. 124.
- Lévesque, C., Trudeau, N., Bacon, J., Montpetit, C., Cheezo, M.-A., Lamontagne, M., and Sioui Wawanoloath, C. (2001, May). *Aboriginal Women and Jobs: Challenges and Issues for Employability Programs in Quebec*, (Le Partenariat Mikimon for Status of Women Canada), Association des femmes autochtones du Québec.
- Lord, S. *Social and Economic Stress and Women's Health in Fishing Communities*, Maritime Centre of Excellence in Women's Health.
- Macdougall, P. J. (1992). *Feminization of Poverty: Personal accounts of rural single parent mothers*, unpublished doctoral dissertation, Acadia University (Wolfville).
- Martel, C., and Poussart, B. (1997). *Portrait Socio-économique des femmes du Québec et de ses régions*, Conseil du statut de la femme, Québec.
- Morton, M., and Loos, C. (1995, Fall). Does Universal Health Care Coverage Mean Universal Accessibility? *Women's Health Issues*, 5(3), pp. 139-142.

- Neis, B., Grzetic, B., and Pigeon, M. (2001, April). *From Fishplant to Nickel Smelter: Health Determinants and the Health of Newfoundland's Women Fish and Shellfish Processors in an Environment of Restructuring*, National Network on Environments and Women's Health/Centres of Excellence for Women's Health, Newfoundland.
- Prairie Women's Health Centre of Excellence. (2001). *Action Plan for Women's Health in Manitoba and Saskatchewan: Key Priorities and Strategies*.
- Purdon, C. (2002). *Rural Women Speak About the Face of Poverty*, Rural Women and Poverty Action Committee, Grey Bruce and Huron Counties, Ontario: Status of Women Canada.
- Reutter, L., Neufeld, A., and Harrison, M. (2000, June). A Review of the Research on the Health of Low-Income Canadian Women. *Canadian Journal of Nursing Research*, 32(1), pp. 75-97.
- Rosenberg, M., W., and Wilson, K. (2000, July). Gender, Poverty and Location: How much Difference do they make in the Geography of Health Inequalities, *Social Science & Medicine*, 51(2), pp. 275-287.
- Steele, M. (2002, July). *Housing Options for Women Living Alone in Rural Areas—Final Report*, Canadian Mortgage and Housing Corporation, (CMHC), External Research Program, Research Report.

Pregnancy, Obstetrics, Childbirth and Breastfeeding

- Bartellas, E., Crane J. M., Daley, M., Bennett, K., and Hutchens, D. (2000, August). Sexuality and Sexual Activity in Pregnancy, *British Journal of Obstetrics and Gynaecology*, 107(8), pp. 964-968.
- Benoit, C., and Caroll, D. (2001, Spring, Vol 4, No 3). Aboriginal Midwifery in Canada: Blending Ancient Traditions and Emerging Forms, *Network Magazine*.
- Bourgeault, I. L. (2002, July). When Services Just Aren't There: Activism among Canadian Mothers. In *Performing Motherhood: Ideology, Agency and Experience Conference*, La Trobe University, Melbourne, Australia.
- Bourgeault, I. L., and Sutherns, R. (2001, Octobre 18-21). *Rural Women's Experiences with Health Information and Resources*, presented at the Health Research in the Rural and Remote Canada: Taking the Next Steps, Saskatoon, Saskatchewan.
- Bourgoin, G., Lahaie, N., Berber, M., Dovigi, C., Picard, L., and Sahai, V. (1997). Factors Influencing the Duration of Breastfeeding in the Sudbury Region, *Canadian Journal of Public Health*, 88(4), pp. 238-241.
- Browne, A. J., Shultis, J., and Watts, M. (1999). Solution-Focused Approaches to Tobacco Reduction with Disadvantaged Prenatal Clients, *Journal of Community Health Nursing*, 16(3), pp. 165-177.
- Buske, L. (2000). Availability of Services in Rural Areas, *Canadian Medical Association Journal*, 162, p. 1193.
- Caroll, J., Brown, J., Reide, A., and Pugh, P. (2000, March). Women's Experiences of Maternal Serum Screening, *Canadian Family Physician*, 46, pp. 405-418.
- Davinson, K. *Factors Influencing Early Prenatal Enrolment in Programs for High Risk Women: Assessment of a Health Program Database*, The British Columbia Pregnancy Outreach Program, M.A. thesis, University of British Columbia (Rural and Remote Health Research Website).
- DeLeeuw, S. (1998). *Young Women's Health Needs in Isolated Northern Communities*, WCC98-7, funded by the British Columbia Centre of Excellence for Women's Health.

- Dion Stout, M., Kipling, G., and Stout, R. (2001, May). *Aboriginal Women's Health Research: Synthesis Report*, Centres of Excellence for Women's Health.
- Harris, S. B., Caulfield, L. E., Sugamori, M. E., Whalen, E. A., and Henning, B. (1997). The Epidemiology of Diabetes in Pregnant Native Canadians, *Diabetes Care*, 20(9), pp. 1422-1425.
- Hutten-Czapski, P. (1999, August 16). *Rural Midwifery*, (Society of Rural Physicians of Canada).
- Hutten-Czapski, P., A. (1999, Spring). Decline of Obstetrical Services in Northern Ontario, *Canadian Journal of Rural Medicine*, 4(2), pp. 72-76.
- Iglesias, S., and Hutten-Czapski, P., A. (1999). Joint Position paper on Training for Rural Family Practitioners in Advanced Maternity Skills and Cesarean Section, *Canadian Journal of Rural Medicine*, 4(4), pp. 209-216.
- Jasen, P. (1997, December). Race, Culture and the Colonization of Childbirth in Northern Canada, *Social History of Medicine*, 10(3), pp. 383-400.
- Kioke, S. (2001, October 18-21). *Revisiting the Past. Discovering Traditional Care and the Cultural Meaning of Pregnancy and Birth in a Cree Community*, presented at the Health Research In Rural and Remote Canada: Taking the Next Steps Conference, Saskatoon, Saskatchewan.
- Klassen, D. R., and Schubert, D. P. (1996). *Survey on Adolescent Knowledge of Sexuality*, Family Medicine North Residency Program, Health Sciences North, McMaster University, Thunder Bay, Ontario.
- Klein, M. C., Christilaw, J., and Johnston, S. (2002). Loss of Maternity Care: The Cascade of Unforeseen Dangers, *Canadian Journal of Rural Medicine*, 7(2), pp. 120-121.
- Loos, C., and Morton, L. (1999). The Value of Using a Prenatal Education Planning Model: Application to an Aboriginal Community, *The Journal of Perinatal Education*, 8(1), pp. 1-9.
- Luce, J. (1998). *Assessing Assisted Reproduction: Experiences of Lesbian and Bisexual Women Living in Northern Communities*, WCC98-8, funded by the British Columbia Centre of Excellence for Women's Health.
- MacLeod, M., and Zimmer, L. (Work in Progress). *Perinatal Services: Assessing the Needs of Special Populations*, University of B.C.
- McIlwain, R., and Smith, S. (2000). Obstetrics in a Small Isolated Community: The cesarean section dilemma, *Canadian Journal of Rural Medicine*, 5(4), pp. 221-223.
- Medical Post. (1996, September 10). Birthing Programs Valuable in Isolated Areas, *Medical Post*, 32(30), p. 80.
- Miskelly, M. *Teenage Pregnancy and Low Birth-Weight in Infants*, M.A. thesis, University of Northern British Columbia, (Rural and Remote Health Research Website).
- Morton, M., and Loos, C. (1995, Fall). Does Universal Health Care Coverage Mean Universal Accessibility? *Women's Health Issues*, 5(3), pp. 139-142.
- Mpofu, D., McDuffie, H., Rennie, D., Stefiuk, W., and Turnell, R. (2001, October 18-21). *Discharge of Mothers and Babies from Hospital after Birth of a Health Full-term Infant: What are the Health Consequences for Rural and Urban Women in Saskatoon Health District?* presented at the Health Research in Rural and Remote Canada: Taking the Next Steps Conference, Saskatoon, Saskatchewan.
- Muckle, G., Ayotte, P., Dewailly, E., Jacogson, S. W., and Jacobson, J. L. (2001). Prenatal Exposure of Northern Quebec Inuit Infants to Environmental Contaminants. *Environmental Health Perspectives—New Series*, 109(12), pp. 1291-1301.
- Northwestern Ontario Women's Health Network and Redlake Women's Information Group. (1990). *Long Distance Delivery: A guide to travelling away from home to give birth*, Rexdale, Ontario: Helmsman Press Ltd.

- Pavan, L. A., and Makin, M. (2000). Review of Cesarean Sections at a Rural British Columbian Hospital: Is there room for improvement? *Canadian Journal of Rural Medicine*, 5(4), pp. 201-207.
- Permaul-Woods, J., Carroll, J., Reid, A., Woodward, C., Ryan, G., Domb, S., Arbitman, S., Fallis, B., and Kilthei, J. (1999). Going the Distance: *Canadian Medical Association Journal*, 161(4), pp. 381-385.
- Poole, N., and Isaac, B. *Apprehensions: Barriers to Treatment for Substance-Using Mothers*, HWHC9-1, funded by the British Columbia Centre of Excellence for Women's Health.
- Prairie Women's Health Centre of Excellence. (2001). *Action Plan for Women's Health in Manitoba and Saskatchewan: Key Priorities and Strategies*.
- Rowntree, C., Irvine, H., Thompson, J., Larsen, D., and Morse, J. (1994, December 22). *Rural Physicians' Perspective on Midwifery in Sunde Alberta*, Society of Rural Physicians of Canada, Rural Medicine Articles, Library.
- Rupert, H., and Lai, D. (1988, Winter). Long Distance Delivery, *Healthsharing*.
- Rural Obstetrics Joint Working Group. (1998, Spring). Rural Obstetrics: Joint position paper on rural maternity care, *Canadian Journal of Rural Medicine*, 3(2), p. 75.
- Sokoloski, E. A. (1995, Spring). Canadian First Nations Women's Beliefs about Pregnancy and Prenatal Care, *Canadian Journal of Nursing Research*, 27(1), pp. 89-100.
- Stretch, N., C., and Knight, C., A. (2002). Community Obstetrics: A new look at group obstetrical care in rural communities, *Canadian Journal of Rural Medicine*, 7(3), pp. 183-190.
- Sugamori, D. M. (1994). *Epidemiology of Pregnancy Outcomes among Native Women of the Sioux Lookout Zone*, Family Medicine North Residency Program, Health Sciences North, McMaster University, Thunder Bay, Ontario.
- Sutherns, R. (2001). *Women's Experiences of Maternity Care in Rural Ontario: Do Doctors Matter?* doctoral dissertation, University of Guelph, 375 pages.
- Sutherns, R., and Bourgeault, I. L. (2001, October 18-21). *Crisis? The Untold Story of Women's Experiences with Maternity Care in Rural Canada*, presented at the Health Research in Rural and Remote Canada: Taking the Next Steps, Saskatoon, Saskatchewan.
- Torr, E. (2000). Report on the Findings of the Consensus Conference on Obstetrical Services in Rural or Remote Communities, Vancouver, BC, Feb. 24-26, 2000, *Canadian Journal of Rural Medicine*, 5(4), pp. 211-217.
- Tromp, M., and Iglesias, S. (2001). Discussion paper on Rural Obstetrical Analgesia and Anesthesia, *Canadian Journal of Rural Medicine*, 6(4), pp. 255-259.
- Webber, G., and Wilson, R. (1993, April). Childbirth in the North, *Canadian Family Physician*, 39, pp. 781-788.
- Williams, R., and Gloster, S. (1999, November). Knowledge of Fetal Alcohol Syndrome (FAS) among Natives in Northern Manitoba, *Journal of Studies on Alcohol*, 60(6), pp. 833-836.
- Wysong, P. (1998, July 21). National Forum outlines 14-point Program to Save Rural Obstetrics: Saskatchewan tries novel approach to upgrade delivery skills, *Medical Post*, 34(26), p. 16.

Rural-Urban Comparative Analysis

- Berthelot, J.-M., Ross, N., and Tremblay, S. (2002). *Regional Socio-economic Context and Health*, Ottawa: Statistics Canada.
- Bryant, H., and Mah, Z. (1992, July). Breast Cancer Screening: Attitudes and Behaviors of Rural and Urban Women, *Preventive Medicine*, 21(4), pp. 405-418.

- Côté, J., Ouellet, L., and Caron, M. (1993). *La Réinsertion sociale en milieu rural et urbain : Opinion des citoyens à l'égard des personnes avec une maladie mentale*, Ministère de la santé et des services sociaux, Quebec: Centre de recherche Université Laval Robert-Giffard.
- Forbes, D. (2001, October 18-21). *Closing the Gap between what is Known and Practiced among Rural and Urban Elder Caregivers*, presented at the Health Research in Rural and Remote Canada: Taking the Next Steps, Saskatoon, Saskatchewan.
- Hornosty, J. (1995). Wife Abuse in Rural Regions: Structural Problems in Leaving Abusive Relationships, (a case study in Canada), available: www.hc-sc.gc.ca/hppb/family.ed_inventory/english/section_1.htm, (accessed 25072001).
- James, A., M. (1994). *Aging in Urban and Rural Areas: Where are the differences? A study of health care utilization by the elderly population of eastern Ontario*, unpublished doctoral dissertation, Queen's University, Kingston, p. 309.
- Leipert, B. *How Women Maintain Their Health in Northern Geographically Isolated Settings*, University of Northern British Columbia, (Rural and Remote Health Research Web site).
- Manual, D., Goel, B., Williams, J., and Corey, P. (2000). Health-Adjusted Life Expectancy at the Local Level in Ontario, *Chronic Disease Canada*, 21(2), pp. 73-80.
- Maxwell, C., Kozak, J., Desjardins-Denault, S., and Parboosingh, J. (1997, September-October). Factors Important in Promoting Mammography Screening Among Canadian Women, *Canadian Journal of Public Health*, 88(5), pp. 346-350.
- Parikha, S. V., Wasylenkia, D., Goeringa, P., and Wonga, J. (1996, April 26). Mood Disorders: Rural/urban differences in prevalence, health care utilization, and disability in Ontario, *Journal of Affective Disorders*, 38(1), pp. 57-65.
- Permaul-Woods, J., Carroll, J., Reid, A., Woodward, C., Ryan, G., Domb, S., Arbitman, S., Fallis, B., and Kilthei, J. (1999). Going the Distance: *Canadian Medical Association Journal*, 161(4), pp. 381-385.
- Phimister, E., Vera-Toscano, E., and Weersink, A. (2002, February). Female Participation and Labour Market Attachment in Rural Canada, *American Journal of Agricultural Economics*, 84(1), pp. 210-221.
- Poole, N., and Isaac, B. *Apprehensions: Barriers to Treatment for Substance-Using Mothers*, HWHC9-1, funded by the British Columbia Centre of Excellence for Women's Health.
- Robinson, R. (2001, October 18-21). *Rural-urban Differences in Mental Health Status*, presented at the Health Research in Rural and Remote Canada: Taking the Next Steps, Saskatoon, Saskatchewan.
- Sweet, L. E., Macdonald, S. M., Reeder, B. A., Chen, Y., and Angel, A. (1997, July 1). Regional and Rural-Urban Differences in Obesity in Canada, *Canadian Medical Association Journal*, 157(1), pp. S10-S16.
- Thomlinson, E. (2001, October 18-21). *Rural and Northern Health Beliefs and Practices*, presented at the Health Research in Rural and Remote Canada: Taking the Next Steps, Saskatoon, Saskatchewan.

Substance Abuse

- Cardwell, M. (1998, May 26). Drug Use a Threat to Canadian Natives, *Medical Post*, 34(20), pp. 32-33.
- Currie, J. C. (2001). Best Practices: Treatment and Rehabilitation for Women with Substance Abuse Problems, [www.hc-sc.gc.ca/hppb/cds-sca/cds/pdf/women-e.pdf], Health Canada.

- Davis, K. (1982). *Networking in Northwestern Ontario: Women, Addictions and Preventative Health Strategy*, Northwestern Ontario International Women's Decade Council, funded by Health Promotion Directorate, Health Services and Promotion Branch, Health and Welfare Canada.
- Dion Stout, M., Kipling, G., and Stout, R. (2001, May). *Aboriginal Women's Health Research: Synthesis Report*, Centres of Excellence for Women's Health.
- Graveline, M., J. (1986). *Northern Native Wife Abuse Prevention Demonstration Project*, (Canada. First Nations and Inuit Health Programs Directorate. Health Programs Support Division; Thompson Crisis Centre, Thompson, MB: Thompson Crisis Centre, p. 57.
- Health Canada. (1996). *Rural Women and Substance Use: Issues and Implications for Programming*, Health Canada, Health Promotion and Programs Branch, Office of Alcohol, Drugs and Dependency Issues, Ottawa: Author, p. 49.
- Office of Alcohol, D. a. D. I., Health Promotion and Programs Branch. *Consommation d'alcool et d'autres drogues chez les femmes en milieu rural: De la problématique aux programmes*, [www.hc-sc.gc.ca/hppb/alcool-autresdrogues/pdf?rural_f.pdf], Health Canada Publications.
- O'Gorman, K. (2001, Summer/Fall). Northern Women's Health Outreach Project, *Canadian Woman Studies*, 21(2), pp. 113-115.
- Pauktuutit Inuit Women's Association. *A Community Perspective on Health Promotion and Substance Abuse*, Pauktuutit Inuit Women's Association.
- Poole, N. (2001, Spring). Bicultural Organizing on Women and Addictions in B.C. *The Network Magazine, Canadian Women's Health Network*, 4(2).
- Poole, N., and Isaac, B. *Apprehensions: Barriers to Treatment for Substance-Using Mothers*, HWHC9-1, funded by the British Columbia Centre of Excellence for Women's Health.
- Ross, H., and Shirley, M. (1997, February). Life-time Problem Drinking and Psychiatric Co-morbidity among Ontario Women, *Addiction*, 92(2), p. 183.
- Williams, R., and Gloster, S. (1999, November). Knowledge of Fetal Alcohol Syndrome (FAS) among Natives in Northern Manitoba, *Journal of Studies on Alcohol*, 60(6), pp. 833-836.

Well-Being

- Gerrard, N. (2001, October 18-21). *Building Resiliency for Rural Life*, presented at the Health Research in Rural and Remote Canada: Taking the Next Steps, Saskatoon, Saskatchewan.
- Kubick, W., and Moore, R. J. (2001, October 18-21). *Women's Diverse Roles in the Farm Economy and the Consequences for their Health, Well-being and Quality of Life*, presented at the Health Research in Rural and Remote Canada: Taking the Next Steps, Saskatoon, Saskatchewan.
- van Roosmalen, E. (1998). *Women's Voices: Women's Perceptions of the Determinants of Health and Well Being, 97/98-Project 1*, funded by the Maritime Centre of Excellence for Women's Health.

Work

- Binkley, M. (2002). *Set Adrift: Fishing Families*, [diss], Toronto: University of Toronto Press.
- Denham, D., and Gillespie, J. (1994). *Work place Learnings about Women Abuse: A guide for change II*, Family Violence Prevention Division, Health Canada.

- Eakin, J., and Brooker, A. (1998, June). *The Restructuring of Work and Women's Health: An Annotated Bibliography*, National Network for the Environment and Women's Health.
- Fast, J., Eales, J., and Keating, N. (2001, March). Economic Impact of Health, Income Security and Labour Policies on Informal Caregivers of Frail Seniors, [www.swc-cfc.gc.ca/publish/resarch/010514-0662564765-e.html], paper, Status of Women Canada.
- Ferrie, J. (1997). Labour Market Status, Insecurity and Health, *Journal of Health Psychology*, 2(3), pp. 373-397.
- Keefe, S. (2002). *Skipper of the Shore Crew: Women and a Fish Plant Closure*, unpublished doctoral dissertation, Wilfred Laurier University, Psychology.
- Leach, B., and Winson, A. (1995). Bringing "globalization" down to Earth: Restructuring and Labour in Rural Communities, *The Canadian Review of Sociology and Anthropology*, 32(3), pp. 341-364.
- Leach, B. (2000). Transforming Rural Livelihoods: Gender, Work, and Restructuring in Three Ontario Communities, in S. Naysmith (Ed.), *Restructuring Caring Labour: Discourse, State Practice, and Everyday Life*, Toronto: Oxford University Press, pp. 209-225.
- Lévesque, C., Trudeau, N., Bacon, J., Montpetit, C., Cheezo, M.-A., Lamontagne, M., and Sioui Wawanoloath, C. (2001, May). *Aboriginal Women and Jobs: Challenges and Issues for Employability Programs in Quebec*, (Le Partenariat Mikimon for Status of Women Canada), Association des femmes autochtones du Québec.
- Martel, C., and Poussart, B. (1997). *Portrait socio-economique des femmes du québec et de ses régions*, Conseil du statut de la femme, Quebec.
- Neis, B., and Williams, S. (1996). "Women and children first: The impacts of fishery collapse on women in Newfoundland and Labrador," *Cultural Survival Quarterly*, Spring, pp. 67-71.
- Northwestern Ontario Women's Decade Council. (1991). *Project Mayday: Mayday in the Community. A Research Study on Women's Experiences in North Shore Single Industry Towns, Mannitouwadge, Marathon Schreiber and Terrace Bay*.
- Phimister, E., Vera-Toscano, E., and Weersink, A. (2002, February). Female Participation and Labour Market Attachment in Rural Canada, *American Journal of Agricultural Economics*, 84(1), pp. 210-221.
- Phimister, E., Vera-Toscano, E., and Weersink, A. (2001). *Female Employment Rates and Labour Market Attachment in Rural Canada*, Analytical Branch Research paper Series, Ottawa: Statistics Canada.
- Skillen, L. (2001). *Reflections of Rural Alberta Women: Work, Health and Restructuring*, University of Alberta, funded by the National Network on Environments and Women's Health.
- Statistics Canada. (2003). *Gender balance of employment in rural and small town Canada, 1987-1999*, Ottawa: Author.
- Williams, S. (1996). *Our Lives are at Stake: Women and the Fishery Crisis in Newfoundland and Labrador*, (Tech. Rep. No. ISER Report No. 11), St. John's, Newfoundland: Institute of Social and Economic Research, Memorial University.
- Winson, A., and Leach, B. (2002, November 23). *Contingent Work, Disrupted Lives: Labour and Community in the New Rural Economy*, Toronto: University of Toronto Press.



The following sources address two of the three core themes of rurality, women and health, with the third being implicit. Also included here is a list of sources that

explicitly include rural populations in their datasets but do not necessarily analyze rurality itself.

Rural Health (Women Implicit)

- Armstrong, R. P. (2001). *The Geographical Patterns of Socio-economic Well-Being of First Nations Communities*, Agriculture and Rural Working paper Series, Ottawa: Statistics Canada.
- Berthelot, J.-M., Ross, N., and Tremblay, S. (2002). *Regional Socio-economic Context and Health*, Ottawa: Statistics Canada.
- Bollman, R. D., Owens, D., and Thompson-James, M. (2001). *Measuring Economic Well-Being of Rural Canadians Using Income*, Agriculture and Rural Working paper Series, Ottawa: Statistics Canada.
- Centre de santé communautaire de l'Estrie. (1996). *Études des besoins en santé de la population Francophone des communautés de Stormont, Dundas et Glengarry*, Centre de santé communautaire de l'Estrie, Cornwall.
- Crump, J. (2001, January 9). Phone Tag: Family doctors in remote settings find they are spending a lot of time on the phone searching for specialists and trying to convince them to see their patients, *Medical Post*, 37(1), p. 37.
- Daniel, M., and Gamble, D. (1995). Diabetes and Canada's Aboriginal Peoples: The Need for Primary Prevention, *International Journal of Nursing Studies*, 32(3), pp. 243-259.
- Driver, D. (1999, May 18). Emergency Program Brings Rural Kids to Cities, *Medical Post*, 35(19), p. 47.
- Dupré-Ollinik, M., and François, J. (1999). *L'adolescence et la santé: Une perspective franco-manitobaine* (Pluri-elles inc.), Winnipeg.
- Farkas, C. (1986, June). Ethno-specific Communication Patterns: Implications for nutrition, *Journal of Nutrition Education*, 18(3), pp. 99-103.
- Hutten-Czapski, P. (2002, June). The State of Rural Health Care, *Canadian Journal of Rural Medicine, Presentation To The Standing Senate Committee on Social Affairs, Science and Technology, May 31, 2002*.
- James, A., M. (1994). *Aging in Urban and Rural Areas: Where are the differences? A study of health care utilization by the elderly population of eastern Ontario*, unpublished doctoral dissertation, Queen's University, Kingston, p. 309.



- Kirmayer, L., Brass, G., and Tait, C. (2000). The Mental Health of Aboriginal Peoples: Transformation of Identity and Community, *Canadian Journal of Psychiatry*, 45(7), pp. 607-616.
- Kirmayer, L. J., Boothroyd, L. J., Tanner, A., Adelson, N., and Robinson, E. (2000, March 1). Psychological Distress Among the Cree of James Bay, *Transcultural Psychiatry*, 37(1).
- Leenars, A., A. (2000, Fall). Suicide Prevention in Canada: A History of a Community Approach. *Canadian Journal of Community Mental Health-Special Issue*, 19(2), pp. 57-73.
- Mavin, R. (1993). *Housing the Rural Elderly: Exploring the potential for the Abbeyfield model*, unpublished doctoral dissertation, University of Guelph, p. 153.
- Ng, E., Wilkins, R., Pole, J., and Adams, O. (1999, March). How Far is the Nearest Physician? *Rural and Small Town Canadian Analysis Bulletin*, 1(5).
- Pittaway, E. (1990). Leisure Lifestyle and Perceived Social Support of Older Adults in Rural Environment, (doctoral dissertation, WLU, 1990), DAI, 52, 4092-.
- Pong, R., W., Akinson, A. M., Irvine, A., MacLeod, M., Minore, B., Pegoraro, A., Pitblado, J. R., Stoes, M., and Tesson, G. (1999, October 18-21). *Rural Health Research in the Canadian Institutes of Health Research*, presented at the Rural Health Research Consortium Conference, Saskatoon, Saskatchewan.
- Raiwet, C. (1990). *As Long As We Have Health: The experience of age-related physical change for rural elderly couples*, unpublished doctoral dissertation, University of Alberta (Edmonton).
- Robinson, R. (2001, October 18-21). *Rural-urban Differences in Mental Health Status*, presented at the Health Research in Rural and Remote Canada: Taking the Next Steps, Saskatoon, Saskatchewan.
- Statistics Canada. Rural and Small Town Canada Analysis Bulletin Series. (This is a series of bulletins on issues in rural Canada, many of which are relevant to women's health, including employment, income disparities, distances to physicians and housing conditions.)
- Thomlinson, E. (2001, October 18-21). *Rural and Northern Health Beliefs and Practices*, presented at the Health Research in Rural and Remote Canada: Taking the Next Steps, Saskatoon, Saskatchewan.
- Wein, E. (1986, Winter). Nutrition of Northern Native Canadians, *Canadian Home Economics Journal*, 36(1), pp. 25-25.
- Williams, A., M. (1996). The Development of Ontario's Home Care Program: A Critical Geographical Analysis, *Social Science and Medicine*, 42(6), pp. 937-948.
- Williams, R., and Gloster, S. (1999, November). Knowledge of Fetal Alcohol Syndrome (FAS) among Natives in Northern Manitoba, *Journal of Studies on Alcohol*, 60(6), pp. 833-836.
- Wilson, K., Crupi, C., Greene, G., Gaulin-Jones, B., Dehouz, E., and Korol, C. (1995, October). Consumer Satisfaction with a Rehabilitation Mobile Outreach Program, *Archives of Physical Medicine and Rehabilitation mobile outreach program*, 10(Archives of Physical Medicine and Rehabilitation), p. 76.
- Winson, A., and Leach, B. (2002, November 23). *Contingent Work, Disrupted Lives: Labour and Community in the New Rural Economy*, Toronto: University of Toronto Press.
- Young, T., and Sevenhuysen, G. (1989, May). Obesity in Northern Canadian Indians: Patterns, determinants, and consequences, *American Journal of Clinical Nutrition*, 49(5), pp. 786-793.

Rural Women (Health Implicit)

- Boivin, M. (1987). Les agricultrices : Un travail à reconnaître sur les plans juridique et économique, (Farm women: Work that needs to be recognized economically and legally), in *Place aux femmes dans l'agriculture (Women's Place in Agriculture)*, Conseil consultatif canadien sur la situation de la femme, Ottawa, pp. 54-71.
- Kenchnie, M., and Reitsma-Street, M. (1996). *Changing Lives: Women in Northern Ontario*, Toronto and Oxford: Dundurn Press.
- Purdon, C. (2002). *Rural Women Speak About the Face of Poverty*, (Rural Women and Poverty Action Committee), Grey Bruce and Huron Counties, Ontario: Status of Women Canada.

Women's Health (Rural Implicit)

- Andrew, C., Bouchard, L., Boudreau, F., and Cardinal, L. (1997). *Les Conditions de possibilités des services de santé et des services sociaux en français en Ontario: Un enjeu pour les femmes*, (Table féministe francophone de concertation provinciale de l'Ontario), Ottawa.
- Belanger, H. C. (1994). *La Santé des Femmes, (The Health of Women)*, Maloine: Fédération des médecins omnipraticiens du Québec, Edisem Inc.
- Bouchard, N., Gilbert, C., Tremblay, M., under the direction of Menard, and Villeneuve, F. (1996). *Les Solidarités Fragiles : Les Femmes et la Prise en charge de personnes en perte d'autonomie, (Fragile Solidarity: Women and Assistance for Individuals Lose Autonomy)*, Actes du Congrès 1996 de la Société canadienne de théologie, Projet de société et lectures chrétiennes., Quebec, pp. 171-186.
- Calhoun, S., and Johnston, W. (2001). *Growing Up Female in New Brunswick, 1979-2000*. New Brunswick: New Brunswick Advisory Council on the Status of Women.
- Coleman, R. (2000, February). *Women's Health in Atlantic Canada: A Statistical Portrait*, The Maritime Centre of Excellence for Women's Health.
- Denham, D., and Gillespie, J. (1992). *Wife Abuse: A Workplace Issue*, Family Violence Program: Canadian Council on Social Development, Health Canada.
- Donner, L. (2000). *Women, Income and Health in Manitoba: An Overview and Ideas for Action*, Winnipeg, Manitoba: Women's Health Clinic.
- Eakin, J., and Brooker, A. (1998, June). *The Restructuring of Work and Women's Health: An Annotated Bibliography*, National Network for the Environment and Women's Health.
- Fuller, C. (1999). *Reformed or Rerouted? Women and Change in the Health Care System*, Vancouver, British Columbia: British Columbia Centre of Excellence for Women's Health.
- Fuller, C. (1999). *Reformed or Rerouted? Women and Change in the Health Care System*, Vancouver, British Columbia: British Columbia Centre of Excellence for Women's Health.
- Heaman, M. (2001, December). Conducting Health Research with Vulnerable Women: Issues and Strategies, *The Canadian Journal of Nursing Research*, 33(3), pp. 81-86.
- Kosny, A. *The Social Determinants of Health & Equity Across the Life Span*, Maritime Centre of Excellence for Women's Health.
- MacLeod, L., and Kinnon, D. (2000). *Taking the Next Step to Stop Women Abuse: From Violence Prevention to Individual, Family, Community and Societal Health*, Health Canada.
- National Clearinghouse on Family Violence. Woman Abuse/Violence Against Women [www.hc-sc.gc.ca/hppb/family.ed_inventory/english/section_1.html], *Annotated Bibliography* (Vol. Health Canada), Health Canada.

- Payne, B., Grant, K., and Gregory, D. (2001, September 30). *Women's Caring Work in the Context of Manitoba Health Reform*, National Network on Environments and Women's Health.
- Reutter, L., Neufeld, A., and Harrison, M. (2000, June). A Review of the Research on the Health of Low-Income Canadian Women, *Canadian Journal of Nursing Research*, 32(1), pp. 75-97.
- Rosenberg, M., and Wilson, K. (2002). *Ambiguity in Geographies of Health and Health Care: The everyday experiences of women's health*. In *The role of ambiguity in health geography*, Association of American Geographers 2002 Annual Meeting.
- Tudiver, S., and Hall, M. Women and Health Care Delivery in Canada, [www.hc-sc.gc.ca/canusa/papers/canada/english/delivery.htm], paper, Health Canada Website (25072001).
- Women's Health Bureau. (2000). Women's Health Strategy, [www.hc-sc.gc.ca/femmes/english/womenstrat.htm], Health Canada (Ed.), Health Canada Web site (25072001).

Women's Health (Rural Participants)

- Black, M. E. A., Stein, K. F., and Loveland-Cherry, C. J. (2001, April). Older Women and Mammography Screening Behavior: Do Possible Selves Contribute? *Health Education and Behavior*, 28(2), pp. 200-216.
- Bouchard, N., Gilbert, C., and Tremblay, M. (1999). Des femmes et de soins. L'expérience des aidantes naturelles au Saguenay, *Recherches Feministes (Feminist Research)*, 12(1), pp. 63-81.
- Caroll, J., Brown, J., Reide, A., and Pugh, P. (2000, March). Women's Experiences of Maternal Serum Screening, *Canadian Family Physician*, 46, pp. 405-418.
- Crawford, B., Meana, M., Steward, D., and Cheung, A. M. (2000, April 9). Treatment Decision Making In Mature Adults: Gender Differences, *Health Care for Women International*, 21, pp. 91-104.
- Fast, J., Eales, J., and Keating, N. (2001, March). Economic Impact of Health, Income Security and Labour Policies on Informal Caregivers of Frail Seniors, [www.swc-cfc.gc.ca/publish/resarch/010514-0662564765-e.html], paper, Status of Women Canada.
- McClure, L., Heinonen, T., and Tudiver, S. (1997). *Women Survivors of Childhood Sexual Abuse: Knowledge and Preparation of Health Care Providers to Meet Client Needs*, 97-T2-048, funded by the Prairie Women's Health Centre of Excellence.
- Rathwell, T. (1999). *A Gender Equity Lens for the Health Policy Domain—A Canadian Gender Curriculum Educational Strategy*, 98/99-PF1, Maritime Centre of Excellence for Women's Health.
- Ross, H., and Shirley, M. (1997, February). Life-time Problem Drinking and Psychiatric Co-morbidity among Ontario Women, *Addiction*, 92(2), p. 183.
- Trute, B. (1988). *Medical Response to Wife Abuse in Manitoba: A Survey of Physicians' Attitudes and Practices: A Final Report*, University of Manitoba, School of Social Work, Child and Family Research Group, p. 27.
- Wakewich, P. (2000b). Contours of Everyday Life: Women's Reflections on Embodiment and Health Over Time, in J. M. S. a. V. A. Baukje Miedema (Ed.), *Women's Bodies Women's Lives: Health, Well-Being and Body Image*, pp. 237-253.

Analysis of the Literature

In this section, the strengths and weaknesses of the current Canadian literature on rural women's health will be discussed, in terms of the amount of material, the extent to

which it is readily available, and how it has been conducted. Key messages, debates and contradictions are summarized, and gaps in the literature are highlighted.

Scope and Sufficiency of the Literature

Consistent with the findings of Kimberley Gandy's 2001 study in rural Nova Scotia, rural women have largely been marginalized and invisible in the literature. Reasons for this include the frequent absence of gender analysis in health research, aggregation of rural and urban responses, and/or the exclusion of rural perspectives altogether.

Although the length of the thematic bibliography demonstrates that a considerable amount of work on the various facets of rural women's health in Canada has occurred, overall, the research is actually quite limited. Some themes relating to rural women's health in Canada have been researched more thoroughly than others, but even in the areas that have been relatively well addressed, much work remains to be done. The existence of several papers on a topic does not constitute a substantial literature. In many cases, existing research is limited to proposals, investigations in progress, or studies with very small sample sizes. Conclusions must therefore be considered preliminary and treated with some caution.

There is nevertheless a growing amount of research in the following areas:

- **Aboriginal women's health**
This category includes a number of well-researched topics, including diabetes; nutrition; cancer screening; violence, sexual abuse and substance abuse; mental health; childbirth and the importance of

cultural sensitivity in Aboriginal health research. This literature appears to be significantly stronger in English than in French.¹⁰ It does not always explicitly address the extent to which the Aboriginal women studied are living in rural or urban areas.

- **Abuse**
There is a growing literature on the unique challenges of abused women in rural communities, including the lack of anonymity, distance to services and scarcity of safe places for women experiencing violence. There are also several studies on addiction and substance abuse within rural populations.
- **Cancer**
Rates and promotion of breast and cervical cancer screening and experiences of dealing with breast cancer are well represented in the English literature, for Aboriginal and non-Aboriginal women. Other types of cancer are not explicitly addressed.
- **Caregiving**
Generally, research pays scant attention to home-based caregivers, yet this review includes several studies, in both French and English, which address the challenges, coping strategies and support needs of rural informal caregivers. Two reports explore the effects of health care reform on caregivers. Most English-

language research in this field has been commissioned by the Centres of Excellence for Women's Health across Canada.

- **Challenges of rural health care provision**

Although not always dealing explicitly with rural women's health, the relevant literature in this area addresses the difficulties in providing and accessing adequate health care in rural communities, particularly in the context of current health care reform. As the primary users of health care, scarcity of services affects women disproportionately. The scope of this review does not include all of the literature on recruitment and retention of rural health care professionals, but even in the rural women's health field, those topics are salient, particularly in terms of physicians and nurses.

The emphasis within this theme are on the perspectives of health care providers and on issues relating to accessibility of services. Although there is a growing trend toward letting women's voices shape research agendas, 'lay' perspectives are scarce in the research on formal health care provision in a rural context. Exceptions are studies on the importance of having female physicians in rural places (Ahmad et al., 2001 and Johnston 1998), and an investigation of women's perspectives on rural maternity care provision (Sutherns 2001).

- **Health care reform**

There are several recent studies on the process and the implications of health system reform on the lives of rural women in Canada, most of which have been commissioned by the Centres of Excellence for Women's Health. They

highlight the costs of reforms, particularly downloading and privatization, on rural women in various provinces, as well as the need to include rural women in decision-making structures.

- **Mental health**

Mental health concerns of rural women (Anglophone and Francophone, Aboriginal and non-Aboriginal) are well reflected in this literature, particularly when studies pertaining to violence are included. Specific areas of emphasis include the impacts of geographic and social isolation and employment insecurity on mental health, high incidences of stress and depression, and the need for more rural mental health services.

- **Occupational health**

Most of the Canadian occupational health and safety literature has concentrated on urban, industrial work environments and on the service sector. There is a growing literature on women's occupational health in Canada (see for example K. Messing (1998) *One-Eyed Science*, Temple University Press) and on women in non-traditional occupations. Within the rural women's health literature, the health concerns of farm women, particularly in terms of economic vulnerability and stress, are well represented, especially in French. There are also several studies that address women in the fishing industry. No studies were located that address women's health in other rural occupations such as mining and forestry, nor is there any literature on rural women in occupations not considered 'rural' themselves. There are some limited discussions, usually embedded within reports on other topics, of the adverse health effects of role strain experienced by rural women when juggling multiple responsibilities.

- **Older women**

Taken together, the number of studies on midlife women, aging and the elderly constitute a significant amount of rural health research. This is all the more striking when placed alongside the virtual absence of research on rural children and adolescents. Specific topics include breast cancer screening, caregiving, housing and the impacts of health reforms.

- **Reproductive health**

Reproductive health, including preg-

nancy, childbirth, obstetric care, midwifery and breastfeeding, is the theme containing the largest number of studies in this review. The challenges of rural obstetric care provision, particularly from the perspectives of physicians, are especially well documented in the Canadian Journal of Rural Medicine. Health experiences of younger women who do not have children are not addressed in current literature.

Accessibility of the Literature

As Colleen Fuller has pointed out, “If women hope to exert influence on the direction of health system reform—whether that influence is exerted at a governance,

provider or patient level—we will need not only information, but guaranteed access to the data” (1999, p. 35). Gathering the sources for this literature review has revealed strengths and weaknesses in terms of the accessibility of the data on rural women’s health in Canada. There is clearly work to be done in making the research more accessible

to a wider variety of audiences, particularly rural women themselves.

Accessibility of information requires finding out about information that exists, obtaining it, and being able to understand and use it. In terms of being aware of what data exists, there are websites, clearinghouses and databases that endeavour to link people with Canadian information. Although none is

devoted to rural women’s health, many offer materials in related fields. Examples of such resources include the Canadian Women’s Health Network, the Centres of Excellence

for Women’s Health, the Ontario Women’s Health Network and other provincial networks, and electronic journal indices such as Medline or the Canadian Journal of Rural Medicine. One strength of such varied resources is that they raise awareness of various types of information, from peer-reviewed academic studies to community reports to public lectures.

They cannot be exhaustive, however, and currently there is no single, clearly identified point of access to rural women’s health information, which inhibits both users and those seeking to disseminate information.

In terms of obtaining the information available, additional barriers exist. Electronic access may not be available, particularly for women in rural areas without Internet

Accessibility of information requires finding out about information that exists, obtaining it, and being able to understand and use it.

service provision. Not all relevant resources are available electronically for free, and the cost of obtaining them can be prohibitive. Many electronic databases even require a subscription, which is costly unless a user is affiliated with a post-secondary educational facility. In other cases, particularly with community-based reports, speeches or conference presentations, the means of contacting the authors is unclear. One exception to this may be government reports, which are usually available free of charge. Much of the French-language literature, for example, on rural women's health

has been produced or commissioned by the Quebec government and is therefore more readily available.

Finally, information is only accessible if it is easy to use. Too often, academic reports that are indexed and relatively readily available are not written in a style that allows for their insights to be easily understood and applied. Community-based reports, often written in a more widely accessible style, are harder to locate. They are also frequently based on smaller sample sizes or less rigorous methodology, making wide implementation of their conclusions more problematic.

Methodology

This section will review the methodologies within the Canadian literature on rural women's health in terms of who is conducting the research, how it has been being done, and the formats in which the results have been communicated. Answers to these questions not only give a fuller picture of the literature, but they also have a direct effect on the questions asked and the nature of the results generated.

The literature in this review comes largely out of the social science tradition.

Biomedical literature was included in the search, but very little relating explicitly to the health of rural women was located. Exceptions are studies addressing prevalence rates of particular medical conditions and procedures among rural populations, such as studies on diabetes, sexually transmitted diseases or cancer among Aboriginal Canadians (see Daniel and Gamble 1995; Harris 1997; Healey et al. 2001; Hegele et al. 2000a and 2000b; Hodgins et al. 2002), Brain's 1997 study on hysterectomy rates in Thunder Bay, or Sugamori's 1994 epidemiological study of pregnancy outcomes in

Sioux Lookout. Banks' 2001 report on Northern communities coping with Hepatitis C is an example of a sociological approach being taken to a biomedical issue.

In the English-language literature, many of the studies most directly related to rural women's health issues have come out of the Centres of Excellence for Women's Health, which have a demonstrated commitment to reaching marginalized women through applied research. (See Appendix B for a list of the reports relating to rural women's health commissioned or produced by the Centres of Excellence for Women's Health). Unfortunately, the same cannot be said for literature in French, insofar as this review did not locate any research directly relevant to the concerns of rural women produced out of the Quebec-based Centre of Excellence. The majority of French-language studies have been produced or commissioned by the Quebec government.

Another significant source of rural women's health information is the *Canadian Journal of Rural Medicine*. Published by the Canadian

Medical Association, this journal provides physicians' perspectives on rural health care provision.

In terms of research methods, the vast majority of the reports in this review stem from 'one-off' studies that use interviews, focus groups and small surveys to collect data from a limited number of participants. The exceptions to this would be a longitudinal study (see Gillis and Perry 1991) or those relying on large datasets (see Manual et al. 2000; Parikha et al. 1996; Phimister et al. 2002, Sweet et al. 1997). This emphasis on small-scale, qualitative research allows the voices of women to be clearly heard and the details of their lives to be communicated (see for example Donner 2000; Macdougall 1992; Merritt-Gray and Wuest 1995; Roberts and Falk 2002; van Roosmalen 1998; Sutherns 2001; Willms 1992). This occurs, however, at the expense of generalizability. This tension is reflected in feminist research more broadly, in which methods have frequently been chosen in part in reaction against the dominant paradigm of positivist scientific research. Doing so yields results that are rich in texture, but often seen as less compelling because of the small sample size. Many of the studies are what Wakewich and Parker (2002) have described as "single-issue or problem-based, [in which] women's health is not studied in the fuller context of women's lives." Examples would include research on specific health concerns such as violence or diabetes or HIV/AIDS. Yet embedded within such single-issue studies, attention is frequently paid to the ramifications of that issue on other parts of women's lives. Moreover, this problem focus is being

gradually counteracted by research that is designed to allow women to tell their own stories of their own health, through which the interconnections between the various social determinants of health are made explicit.

Similarly, although many of the relevant studies focus on specific stages of a woman's life, studies that adopt a life course approach to health are limited. For example, analyses of health problems at a particular phase of life do not assess how those problems may affect or be affected by other phases.

As for the formats chosen to communicate research results, most of the studies in this review have been published in peer-reviewed academic journals. Others, such as those commissioned by the Centres of Excellence for Women's Health, exist as reports and working papers. The same is true for studies distributed by community groups (see for example Davis 1982; Ontario Native Women's Association 1989; Quebec Native Women 1993; Purdon 2002). Still others have been published in magazines such as the Canadian Women's Health Network publication called *The Network* (see Benoit and Carroll 2001; Dion Stout, Kipling and Stout 2002; Hannis 2002; Pauktuutit Inuit Women's Association of Canada 2002; Poole 2001), while others are conference presentations, dissertations and speeches. There are also several research proposals (see Amaratunga 2000; Browne 1998; DesMeules 2001; McClure et al. 1997; Mitchell 1997; Wakewich 2002). See Section 5.2 for a brief discussion of the accessibility of these various formats.

Key Messages

Having assessed the scope, accessibility and approaches of the literature on rural women's health in Canada, attention will now turn to the content of that literature. This section offers a synthesis of what is known in this field, based on the Canadian literature that addresses rurality explicitly. It is followed by sections on tensions and gaps in the literature.

The literature on rural women's health in Canada exists at the intersection of research on rural health and women's health. From this literature, it is clear that living rurally and being a woman both affect health in a number of interrelated ways. Place is more than geographic and gender is more than biological—both are social concepts, and both matter to health.

Rurality is an important determinant of women's health. Its implications should be taken into account in any detailed analysis of women's health experiences and in policy development. Those implications may be positive or negative, or both simultaneously. In the literature, rurality is depicted as primarily a negative determinant of women's health. Seven specific ways in which women's health is affected by rurality are outlined here:

a) **Limited health care services**—The scarcity and geographic dispersion of rural health care services limit access to appropriate health care (see for example Hutten-Czapski 2002). Such overall scarcity affects women disproportionately as the main users of health care services and as the ones traditionally responsible for maintaining life at home if a family member needs to travel elsewhere for care. Women generally prefer to see female health care providers (Johnston

1998), and gender has been shown to play a role in sex-sensitive examinations such as breast and cervical cancer screening (Ahmad 2001), yet in rural contexts the choice of a female physician is rarely available. Services specifically benefiting women are also scarce, including shelters against violence and gynecological cancer screening and treatment.

Poor access to health services can directly affect health services utilization rates, quality of life and morbidity (see Gucciardi and Biernie-Lefcovithc 2002; Morton and Loos 1998). For example, Crump's 2001 article describes the difficulty family physicians experience in getting their rural patients to see specialists, largely due to the inconveniences of getting there. Gillis 2001 discusses how lack of access to facilities inhibits rural residents' physical activity. Breast and cervical cancer screening rates are lower in rural areas due to poor accessibility of services, and cervical cancer rates are higher, likely due to a lack of early detection (Bryant 1992; Clarke 1998; Deschamps et al. 1992; Hislop 1997; Maxwell et al. 1997; Woods 2001; Young et al. 2000). Deleeuw (1998) links higher rates of sexually transmitted diseases and teenage pregnancies to the inadequacy, poor availability, and poor accessibility of health services in rural and remote communities. Women frequently report lower satisfaction with their birth experiences when required to leave their communities to have their babies (see Webber 1993).

All of this points to the importance of health services being available as close to home as possible. In rural areas, that

means investing in mobile outreach programs (see for example Wilson et al. 1995). For instance, one interesting study, reported by Church et al. in 2000, has explored the use of audio teleconferencing to provide social support to women with breast cancer in the rural Maritimes.

- b) **Limited health information**—The lack of physicians in rural Canada means that women lack access not only to primary health care, but also to health information, since physicians are a key source of such information for Canadian women (Klassen 1996; Sutherns 2001). The same is true in other areas as well; when services such as midwifery, physiotherapy, anti-violence counselling or Alzheimer’s support are unavailable, the scarcity affects more than the direct provision of care. It also limits women’s access to information. (See for example Bowd and Loos 1996; Bruhm 1998; Forsdick Martz 2001; Martz and Saurerer 2000).

As with a lack of direct clinical care, a lack of information can lead to higher incidence of disease. For example, the high prevalence of diabetes among Aboriginal women is linked in part with a lack of information on prevention (Harris 1997; Hegele et al. 2000).

The Internet is an increasingly important source of health information. There is no literature specifically addressing women’s use of the Internet to access health information in rural areas, but Internet technology is not available to all rural, remote or Northern communities across the country.

- c) **Limited community services and infrastructure**—For rural women, a lack of year-round access to nutritious food, affordable transportation and housing, safe roads, job opportunities, support groups and child care services affects their health at least as much as a lack of physicians. These emerge as important issues within the literature, despite not having a specific body of research devoted to them. (See for example Everitt 1996; Graveline 1990; Gillis 1991; Haas 2002; Hornosty 1995; Kubik and Moore 2001; Meadows et al. 2001; Steele 2002; Sutherns 2001). It is therefore important to look beyond the explicit titles of the studies to the recurring themes that tie the

various topics together. The literature points clearly to the importance of non-medical social determinants such as financial insecurity, role strain and social support in shaping women’s health experiences.

- d) **Lack of anonymity**—Rural places are small, so people tend to know one another through face-to-face relationships. The phenomenon of

‘being known’ in a small place can affect health positively, in terms of social support, and negatively, in terms of a reluctance to admit need or access services. Both sides particularly affect women, as the primary users of health care services and to the extent that they are at the heart of maintaining social relationships.

The darker side of being known is discussed most frequently in the literature on violence (Hornosty 1995; MacLeod 1989; Struthers 1994) and abortion (Eggertson 2001). Maintaining confidentiality, keeping up appearances, and

In small communities, privacy is especially difficult to maintain.

avoiding stigma are important motivators that affect anyone's willingness to access health care services. In small communities, privacy is especially difficult to maintain.

- e) **Occupational health effects**—Although the relevant literature is largely limited to farming and fisheries, rural occupations can present health benefits and risks to rural women. Exposure to nature and working outdoors are documented as positive working conditions, but these are offset by economic insecurity, separation from family, long hours, exposure to environmental toxins, workplace accidents and other occupational hazards of rural work.¹¹
- f) **Demand for culturally sensitive health care**—The rural women's health literature in Canada, in contrast to that coming out of the United States, does not often speak explicitly of a "rural culture." It does,

however, call for health services to be customized to suit the cultural context in which they are being delivered, particularly within the literature on Aboriginal women's health (see Benoit 2001; Black and Cuthbert Brandt 1999; Browne 2001; Browne et al. 1997; Farkas 1996; Hannis 2001/2002; Herbert 1997). Similar calls for greater sensitivity to diversity in rural contexts are found in the articles on lesbian health.

- g) **Invisibility**—Another recurring theme in the literature is the invisibility of rural women's health concerns, reflected in the scarcity of research and in the findings of existing studies. Rural women's interests are marginalized in health policy decision-making, largely because rural women themselves are rarely part of that process. (See for example Gandy 2001; Gerrard 2001; Graveline 1990; Heaman 2001; Kenchnie and Reitsma-Street 1996; Lellava 2000; Reutter 2000).

Tensions within the Literature

Although the research on rural women's health in Canada does include some clear messages about the importance of rurality's influence on health, it also contains numerous debates and contradictions. Further empirical research is needed to move forward in some of the areas described below:

- a) **What is rurality and does it matter?**—Despite the word 'rural' appearing in the title of articles, it often disappears in the analysis. Rural participants may have been included in a data set, but their responses are rarely disaggregated and analyzed separately. The significance of rurality, or lack of it, is left unaddressed. In many cases, rurality is not defined at

all. When definitions are offered, they are often inconsistent or inadequate, making comparability of results problematic.

- b) **Rurality matters, but how much?**—In many areas, as outlined above, living rurally interacts with other determinants of health to shape health experiences quite directly. In other cases, where it is analyzed at all, there may be no differences between rural and urban populations. (See for example Parikha et al. 1996 for a study on rural and urban mood disorder prevalence). Where differences do exist, rurality can act positively and negatively, often in contradictory ways, to affect health.

This tension is exacerbated by the lack of longitudinal and/or large-scale research projects which would increase confidence in the results of the existing research into rural women's health.

c) **Rural or rurals?**–

In stressing the importance of using a rural lens in women's health research, one risks implying that there is a single experience of rurality that affects every woman's health in similar and predictable ways. While the literature calls for rurality's influence to be recognized, that must occur alongside recognition of the enormous diversity within rural communities and among rural people. Rural experience in Nunavut will not be the same as that in Newfoundland. In both cases, rurality matters, but the specifics of how that occurs must emerge through analysis grounded in women's experiences in each place.

d) **Is there a rural culture?**–A similar tension emerges when rural places are generalized in the literature in terms of their culture. Characteristics such as self-reliance and conservatism likely play important roles in affecting women's health experiences and should not be ignored, yet applying those characteristics to all rural communities is problematic. In the Canadian literature, this tension has resulted in an overall reluctance to address culture, or in a tendency to do so based on poorly supported arguments.

e) **Is there a rural women's culture?**–Just as rural communities are described in

particular ways that tend to mask the diversity within them, so too are rural women. While there is some truth to the

description of rural women as traditional in their roles, there is little analysis of the structural constraints shaping those roles, or of the myriad ways in which women move beyond gender stereotypes.

f) **Are rural women healthier?**–The

amount of research data on rural women's health status is very limited. The research that does exist paints a contradictory picture of whether living rurally affects health outcomes positively or negatively.

g) **Invisible but not anonymous?**–The literature describes rural women as being largely invisible and many of their individual experiences include reports of being socially isolated, yet at a community level they complain of never being anonymous. This lack of privacy alongside a lack of attention in rural places has been described by Coakes and Kelly this way: "As a way of coping with being too close, individuals create emotional distance, in turn exacerbating any feelings of isolation. In effect, individuals are simultaneously too close and too distant."¹²

h) **What is reasonable to expect?**–Satisfaction with health care quality is directly related to expectations of that care. Implicit in the literature are tensions around what level of access to health care it is reasonable for people in rural, remote and Northern communities to expect. On one hand, there are those who would

Satisfaction with health care quality is directly related to expectations of that care.

suggest that deciding to live rurally is a decision to forego immediate access to health care; therefore rural residents should not expect similar health care access to urban dwellers. Yet The Canada Health Act guarantees accessible health

care to all citizens. On the other hand, the literature also suggests that rural residents have surprisingly low expectations of their health care, and are therefore not dissatisfied with care that might be deemed by others to be unsatisfactory.

Gaps in Current Research

Based on the foregoing analysis, the following gaps in the current English and French Canadian literature on rural women's health are evident:

- a) Most **health research tends to ignore women, or rural realities, or both**. As a result, the amount of research addressing the specific health concerns of rural women is limited.
- b) Where it is addressed in the literature, **rurality is either not defined or it is defined inconsistently**. The terms "rural", "remote" and "northern" are used to mean different things. This lack of clarity of terminology jeopardizes the comparability of research studies, necessary for the building of a substantial body of literature.
- c) Rurality is frequently treated as a homogeneous, straightforward, usually negative influence on health. There is a **lack of attention to the diversity inherent in rurality, and an undervaluing of the specific positive and negatives influences of place on health**.
- d) There is a **considerable lack of statistical and/or epidemiological data on rural women's health in Canada, as well as longitudinal data**. Larger data sets may have included rural women in their sample, but extracting those data while still retaining their meaning is problematic. Smaller, short-term studies make comparability and generalizability difficult, which may be seen by some decision makers as compromising the validity of the research results.
- e) The **cumulative impact of and interplay between various social determinants of health remains under-represented** in current research. Single-issue studies, those which fragment the female body, or that fail to embed women's health experiences in the fuller context of their lives do not reflect the ways in which women perceive and experience their health. More specifically, there is a virtual absence of research on environmental determinants of women's health.
- f) Some **specific populations are under-represented in current research**. These include Inuit and Métis women, immigrant women, rural children and adolescents; health professionals beyond physicians and nurses; women from the Territories and Prince Edward Island, coastal women, and Francophone women living outside of Quebec. Similarly, there is an absence of rural occupational health literature beyond farming and fishing.
- g) There is a **failure to consider the importance of cultural values in shaping ideas and experiences of health**. Although culture is usually taken into consideration in reference to

Aboriginal or immigrant populations, distinctive cultures of 'white' rural, remote and Northern populations are rarely acknowledged. There is little Canadian research into how cultural values such as stoicism, self-sufficiency and independence, for instance, influence rural

women's willingness to acknowledge stress or to accept assistance (Wakewich and Parker, 2002). Analyzing rural culture can and should be done in ways that do not homogenize the diversity within rural populations and rural experiences.

Research and Policy Directions

The literature on Canadian rural women's health, as well as the gaps therein, contain numerous suggestions for researchers and policy makers, as summarized below:

1. **Use a gender lens**—A focus on rural health is not enough to ensure that the needs of rural women are adequately addressed. Research and policy must engage in gender analysis.
2. **Use a rural lens**—As demonstrated in the previous section, rurality matters to women's health, so its influence should be taken into consideration, explicitly and deliberately.
3. **There is more than one 'rural'**—When taking rurality into account, do not assume that everyone's experience of living rurally is the same. Rurality exerts an influence on women's health, but that influence is not straightforward or predictable, nor is it the same for all women. Be sensitive to difference, and incorporate it intentionally in research and policy designs.
4. **One size does not fit all**—Policies designed with an urban environment in mind should not be assumed to be suitable for rural contexts.
5. **Health care means more than doctors**—Accessible health care services require more than attention to the recruitment and retention of physicians. Other health care professionals are equally important to women's choices, as are informal care providers and the infrastructural investments that make it possible for women to act on the choices they have.
6. **Economic and social services are investments in health**—Because health is socially determined, and social determinants are interactive and cumulative, any investment in improving the social and economic situation of rural women will yield beneficial returns in terms of health.
7. **Adopt multidisciplinary approaches**—Qualitative and quantitative, large and small scale studies from throughout the country are needed to ensure that the body of Canadian research on rural women reflects the diversity and richness of Canadian rural women themselves.

Conclusion

The literature on the health of rural, remote and Northern women in Canada is limited but growing. It highlights problems of access, marginalization and invisibility faced by rural women, in the literature and in

their lives. The research, largely based on women's lived experiences, offers direction to researchers and policy makers as to how to address the concerns of rural women more effectively in their work.

Appendix E1

Methodology: Where We Searched and What We Searched For

Pamela Wakewich and Barbara Parker conducted the initial literature search between July and October 2001¹³. In December 2002, their search was updated by Rebecca Sutherns, Miki Ackermann, Karima Hashmani and Christine Oldfield to include research completed in 2001 and 2002. It was also expanded to include additional databases.

The following databases were searched :

- Agricola Plus Text
- Canadian Business and Current Affairs
- Canadian Research Index
- CHID Online
- CINAHL (Nursing and Allied Health Literature)
- Family and Society Studies Worldwide
- First Nations Periodical Index
- Humanities and Social Sciences FG (Wilson Web)
- Medline (National Library of Medicine)
- PAIS
- Popmed
- PsychInfo (Psychological Abstracts)
- Psychology Journals
- Social Work Abstracts 1977-2002
- Sociofile (Sociological Abstracts 1986-2002)
- Women's Resources International

The following keywords were used to search the databases:

women, woman, rural, remote, northern, health, Canada.

These words were then combined with:

well-being, country, gender, determinants, perceptions, lifestyle, quality of life, farm, agriculture, fishing, fishery, coastal, mining, forestry, single resource, single industry, occupational health and safety, education, literacy, illiteracy, environment, housing, place and health, smoking, social support, poverty/income, employment, violence/abuse, addictions, substance abuse, alcoholism, suicide, transportation, isolation, screening, prevention, diagnosis, health promotion, disabilities, race, culture, visible minority, abortion, contraception, Aboriginal, Native, Inuit, First Nations, Métis, elderly, mid-life, mother, adolescent, child, life course, lesbian, home care, care giver, care giving, eating disorders, body image, nutrition, exercise, physical activity, genetics, sexuality, HIV, AIDS, pregnancy, childbirth, reproduction, mental health, depression, nurses, health professionals, doctors, physicians, chiropractors, diabetes, osteoporosis, breast cancer, cervical cancer, cancer.

The following websites were searched for all research and publications during late December, 2002 and early January, 2003:

- Agriculture and Agri-Food Canada
www.agr.ca/cris/directories/women_e.html
- The Atlantic Centre of Excellence for Women's Health
www.medicine.dal.ca/mcewh
- The British Columbia Centre of Excellence for Women's Health
www.bccewh.bc.ca
- Canadian Women's Health Network
www.cwhn.ca
- The Centre for Rural and Northern Health Research (CRANHR—
Lakehead and Laurentian sites)
www.flash.lakeheadu.ca/cranhr
www.laurentian.ca/www/cranhr/index.html
- The Centre of Excellence for Women's Health—
Consortium Université de Montréal
www.cesaf.umontreal.ca
- CRIAW
www.criaw-icref.ca/index-e.thm
- Federated Women's Institutes of Canada
www.nald.ca/fwic.htm
- Government of Canada, Rural Information Services
www.rural.gc.ca/cris/directories/women_e.phtm
- Health Canada
www.hc-sc.gc.ca
- Ministries of Health and Social Services websites for all provinces and territories
- National Action Committee on the Status of Women
www.nac-cca.ca
- The National Network on Environments and Women's Health
www.yorku.ca/nnewh
- Native Web
www.nativeweb.org
- Ontario Farm Women's Network
www.ofwn.org
- The Ontario Women's Health Council
www.ontariowomenshealthcouncil.com/E/index.html
- Ontario Women's Health Network
www.owhn.on.ca
- Paukuutit Inuit Women's Association
www.paukuutit.on.ca
- Planned Parenthood Federation of Canada:
The How to Rural Tool Kit for Sexual Health Programs and Services
www.ppfc.ca/toolkit/english/five/rural.htm
- The Prairie Women's Health Centre of Excellence
www.pwhce.ca



- Rural Womyn Zone
www.ruralwomyn.net
- Statistics Canada
www.statcan.ca
- Status of Women Canada
www.cfc.gc.ca/direct.html
- University of Guelph, Rural Studies Programs
www.uoguelph.ca
- University of Northern British Columbia, Rural and Remote Health Research
www.unbc.ca/ruralhealth/
- Women Space
www.womenspace.ca
- Women's Health Matters
www.womenshealthmatters.ca

A general web search using the Google search engine was conducted in January 2003, using women, rural, remote, health, Canada as key words.

Specific journals were explored for relevant articles (using the keywords: women, rural, health, Canada-if applicable):

- *Canadian Journal of Rural Medicine*
- *Canadian Journal of Sociology*
- *Canadian Woman Studies*
- *Health and Place*
- *Journal of Rural Nursing and Health Care*
- *Journal of Rural Studies*
- *Rural Health*
- *The Canadian Geographer*



Books were located through the University of Guelph library catalogue, on-line at Amazon.com and with the following publishers (using the keywords: women, rural, health, Canada):

- Brill Publishing
- National Academy Press
- Oxford University Press
- Cambridge University Press
- Palgrave MacMillan Press
- University of Toronto Press

All relevant sources were then read and summarized, with the bibliographic details, keywords and an abstract being entered into *Citation* bibliographic software. Abstracts, whenever possible, include the topic area, population, location, methodology, time frame, key findings and recommendations, as well as how diversity, health and rurality were addressed. The literature is now available in a searchable electronic database format, through NNEWH at York University in Toronto (416-736-5941). NNEWH also holds hard copies of many of the sources listed in this review.

Appendix E2

Reports on Rural Women's Health

by the Centres of Excellence for Women's Health

- Amaratunga, C. (2000). *Breast Cancer Action Nova Scotia*, 99/00-PD2, funded by the Maritime Centre of Excellence for Women's Health.
- Botting, I., Neis, B., Kealey, L., and Solberg, S. (2000, July). *Health Care Restructuring and Privatization from Women's Perspectives in Newfoundland and Labrador*, National Network on Environments and Women's Health.
- Browne, A. (1998). *Improving Health Care Services for First Nations Women: A Community Case Study*, WCC98-2, funded by the British Columbia Centre of Excellence for Women's Health.
- Browne, A., Fiske, J.-A., and Thomas, G. (1997). *Northern First Nations Women's Interactions with the Mainstream Health System*, WCC97-3, funded by the British Columbia Centre of Excellence for Women's Health.
- Bruhm, G., and Poirier, L. (1998). *The Caregivers Research Project*, 97/98-SPF2, funded by the Maritime Centre of Excellence in Women's Health.
- Campbell, J., Bruhm, G., and Lilley, S. (1998, November). *Caregivers' Support Needs: Insights From the Experiences of Women Providing Care in Rural Nova Scotia*, the Maritime Centre of Excellence for Women's Health/Dalhousie University.
- Coleman, R. (2000, February). *Women's Health in Atlantic Canada: A Statistical Portrait*, the Maritime Centre of Excellence for Women's Health.
- Deiter, C., and Otway, L. (2001). *Sharing Our Stories on Promoting Health and Community Healing: An Aboriginal Women's Health Project*, Prairie Women's Health Centre of Excellence.
- DeLeeuw, S. (1998). *Young Women's Health Needs in Isolated Northern Communities*, WCC98-7, funded by the British Columbia Centre of Excellence for Women's Health.
- Donner, L. *A Rural Women's Health Program: The Experience of the South Westman RHA*, (Prairie Women's Health Centre of Excellence (PWHCE)).
- Eakin, J., and Brooker, A. (1998, June). *The Restructuring of Work and Women's Health: An Annotated Bibliography*, National Network for the Environment and Women's Health.
- Fillmore, C., Dell, C., A., and the Elizabeth Fry Society of Manitoba. (2000). *Prairie Women, Violence and Self-Harm*, Prairie Women's Health Centre of Excellence.
- Friars, G. (2000). *New Brunswick Women's Health Initiative Project*, Final Report, Maritime Centre of Excellence for Women's Health Website (www.medicine.dal.ca/acewh).
- Fuller, C. (1999). *Reformed or Rerouted? Women and Change in the Health Care System*, Vancouver, British Columbia: British Columbia Centre of Excellence for Women's Health.
- Gandy, K. (2001). *Single Parent Women's Experiences Performing the Required Tasks of Health Provider for Their Families*, 00/01-ST1, funded by the Maritime Centre of Excellence for Women's Health.
- Issac, B., Anderson, L., Healy, T., Herringer, B., and Perry, T. (1999). *Out in the Cold: The Context of Lesbian Health in Northern British Columbia*, British Columbia Centre of Excellence for Women's Health.

- Jaffe, J., and Blakely, B. (1999). *Coping as a Rural Caregiver: The impact of health care reforms on rural women informal caregivers*, Prairie Women's Health Centre of Excellence.
- Jordan, P. (Funded in 1997). *Decisions, Decisions: Experiences of Women Who Have Undergone Elective Hysterectomies in the Northern Interior Health Region of B.C.*, British Columbia Centre of Excellence for Women's Health.
- Kosny, A. *The Social Determinants of Health and Equity Across the Life Span*, Maritime Centre of Excellence for Women's Health.
- Kosny, A. (2000). *Trying to Work It Out: Newfoundland Women's Experiences in Small Workplaces*, National Network on Environments and Women's Health (www.yorku.ca/nnewh).
- Lord, S. *Social and Economic Stress and Women's Health in Fishing Communities*, Maritime Centre of Excellence in Women's Health.
- Luce, J. (1998). *Assessing Assisted Reproduction: Experiences of Lesbian and Bisexual Women Living in Northern Communities*, WCC98-8, funded by the British Columbia Centre of Excellence for Women's Health.
- MacLeod, M., and Zimmer, L. (Work in Progress). *Perinatal Services: Assessing the Needs of Special Populations*, University of B.C.
- Martz, D., and Sarauer, D. *Domestic Violence and the Experiences of Rural Women in East Central Saskatchewan*, Prairie Centre of Excellence in Women's Health.
- McClure, L., Heinonen, T., and Tudiver, S. (1997). *Women Survivors of Childhood Sexual Abuse: Knowledge and Preparation of Health Care Providers to Meet Client Needs*, Prairie Women's Health Centre of Excellence.
- Morrow, M., and Chappell, M. (1999). *Hearing Women's Voices: Mental Health Care for Women*, Vancouver: British Columbia Centre of Excellence for Women's Health.
- Neis, B., Grzetic, B., and Pigeon, M. (2001, April). *From Fishplant to Nickel Smelter: Health Determinants and the Health of Newfoundland's Women Fish and Shellfish Processors in an Environment of Restructuring*, National Network on Environments and Women's Health/Centres of Excellence for Women's Health, Newfoundland.
- Northern Secretariat of the B.C. Centre of Excellence for Women's Health. *The Determinants of Women's Health in Northern Rural and Remote Regions: Examples and Recommendations from Northern B.C.* B.C. Centre of Excellence for Women's Health. University of Northern British Columbia, Prince George.
- Payne, B., Grant, K., and Gregory, D. (2001, September 30). *Women's Caring Work in the Context of Manitoba Health Reform*, National Network on Environments and Women's Health.
- Poole, N., and Isaac, B. *Apprehensions: Barriers to Treatment for Substance-Using Mothers*, HWHC9-1, funded by the British Columbia Centre of Excellence for Women's Health.
- Prairie Women's Health Centre of Excellence. (2001). *Action Plan for Women's Health in Manitoba and Saskatchewan: Key Priorities and Strategies*.
- Rathwell, T. (1999). *A Gender Equity Lens for the Health Policy Domain—A Canadian Gender Curriculum Educational Strategy*, 98/99-PF1, Maritime Centre of Excellence for Women's Health.
- Roberts, J., and Falk, M. (2001). *Women and Health: Experiences in a Rural Regional Health Authority*, Prairie Women's Health Centre of Excellence.
- Scott, C., Horne, T., and Thurston, W. (2000). *The Differential Impact of Health Care Privatization on Women in Alberta*, Prairie Women's Health Centre of Excellence.

- Skillen, L. (2001). *Reflections of Rural Alberta Women: Work, Health and Restructuring*, University of Alberta, funded by the National Network on Environments and Women's Health.
- van Roosmalen, E. (1998). *Women's Voices: Women's Perceptions of the Determinants of Health and Well Being*, 97/98-Project 1, funded by the Maritime Centre of Excellence for Women's Health.
- Wakewich, P. (2002). *Mapping Research on Women and Health in Northwestern Ontario*, National Network on Environments and Women's Health.
- Willson, K., and Howard, J. (2000). *Missing Links: The Effects of Health Care Privatization on Women in Manitoba and Saskatchewan*, Prairie Women's Health Centre of Excellence.



Endnotes

- 1 With assistance by Miki Ackermann, Karima Hashmani, and Christine Oldfield.
- 2 Rebecca Sutherns can be contacted at 519-833-0952 or rebecca.sutherns@sympatico.ca
- 3 Unpublished report.
- 4 Project # 2 of the National Project. Included in the Final Summary Report.
- 5 Rural and Remote Women's Health: Policy and Research Directions. Centres of Excellence for Women's Health.
- 6 The Centres are indebted to Pamela Wakewich and Barbara Parker for their October 2002 piece entitled, "Rural and Remote Women's Health in Canada: A Literature Review and Research Inventory," (unpublished) which provided many of the research sources listed here and served as the starting point for this analysis.
- 7 To enhance the readability of the document, "rural women's health" is employed in place of "rural, remote and Northern women's health," except in cases where a distinction between rural, remote and northern is being explicitly made.
- 8 The term "rural" was defined broadly in the search strategy so that the literature review would be as comprehensive as possible. For a discussion of how rurality is defined in the literature itself, see pg. E47.
- 9 For an annotated bibliography of French language literature on Canadian rural, remote and Northern women's health, see Dallaire, Christine and Martin, Véronique, (August 2002) *Femme, Santé et Milieu Rural au Canada*, Section D of Rural and Remote Women's Health: Policy and Research Directions. Centres of Excellence for Women's Health.
- 10 The parameters of the French-language search strategy excluded articles directly related to Aboriginal women's health. Such articles would, however, have been captured in the database searches for the English-language search since the language was not used as a limiting factor, yet none was found.
- 11 See bibliography for references in this area, under the headings "Occupational health and safety" and "Work"
- 12 Coakes, S. J., and Kelly, G. J. (1997). Community Competence and Empowerment: Strategies for Rural Change in Women's Health Service Planning and Delivery. *Australian Journal of Rural Health*, 5, p. 27.
- 13 Complete details of that search strategy are available in Wakewich and Parker (2002) "Rural and Remote Women's Health in Canada: A Literature Review and Research Inventory," (unpublished).



Rural, Remote and Northern Women's Health:
Policy and Research Directions

Results from Francophone Focus Groups with Women in Rural and Remote Communities in Canada

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Project #4 of the National Rural and Remote
Women's Health Study

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francophone de concertation provinciale de l'Ontario

Table of Contents

Acknowledgments	F2
Introduction	F3
Methods	F4
Recruitment of participants	F5
Total number of participants = 30 Francophone women	F5
Commentary on who was in attendance	F6
Commentary on who was not in attendance	F7
Suggestions for improvement	F7
Suggestions to improve the questionnaire for future research	F7
Results and analysis of focus group and telephone interviews	F8
Presentation and analysis of focus group and interview discussions	F14
Questions and themes addressed	F14
Health	F14
Health and Rurality	F19
Rurality	F30
Policy Framework	F34
Research Agenda	F42
General Comments	F45

List of Figures

Figure 1.	Age Distribution of Participants	F8
Figure 2.	Level of Education Completed	F9
Figure 3.	Household Income	F9
Figure 4.	Occupation	F10
Figure 5.	Estimated Population of Participants' Home Community	F10
Figure 6.	Marital Status	F11
Figure 7a.	Age of Participants' Children	F11
Figure 7b.	Number of Children per Participant	F12
Figure 8a.	Number of Participants who Live and Work in the Same Geographic Region	F12
Figure 8b.	Distance Between Home and Work	F12
Figure 9a.	Time Travel to Nearest Health Care Provider	F13
Figure 9b.	Distance to Nearest Health Care Provider	F13

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Results from Francophone Focus Groups with Women in Rural and Remote Communities in Canada

Introduction¹

In the public and political debates across Canada concerning the restructuring and providing equitable access to care to people in rural and remote communities, the consideration of gender and women's health is needed to complete the picture of health needs, service provision and utilization.

In response to this critically important issue, the Centres of Excellence for Women's Health created a National Research Steering Committee on Rural and Remote Women's Health as part of the network of affiliated researchers and community women across Canada. As part of the national project the National Network on Environments and

Women's Health (NNEWH) invited *La Table féministe Francophone de concertation provinciale de l'Ontario*, a community partner of NNEWH to facilitate focus groups with Francophone minority women. This report summarizes the findings from six focus groups and one individual interview conducted in French with 30 women, either held in person or by teleconference.

Key Objectives/Research Questions:

The key issues which guided the overall National Study of Rural and Remote Women's Health and Health Care in Canada included the following:

In terms of health...

- What are the things that promote the health of women living in rural and remote areas of Canada?
- What are the things that threaten the health of women living in rural and remote areas of Canada?

In terms of health care...

- How satisfied are women with the quality of health care in their area?

In terms of rural/remote living...

- What is it that makes a woman's life rural and/or remote?

- In what specific ways does living rurally or remotely affect the health of women?

In terms of policy to address the above...

- What policy issues are women living in rural and/or remote areas concerned about?
- What do they want changed to better promote their health?

Finally, in terms of the need for further research...

- Are there rural and remote women's health issues about which more information is needed in order to prompt appropriate action?

Methods

Survey and Interview Guide

The Francophone focus groups used the short demographic survey (Appendix D) and a focus group interview guide (Appendix E) developed by Dr. Rebecca Sutherns under the direction of the NRSC and translated by Dr. Christine Dallaire. The Research Steering Committee approved the final versions of the guidelines and questions to be used by facilitators in April 2002, after they had been reviewed for plain language and clarity (see Appendix F for full instructions to facilitators).

Ethics Review was provided by York University under application by Marilou McPhedran and Suzanne MacDonald PhD. In addition, ethics approval for the Francophone focus groups was also obtained through the University of Ottawa with which Dr. Christine Dallaire is affiliated.

Facilitators were expected to adhere to the guidelines and the theme areas of the questions provided. Additional questions were provided to prompt discussion within a focus group if needed. This kind of flexi-

bility was approved of in principle by the Research Steering Committee, according to the principles of responsive qualitative research; that is, as long as the intent and content did not significantly differ from the parameters approved by the ethics review.

Conduct of Focus Groups

All Francophone focus groups were conducted by Dr. Christine Dallaire with the assistance of Mme Guylaine Leclerc from the Table féministe. Each focus group began with an explanation of the study both specifically and within the broader context of the national study. Participants were then asked to sign a consent form (Appendix G) and to complete a self-administered demographic survey. No identifiers were included on the survey and participants were told that completing the survey questions was voluntary and that the information contained therein would be kept confidential.

Following the completion of the survey, Dr. Dallaire would turn on the tape recorder and start with the focus group interview guide questions. Mme Guylaine Leclerc would also

start taking notes of the content of the discussions. During the conduct of the taped group interview, women could ask for any of their

comments to be stricken from the record. The focus groups lasted from 1.5 to 3 hours.

Recruitment of participants

The Table féministe recruited Francophone focus group and interview participants through the regional chapters of various national and provincial Francophone women's groups, such as:

Union culturelle des franco-ontariennes
Fédération des femmes canadiennes-françaises
Fédération des femmes acadiennes de la Nouvelle-Écosse
Fédération des femmes acadiennes du Nouveau Brunswick
Instituts féminins (New Brunswick)

Réseau national action éducation femmes
Le Cercle des fermières du Québec
Société Saint-Thomas d'Aquin (PEI) AFEAS
Fédération des agricultrices du Québec
Réseau québécois d'action pour la santé des femmes

Participants were also recruited through Francophone health centers:

Centre de santé Évangéline (PEI)
Centre de santé de l'Estrie (network of Francophone community health centres in Eastern Ontario)



Total number of participants = 30 Francophone women

- Ontario, eight women in two focus groups (Northeastern Ontario: Kapuskasing, Earleton, Chapleau et Casselman; Eastern Ontario: Casselman, Alexandria, Cornwall, Stormont-Glengarry-Dundas townships)
- Maritimes, nine women in one focus group (New Brunswick: Grande Digue, Shediac, Moncton, Grand Barachois; Nova Scotia: Cheticamp) and four women in teleconference focus group (Prince



Edward Island: Wellington, Abram-Village, Summerside)

- West, five women in one focus group (British Columbia: North Vancouver; Saskatchewan: Regina, Gravelbourg; Manitoba: Winnipeg)
- Quebec, three women in one focus group and one woman in a telephone interview (Laurentians: Saint-Jérôme, Beauce: St-Pierre de Broughton; Gaspésie: Sayabec; Montreal)

The PEI teleconference interview involved women from the same geographical community while one of the Ontario focus groups involved health professionals working within the same network of community centers in Eastern Ontario. All other focus groups

included women from different regions within the same province (the Quebec focus group, the other Ontario focus group) or women from different provinces (the Maritime focus group and the Western focus group). Our objective was to gather data from Francophone women from a variety of regions (majority-Quebec, majority-local communities within Anglophone provinces, majority-local communities in bilingual province/New Brunswick, minorities) and that represented a diversity of rural experiences (farming, fishing, pulp and paper communities). To limit travel costs of participants, focus groups were held in urban central areas (Moncton, Regina, Montreal, Ottawa). Only one focus group was held in a rural town, in Chrysler Ontario.

Commentary on who was in attendance

Since we recruited mainly through women's organizations, interview participants were the members of these organizations, thus they were part of social, professional and/or political network. These women were involved at various levels in local or provincial women's groups, and in some ways they represented the women's leadership of their communities. However, they were mostly involved in the field of social services, health services and family issues (while men are still dominating the municipal and Francophone political leadership).

Other participants were recruited through health organizations. They were health care and service providers (nursing, health promotion) or community organizers for health centers (developing health care programs and services).

Many of the women had different responsibilities and spoke from various perspectives. They were, for instance, involved in women's groups, leading volunteers in social

and health care services (school breakfast, meals on wheels, etc.) and members of health care decision-making bodies (hospital/community health center committees and boards).

A few of the women interviewed did not live in rural areas at the time of the interviews but had:

- a) lived in rural areas
- b) and/or participated as representatives of women's provincial organizations and answered questions in light of their experiences of serving women in rural and/or remote areas and in light of the reported experiences of rural and remote women of their organizations.

While we did not ask questions about participants' cultural or ethnic background, we would hypothesize that most women, if not all women, were of French Canadian or Acadian ancestry and thus shared some basic cultural characteristics.

Commentary on who was not in attendance

Younger women (18 to 35 years old) were not well represented among focus group participants, nor were immigrants and members of visible minorities. Younger women are not well integrated in Francophone women's association as they are, on the one hand, not attracted to what appear to them, at least in rural areas, as being "older" women's groups, and on the other hand, too busy trying to juggle their professional and family responsibilities. We suspect that these women are involved in other types of organizations such as school committees and associations of leisure/sport

activities to ensure opportunities for their children. French-speaking immigrants and members of visible minorities have founded women's groups but they are concentrated in urban areas.

We did contact a group of Francophone rural women living with disabilities, but they were not available at the time of the scheduled focus groups.

It is also important to remember that women not involved in community or women's associations were not represented in these focus groups.

Suggestions for improvement

Recruiting through associations provided us with an important network of potential participants. In some cases, names and contact information of rural and remote women were provided to us and we were able to communicate with potential participants. Yet, some women did not turn up despite confirming their attendance. We have found that it is sometimes difficult to get direct access to women since in other cases, the organizations either took on the responsibility of recruiting participants,

sometimes successfully but not always (in Quebec for instance) or they simply did not wish to collaborate as they felt the potential rural women concerned about health issues were already busy attending another regional Francophone health meetings (which we were not aware of when the focus groups were scheduled). It would be better to directly communicate with participants even when they are recruited through other organizations and to frequently communicate with the various organizations.

Suggestions to improve the questionnaire for future research

- 1) Some questions need to be more specific since participants did not know how to answer them (answers varied since the reference—village, region, community—varied)
 - a) Do you live in the same geographic area as where you work?

*Is too vague, perhaps substitute "municipality, village, town" for "geographic area"

- b) If different, what is the approximate population of where you work?

*Be more specific, perhaps substitute "municipality, village, town" for "where"

2) Questions about the distance to specialist services and alternative health need to be morespecific as well. Either include some blank spaces where women can identify the type of specialist, then the distance to get to his/her services or provide a detailed list of specialist services. The same applies to the question about alternative health service providers.

For these same questions, it might be better to ask for only the distance in km or the time to get to the services. (Unless it is felt that distance in km does not reflect the actual time when considering road conditions when driving.)

Results and Analysis of Focus Groups and Telephone Interviews

The presentation of the data that follows begins with a description of women’s demographic backgrounds. Demographic data presented (Figures 1-10) here were drawn from those tabulations completed by Dr. Christine Dallaire and graphics prepared by Karima Hashmani at the National Network on Environments and Women’s Health.

This is then followed by a summary of the key themes highlighted by women in the focus groups organized into five broad conceptual categories including their views on: health, health care, rurality, and their recommendations for policy and research. The analysis concludes with general comments about the similarities and differences among participants’ responses as well as other issues raised by their responses.

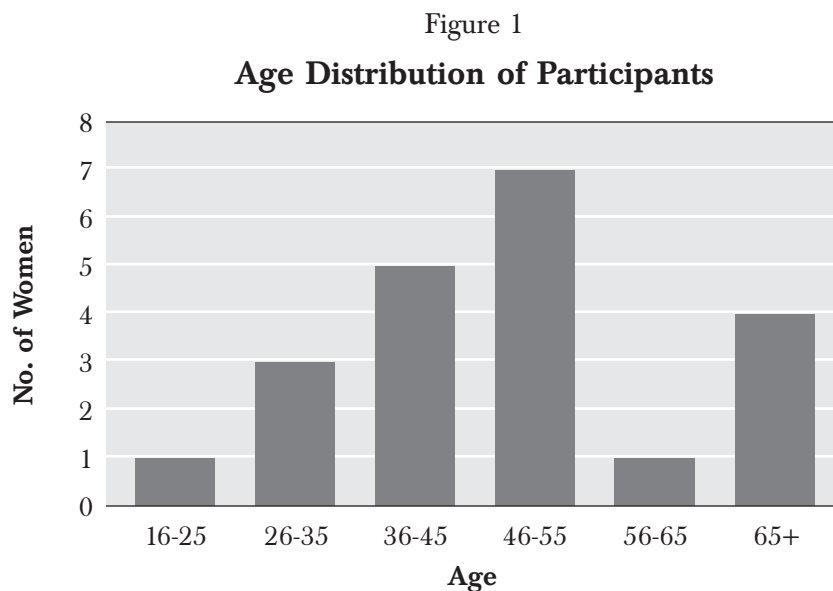
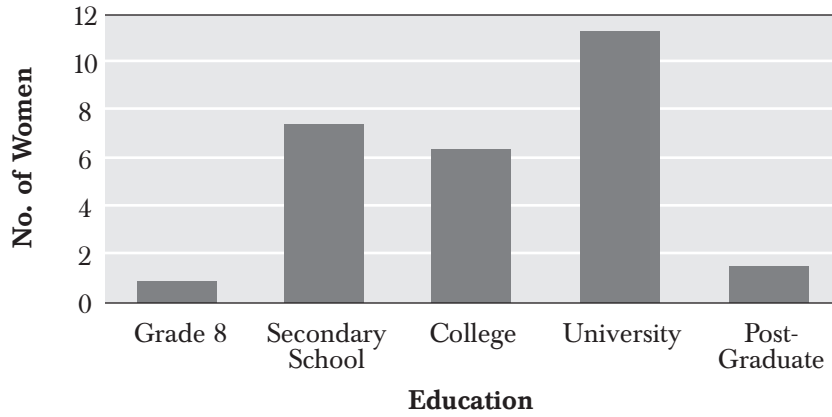


Figure 2

Level of Education Completed



** N.B. Initial data collection identified registered nurse as a completed level of education, and the category has been amalgamated into the college category based on assumption, not a certainty. The university category includes some women that participate in university for the elderly. **

Figure 3

Household Income

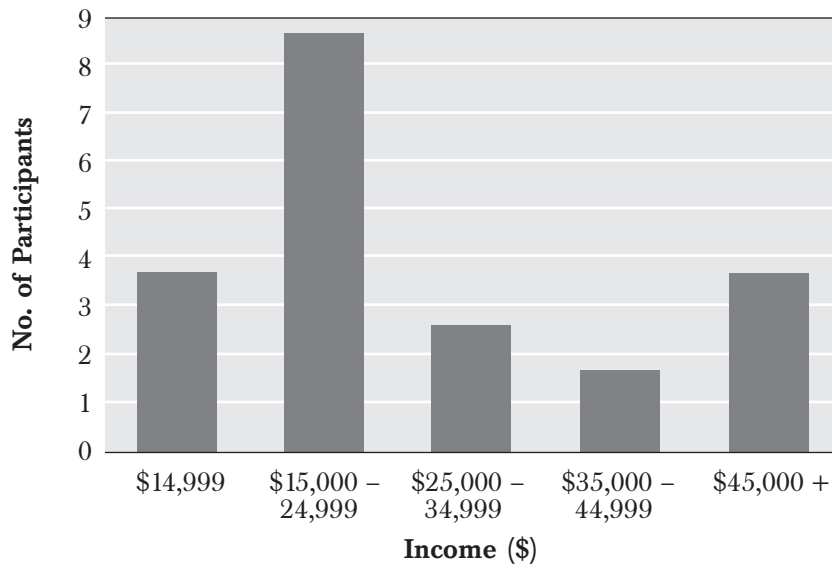


Figure 4
Occupation

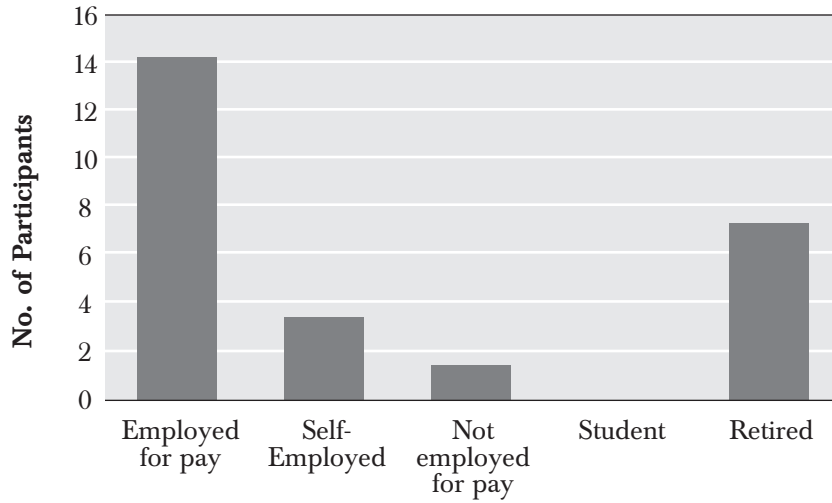


Figure 5
Estimated Population of Participants' Home Community

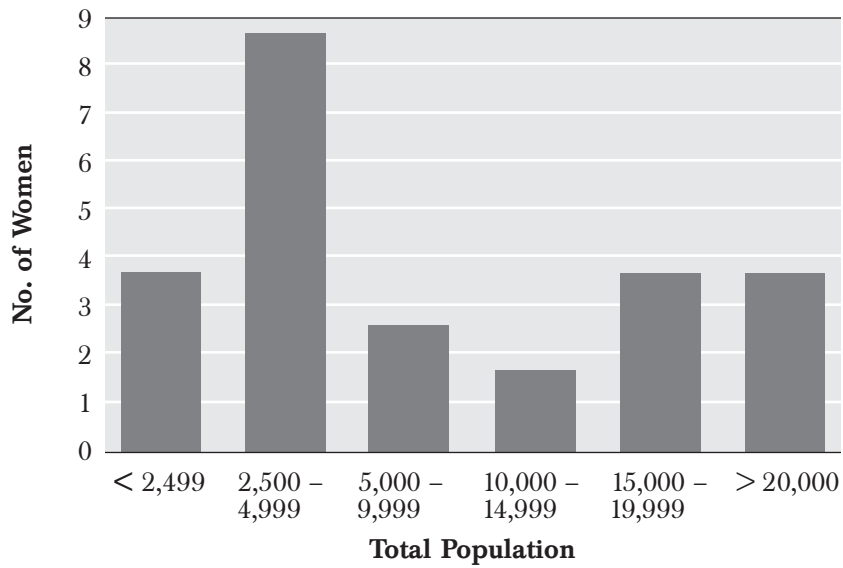


Figure 6

Marital Status

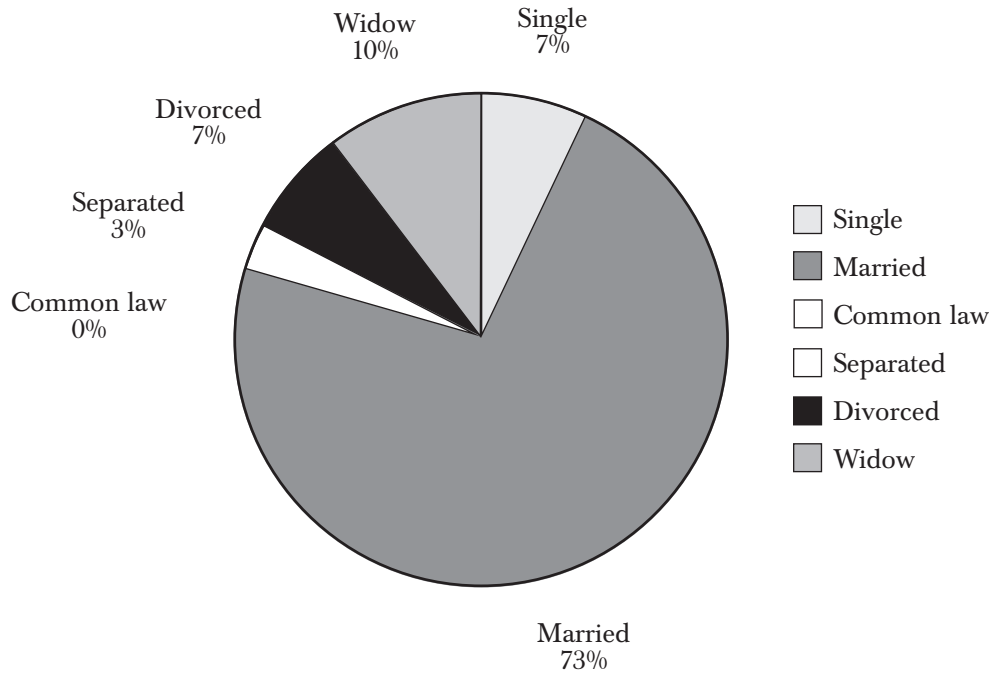
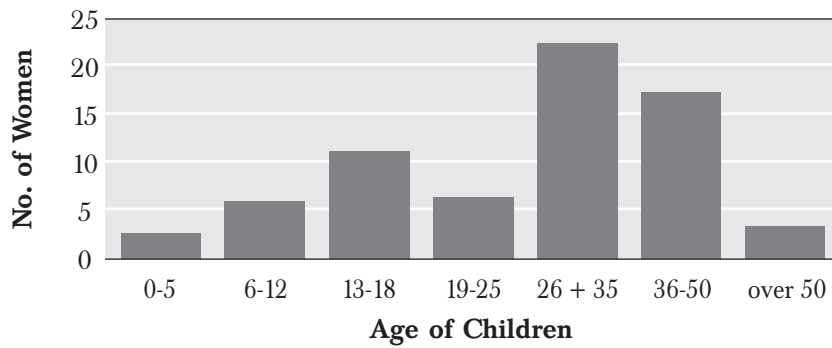


Figure 7a

Age of Participants' Children



Average age of women: 29.03

Medium age range: 19-25

Figure 7b

Number of Children Per Participant

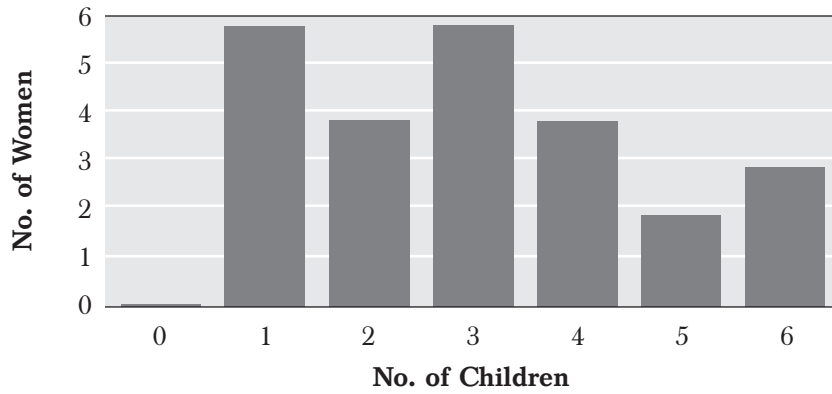


Figure 8a

Number of Participants Who Live and Work in Same Geographic Region

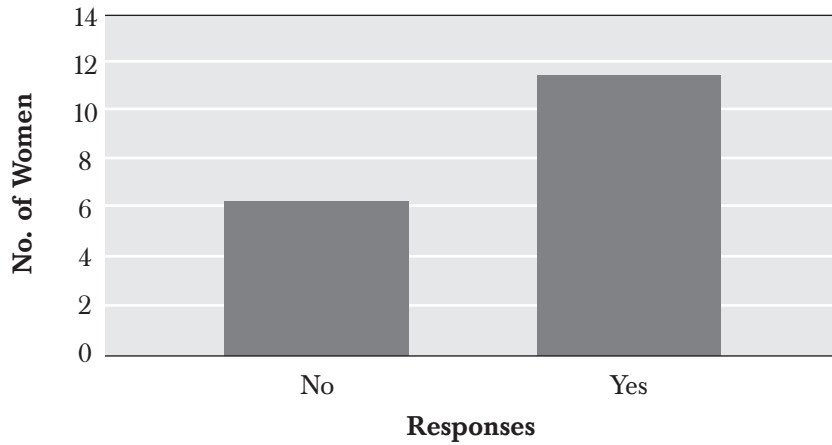


Figure 8b

Distance Between Home and Work

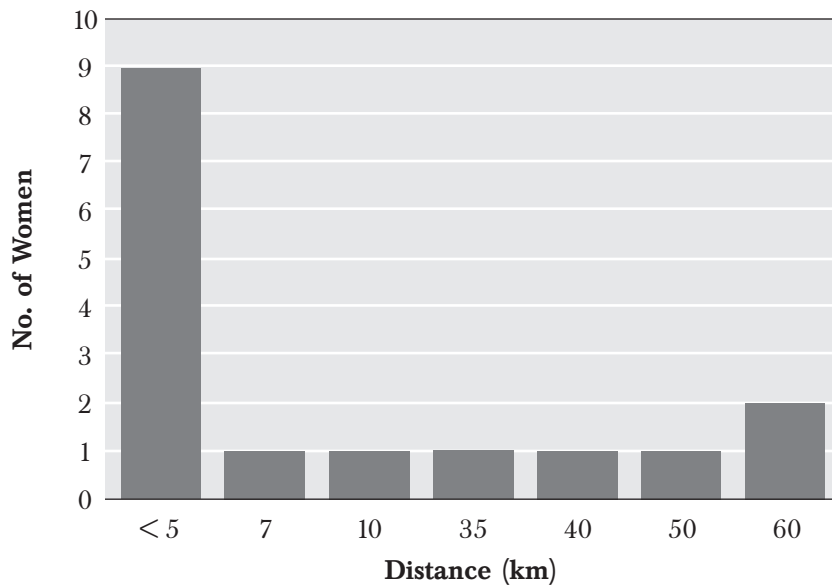
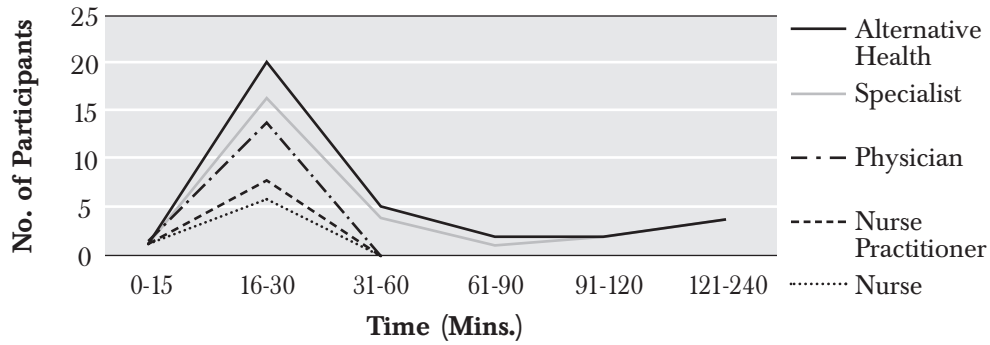


Figure 9a

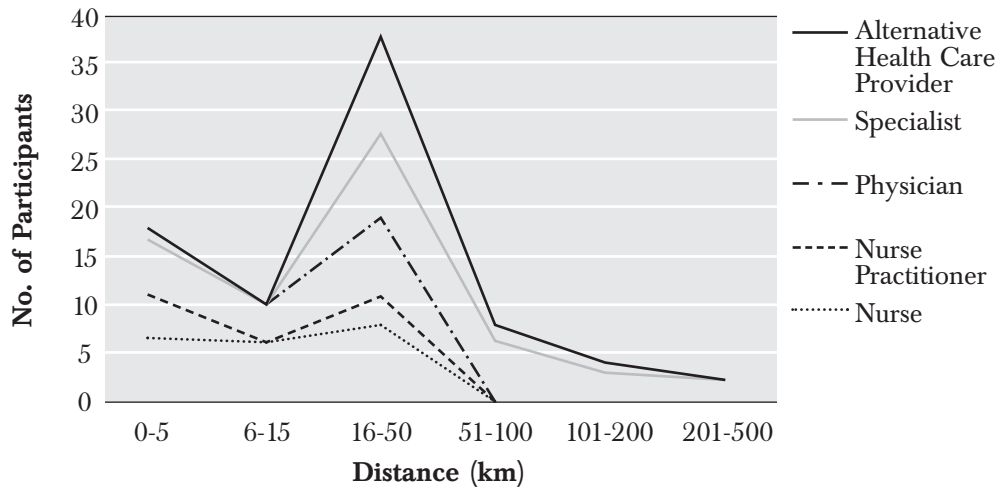
Time Travel to Nearest Health Care Provider



Health Care Providers	Number of Respondents	Average Travel Time
Nurse	7	22
Nurse Practitioner	2	22.5
Physician	6	26.25
Specialist	15	74.17
Alternative Health Care Provider	10	58.75

Figure 9b

Distance to Nearest Health Care Provider



Health Care Providers	Number of Respondents	Average Distance
Nurse	21	26.25
Nurse Practitioner	9	36.67
Physician	20	21.3
Specialist	20	100.71
Alternative Health Care Provider	15	53.18

Presentation and analysis of focus group and interview discussions

For the purpose of this report, results are organized in such a way to correspond to the questions outlined in the focus group guidelines. However, it should be noted that during the actual discussions among participants, answers to different questions did emerge at various points during the interviews, not merely in the order the questions

were asked. Thus, the structure of the presentation of the results respects the order of the focus group guidelines, but the answers to the questions are drawn throughout the interview transcripts.

For example, participants' responses concerning the health of women in general

Questions and themes addressed:

Health

Table 1 Responses to the question: What assets/resources promote your health/the health of your clients?		
Type of advantage	Examples	Further explanation/detail
Assets for women's health in general	Education	"Women are more educated today"
	Knowledge and political and/or community involvement	"Women are now more 'politicized'"
	Awareness women's equity issues	"We talk more about women's equity today"
	Longer lifespan	
	Involvement in the workforce	
	Women are now more conscious of their limits	
	Promotion and access to physical activity programs, services and resources	
	Positive attitude of provincial government to improve provision of French services (PEI)	
Resources for women's health in general	Women's groups	Workshops, forums, information days, colloquiums
		Sharing information, awareness (equity, family, self-esteem, self-confidence, healthy meals, etc.)
		Support, services
	Internet discussion list	
More information is available	Media (television, radio, newspapers, magazines), cereal boxes, etc.	
	Internet (i.e. Health Canada Website)	

are presented separately from those regarding rural and remote women's health in order to better distinguish and focus on issues particular to rurality. However, during the discussion, the questions regarding the factors that have a positive or a negative impact on women's health in general and on rural and remote women's health were discussed concurrently.

None of the participants had spontaneous answers to the question regarding the factors that have a positive impact on the health of women in general or of women living in rural and/or remote areas. However, once they started identifying such factors, participants did come up with a variety of other advantages/benefits.

It is noteworthy that as all participants were involved one way or another with women's groups, they insisted on the importance of such organizations for sharing information, providing services and promoting women's equity in terms of access to the workforce, developing a greater autonomy and changing attitudes among women, their families, their communities and society at large (perhaps, the change in attitudes are not felt to be fast enough!). It was through their participation in women's groups that participants became more:

- a) aware of women's issues and gained access to a wide variety of information/education on issues such as health, family violence, nutrition, self-esteem and financial security

Table 2 Responses to the question: What services promote your health/the health of your clients?		
Type of advantage	Examples	Further explanation/detail
Services for women's health in general	More programs targeting specific women's health issues	Breast cancer, mother-daughter walks, programs for young mothers, breast cancer detection programs
	Access to physical activity programs and services aerobics, yoga, Tai chi	Fitness centres and fitness centres specific for women,
	More hospitals and more health services (compared to what was available not so long ago)	CLSC (Quebec), info 24 hrs 7 days/week
		Extramural program (New Brunswick); homecare by interdisciplinary team, 24 hrs, 7 days/week
		Public health programs; health promotion, nurses, dietitians, inspectors, etc.
		Women's shelters
		Centres and institutions for those dealing with mental health problems
		Centres for single mothers
Larger variety of services (chiropractors, physiotherapists, etc.)		

b) politicized and involved in their community (not just in women's issues, but health, schools, elderly, etc.).

Participants acknowledged the advantages of their involvement in women's organizations and recognized that not all women benefit from such networks.

Du côté de l'Association des femmes, dans les dernières années, tout ce qu'il y a à faire avec la violence familiale, la sensibilisation, tous ces projets, le bien-être, toutes sortes d'activités de promotion puis beaucoup sur l'estime de soi, la confiance en soi. Il y a eu beaucoup, beaucoup de programmation de la part de l'Association. À un moment donné, on faisait juste des fashion shows, mais là, c'est beaucoup plus proactif.

For the Women's Association, during the first years, everything that has to do with family violence, consciousness raising, all these projects, well-being, all kinds of promotion activities and lots on self-esteem, self-confidence... There have been lots and lots of activities put forth by the Association. At a given time, we only did fashion shows, but now, it is much more proactive.

Réseau Femmes Colombie-Britannique a un service qui s'appelle l'Inform'Elle, qui est un service d'écoute, de soutien puis de référence qui a commencé initialement pour travailler auprès des femmes violentées mais qui

devient un soutien puis un service de références, qui fait beaucoup d'appui et puis qui développe le réseau.

Réseau Femmes in British Columbia has a program called l'Inform'Elle, which is a call-in service that gives support and references. It was initially created to work with women living with violence, but that is becoming more of a support and reference service that gives a lot of support and is developing the network.

Bien, moi, je prétends qu'au niveau des membres de l'UCFO, on est choyées puis on se gâte. Puis on gâte nos membres parce que quand on a des activités en grands groupes, on a des invités puis on va toujours chercher pas mal la crème des invités. Si je prends comme un exemple, nous autres, pour AGRA, j'ai appelé à l'hôpital Montfort. Cinq semaines plus tard, j'ai eu la réponse que j'étais pour avoir une madame Bouchard comme conférencière. Et le thème qu'on voulait développer, c'était la santé mentale.

I think that UCFO members are lucky and spoiled. We spoil our members because when we have large group activities, we have speakers, and we always get the best speakers. If I take for example at our Regional AGM, I called Montfort Hospital. Five weeks later I got the answer that we would have Ms. Bouchard as a speaker. The theme we wanted to broach was mental health.



Table 3 Responses to the question: What barriers/attitudes/ threaten your health/the health of your clients?		
Type of disadvantage	Examples	Further explanation/detail
General barriers to women's health	Lack of financial resources	New medication/solutions not financed fast enough
		Cost of medication <ul style="list-style-type: none"> – For those with no group health insurance – For women when the husband turns 65 (and the women are no longer covered by husbands employer health plan)
		Income (elderly and those receiving social assistance are particularly vulnerable)
	Health system is under funded	
	Health research results/conclusions not implemented fast enough	
	Economic conditions	Precarious employment
		Having to move to find employment
		Contract employment/lack of job security
		Lack of control on one's economic production
	Having to fight to obtain services in French	Having to lobby the government
Having to claim French services		
General attitudes that negatively affect women's health	Women wait before they seek health services	Afraid to be sick
		Wait until it goes away
	Social attitudes and demands of women	Women are too busy and have too many responsibilities
		Who takes care of the caretaker?
	Health discourse focused on medicalization and treatment of disease	While women have a more holistic perception of health; some women do not trust "modern" medicine
	Insufficient communication of information to women	Most information is shared among health professionals/administrators and/or leaders (who are mostly men)
	Women and especially elderly women are not taken seriously	
	Negative attitudes of Anglophone majority towards Francophones	With regards to the needs of Francophones and to the provision of services in French
Lifestyle	Women in the workforce working too much	
	Youths <ul style="list-style-type: none"> – Diet – Internet – Lack of physical activity 	

Table 4 Responses to the question: What rules/lack of services threaten your health/the health of your clients?

Type of disadvantage	Examples	Further explanation/detail	
General rules that negatively affect women's health	Alternative health and services are not covered by therapeutic medical insurance	Physiotherapy, chiropractors, massage therapy, acupuncture, homeopathy, etc.	
	Few or no services in French	When there is translation (either you bring someone, or the hospital provides someone) the patient loses her privacy	
		It takes twice as long to get the service in French or when using translation services	
		Lack of French-language training for health professionals	
General lack of services that negatively affect women's health	Prevention services are ignored, not financed and non-existent		
	Government funding cuts for women's organizations	Can no longer offer services	
	Lack of daycare services	For the women that are ill and for caregivers	
	Cuts in existing services	To different extent from province to province	
	Centralization of services	Less personalized services (Tele-health now replaces regional services that answered needs in a more personalized way)	
	Insufficient (or inexistent) support		For sick women
			For caregivers
			For those getting tests, waiting for results, After medical intervention
Waiting lists			

This question certainly elicited spontaneous and numerous answers.

The overall lack of funding for the health-care system and the rising costs of health care were common complaints. Participants also identified situations that particularly disadvantaged women, such as the cost of medication for under 65 year old married women whose husbands are over 65 years old and who no longer benefit from pension medical insurance plans.

Ça revient à dire nos attentes, les attentes que la société met sur nous autres, les attentes qu'on se met sur soi-même, les attentes que notre mari met sur nous autres, les attentes que nos enfants mettent sur nos épaules. Il y a des journées que je me demande comment est-ce que les femmes font pour faire puis tout réussir. Il doit y avoir des manquements à quelque part!

It boils down to voicing our expectations, the expectations society puts on us, the expectations we put on ourselves, the expectations our husband puts on us, the expectations our children put on our shoulders. Some days, I ask myself how women manage and succeed in

everything. There must be some misses somewhere!

Focus group participants also offered many comments regarding the social role and responsibilities women are expected to assume that overburden them and tax their own health. Such roles mostly concern the personal sacrifices of women who take care of family members in addition to being predominantly responsible for child-care and housework, even when they are in the paid workforce.

Il y a un petit aspect qui me dérange peut-être un peu et puis je veux m'assurer qu'on puisse en parler. C'est les femmes qui prennent soin de leurs parents et qui finissent par mettre leur santé en péril parce qu'elles font du travail pour lequel elles ne sont pas formées puis elles prennent soin de personnes qui sont presque plus autonomes du tout. Mais ces [femmes] finissent par être malades elles-mêmes parce qu'elles n'ont pas les outils nécessaires. Et elles n'ont pas la formation nécessaire. Et elles travaillent des heures ridicules sans pouvoir être

payées parce que [elles prennent soin d'un] membre de la famille. Donc, je pense que c'est un aspect extrêmement important parce que tu as le côté de la personne même qui est chez elle et puis tu as la personne qui en prend soin qui finit par être dans le système elle aussi. Et puis qui vit dans

la pauvreté souvent parce qu'elle ne veut pas se faire payer pour le travail qu'elle fait.

There is a small aspect that bothers me a bit but that I want to make sure that we talk about. It is the women who take care of their parents and end up putting their health in jeopardy because they

are doing work that they are not trained for and they are taking care of persons that have lost almost all autonomy. But these women end up being sick themselves because they don't have the necessary tools. And they don't have the necessary training. And they work ridiculous hours without being able to get paid because they are taking care of a family member. I think that it is an extremely important aspect because you have the person that is at home and you have the person that takes care of them who ends up also being in the system. And ends up living in poverty because she doesn't want to be paid for the work she does.

And they work ridiculous hours without being able to get paid because they are taking care of a family member.

Health and Rurality

Many women spontaneously discussed the positive impact of environmental factors, such as better air quality and better access/opportunities for outdoor physical activities.

In addition, participants focused on the quality of social relationships and support networks in smaller communities. These closer ties and community spirit would also translate into safer communities and better interactions with healthcare providers, particularly those who have made a long-term commitment to the community.

Surtout, mais même dans nos petits villages, tu remarqueras que les gens, on doit compter beaucoup sur du bénévolat. Et puis souvent, la vie est quand même plus active. Tu vas retrouver des organismes, des regroupements que tu ne retrouves pas ailleurs. Je vais juste prendre comme exemple après des funérailles, il y a tout un réseau pour recevoir les familles puis ça se fait automatiquement. Mais ça prend des gens, ça prend de l'engagement, ça prend du temps... Et puis tu retrouves plus le mouvement scout dans les petites paroisses et puis l'engagement au niveau du hockey dans les petits centres.

Especially, and even in our small villages, you will notice that people must depend a lot on

Table 5 Responses to the question: In what specific ways does living rurally or remotely positively affect your health or the health of those in your care?

Type of advantage	Examples	Further explanation/detail
Assets specific to living in rural and remote areas	Environment	Air Quality
		Space
		Peaceful
	Lifestyle / Exercise	Exercise, working/spending time outdoors
		Resources to spend time outdoors (ski trails, hiking trails, etc.)
		On farms, outdoor and/or physical work
	Ownership of home	
Smaller communities/ Geographic proximity	Shorter distance to local services, more convenient; walk within villages/towns; short car rides	
Quality of social relationships	Knowing your neighbors and community members	
	Family and social support	
	Being involved, volunteering	
	Community participation; pull together	
Less Stress	No congestion/traffic	
	Pace seems slower	
Resources specific to rural and remote areas	Information/ communication	Not many services, but communication is efficient—aware of what does exist in French
Services specific to rural and remote areas	New model of integrated services / Community health centers	More and better access to services
	Quality of care	When a health-care provider decides to establish him or herself in a rural community and actually stays, he/she knows everyone; seem more dedicated and concerned

volunteers. And often, life is more active. You will find organizations, networks that you won't find elsewhere. I'll just take the example after a funeral, there is a whole network that welcomes the families, and that is done automatically. But it takes people, it takes involvement, it takes time... And you will find more scouts in small parishes and the involvement in hockey in small communities.

Pour moi, une grosse force, c'est concentré dans notre région, c'est notre Centre de santé communautaire avec les services en français et des personnes disponibles pour nous aider. Les gens sont connus, le personnel est connu de la communauté, ce qui fait une grosse différence. On accueille des gens et le vouloir d'aider. Alors, je pense que les

personnes de la communauté se sentent à l'aise d'aller demander des questions, même si c'est juste une question à l'infirmière publique : « Est-ce que je devrais aller voir le médecin? »

For me, one of our big strengths is, especially in our region, is our Community health centre with services in French and persons available to help us. The people are known, the personnel is known in the community, which makes a big difference. We welcome people and want to help. So, I think that people feel at ease to ask questions, even if it's just a question to the public nurse: "Should I go see the doctor?"

Mais un autre point, moi, je trouve qui est positif, c'est que les gens en milieu rural—que ce soit dans les petites communautés ou sur les fermes—se

connaissent entre eux autres. Donc, il y a les aidants naturels qui sont des appuis, qui font que les gens se rendent service. Les gens s'entraident et puis c'est un point rassurant. Ça, je pense qu'au point de vue santé, ça ôte un stress.

Another point I find is positive is that people living in rural areas, whether it be small communities or farms know each other. So they help and support each other. People help each other and it's a reassuring point. I think that in a health aspect, it takes away stress.

Rural women noted that some programs have been developed to provide better access to health-care services.

Le service peut-être le plus spécifique pour les femmes, il faut qu'on le mentionne, c'est la mammographie ambulante qui va d'une communauté à l'autre à tous les deux ans. Ça fait que ça, c'est un atout. Dans notre communauté rurale, à tous les deux ans, le gros trailer arrive pour une semaine, deux semaines. Alors, c'est que ça permet quand même aux femmes qui ne conduisent pas, puis le service d'autobus est beaucoup plus questionnable depuis à peu près cinq ans, alors, il n'est pas aussi régulier. Alors, il y a tout ça qui joue. C'est un positif, et je sais que dans ma communauté, ça eu des effets bienfaisants. Des jeunes femmes qu'on a trouvé tout de suite qu'elles avaient le cancer du sein puis elles avaient 32, 35 ans, qu'on n'aurait pas, probablement, si la roulotte n'était pas venue, qu'elles n'auraient peut-être pas été se faire vérifier aussi vite.

Maybe the most specific service for women, we have to mention it, is the travelling mammog-

raphy that goes from one community to the next every two years. That is a plus. In our rural community, every two years, the big trailer arrives for a week or two. So, it gives the women who don't drive, and the bus service has been much more questionable for the last five years, so it isn't as regular. So all of that has an effect. It's positive, and I know that in my community, it has had positive effects. Young women whom we found out right away had breast cancer at 32, 35 years, that we probably wouldn't have found if the trailer hadn't come, they wouldn't have got checked as quickly.

They also praised the model of integrated services for minority Francophones or the Québec CSLC model. However, these integrated French-language services are certainly not common or generalized throughout the country. What is important from the interviews is that women feel that the services that do exist are accessible (whether they are in French or not) but these services are very limited.

Les one-stop shop où les personnes peuvent parler à un ergothérapeute, une physiothérapeute, une nutritionniste, une infirmière en santé publique, d'aller de kiosque en kiosque pour aller chercher de l'information.

The one-stop shops where people can talk to an occupational therapist, a physiotherapist, a nutritionist, a public health nurse, to go from kiosk to kiosk to get information.

For me, one of our big strengths, especially in our region, is our community health centre with services in French and persons available to help us.

Table 6 Responses to the question: In what specific ways does living rurally or remotely negatively affect your health or the health of those in your care?

Type of disadvantage	Examples	Further explanation/detail	
Barriers specific to rural and remote	Distance	Extra financial cost	
		Stress	
		Far from decision-makers	
		Having to take days off from work to access services	
		Having to find childcare	
		To avoid the complications of the travelling, will wait longer before seeking services (but then it might be to late)	
		Waiting lists for appointments with a specialist (patients might just give up)	
		Having to leave your hometown to get treatment (i.e. cancer) or services	
		– Loss of social support	
		– Extra costs for those that come to help you	
Barriers specific to rural and remote	Distance	Weather/seasonality (because of the distance to the services and risk of accidents when travelling); canceling appointments because of weather means that you are back at the bottom of the waiting list	
		To Francophone services (general or specialized)	
		High food costs (fruits, vegetables, etc.)	
		Urbanization/extended family leaving	Distance from children and family members
			– Less family members left in the area, younger ones moved away
			– Children leave to establish themselves in urban areas
		This is hard on women’s morale and emotional/mental health	
		Having to leave rural areas to get closer to specialized services	Elderly people will move to the city
		Accessibility for people with physical constraints	Wheelchairs
		Housing	Less specialized housing for the elderly, but an aging population in rural areas
High cost of specialized housing/centers for elderly (no income left)			
Less specialized housing for people with disabilities			
Substandard housing			
Lack of resources for Francophones	Institutions, organizations, etc.		

Table 7 Responses to the question: In what specific ways does living rurally or remotely negatively affect your health or the health of those in your care? (continued)

Type of disadvantage	Examples	Further explanation/detail
Barriers specific to rural and remote	Seasonal employment	Cannot leave for specialized services during working period
		Put off seeking services until it becomes urgent/emergency
		Low annual income
	Isolation	Mental health issues/loneliness
		Lonely elderly widows (who do not drive) Difficult to integrate in a rural area when you are not "from there", especially for women at home with no means of transportation
	Economic hardship in single industry communities	Limited employment for women Low income for women
	Farming	Work is never done; more than 40-hour weeks Occupational accidents and injuries
Compromised confidentiality	Health professionals and other health care employees know all the patients; stigma related to specific health issues (i.e. mental health, contraception) so patients prefer to not seek medical help in their communities	
Low levels of education	Illiteracy	
Attitudes specific to rural and remote	Social expectations of women	Women's responsibilities for their family and larger social network (even more pronounced and conservative in rural and remote areas)
		Too much is expected of women as caretakers Staying in bad relationships; affecting self-esteem
	Religious and moral beliefs or expectations of girls and young women	Lack of education in sexual issues (taboo topics: venereal diseases, contraception, abortion, homosexuality) Lack of services for pregnant teens
Rules specific to rural and remote	Reimbursement for travel to visit specialists	Is not offered in all provinces
		It takes a long time to get the reimbursement cheque
		Does not cover all costs

Table 8 Responses to the question: In what specific ways does living rurally or remotely negatively affect your health or the health of those in your care? (continued)

Type of disadvantage	Examples	Further explanation/detail
Lack of services specific to rural and remote	Lack of information	To deal with specific health issues/problems (i.e. how to live with breast cancer)
		About local/rural populations to better plan health services
	Lack of health services	No access to specialized support groups (i.e. cancer)
		Lack of mental health services in French
		Long waiting lists for specialized care (when some specialists do travel to rural areas)
		Lack of health-care providers (especially family physicians but also nurses, physiotherapists, etc.); problems of recruitment and retention
		Lack of specialized services (dietician, etc.)
		Patients are hostage to one health professional's treatment plan; no chance for a second opinion
		Lack of coordination between health agencies
		Loss of specific local services as a result of provincial health restructuring and centralization of services (i.e. provincial tele-health rather than regional services)
	No transportation services	For women who do not drive or own a car
		When there is only one car for the family (used by the husband to get to work and the women has to travel away for health services)
Public transportation: nonexistent – no train – few buses and only for long distances; not for travel within the community or within the region – flights are expensive		
Lack of services in French	Dispersed Francophone population, thus less services	
	Health professionals who can speak in French do not advertise it	
	Lack of French-speaking health professionals	
	When there are Francophone services, they are soon overcrowded	
Lack of childcare services	Insufficient regulated childcare spaces	
	Low quality of childcare services	

Table 9 Responses to the question: In what specific ways does living rurally or remotely negatively affect your health or the health of those in your care? (continued)

Type of disadvantage	Examples	Further explanation/detail
Lack of services specific to rural and remote	Lack of prevention services or greater distance to existing services	Less choices for physical activity No fitness centres, pools, etc. Less organized sports
	Quality of services	Not equal to that in urban areas – No choice in selecting specialist or doctor – Getting a service depends on who you know Specialists are not necessarily cognizant of the distance patients have to travel to see them – Travel to get results, after a previous travel for the tests, and be told nothing is wrong – Different trips for different tests rather than doing them all at once

All the problems identified are linked to the greater distance women have to travel to access specialized health services and transportation problems. These were the first answers of participants to this question. They emphasized the financial cost as well as the stress and complications that travelling long distances and separation from one's family and social support impose on rural and remote Francophone women. The significant and inevitable impact of distance from specialized health-care providers was certainly the one issue that created a consensus among the women interviewed. (Access to local health services in terms of distance was not seen as a problem when travelling to town and in town. When one has a driver's licence and access to a car this is fairly easy in small towns—no traffic, plenty of parking...)

Les gens de milieu rural sont envoyés en avion à la ville pour des chirurgies, pour n'importe quoi qui est un peu plus spécifique. Et puis ils sont ici, tous seuls, à combattre un cancer en milieu urbain, à combattre un cancer. Y'a rien. Et quand on met la langue là-dedans, bien ils arrivent ici en anglais, et c'est pas mieux non plus.

Rural people get sent by plane to the city for operations, for anything that is a bit more specific. And they are here, all alone, fighting a cancer in an urban environment. There's nothing. And when we factor in language, well they get here in English and that's not any better.

Et puis vivre ça seul, parce que souvent, la famille n'a pas les moyens de les suivre avec leur thérapie. C'est beaucoup. C'est dur sur la santé des personnes. Ça leur enlève le goût de vivre, le support moral qui tombe sur leur famille.

Évidemment souvent c'est les femmes qui donnent cet appui. Donc, elles doivent perdre du temps de travail. Elles doivent payer des frais de garderie pour pouvoir suivre la personne, pour les enfants. Donc, il y a toujours, ça finit toujours par tomber un peu du côté financier ou du côté social sur les épaules de la femme.

And living that alone, because often, the family can't afford to follow them during their therapy. It's a lot. It's hard on people's health. It takes away their will to live, the moral support that comes from the family.

Obviously, it's often women that give this support. So, they have to take time off work. They have to pay the babysitter to be able to follow the person, for the kids. So it always ends up by falling on women's shoulders financially or socially.

L'inquiétude, le stress. Et on va retarder plus. Ah, on va attendre. Il faut que j'aille en dehors de la ville. On va attendre et on va voir.

Modératrice : *Le déplacement est fatigant?*

Oui et de laisser notre milieu pour te dépayser complètement.

Et là, on aggrave notre cas et puis quand on décide bien souvent, il est trop tard parce qu'on avait pas les soins sur place.

On prend des chances et on joue avec notre santé.

Worries, stress. We will wait longer. Oh, we will wait. I have to go out of town. We will wait and see.

Facilitator : *The travelling is tiring?*

Yes and to leave your environment and be in a totally unknown place.

And then, we make our case worse when we finally decide, it's too late because we didn't have the services in the community.

We take chances and play with our health.

Une autre chose que chez nous, on se rend compte, c'est quand il faut que tu ailles voir un spécialiste, c'est toujours loin. Et puis ces spécialistes n'ont aucun respect pour toi comme patient, le fait que tu as [fait] une grande distance. Ils peuvent te faire retourner pour cinq heures de route pour te donner le résultat de tes tests et puis pour te dire qu'il n'y avait rien, tu n'avais pas de problème. Tu vas être dans le bureau du médecin quelque chose comme cinq minutes et puis tu as voyagé cinq heures pour y aller mais il faut que tu retournes chez vous cinq heures. Ça fait que ça, c'est un petit peu de sensibilisation au niveau des bureaux de spécialistes.

Another thing that we notice at home, is that when you have to see a specialist, it's always far. And certain specialists have no respect for you as a patient, the fact that you have travelled far. They can ask you to do a five-hour drive to give you a test result and to tell you that there wasn't anything, that you didn't have any problem. You'll be in the doctor's office for something like five minutes and you travelled five hours to get there and you have to travel another five hours to go home. That needs a bit of consciousness raising in specialist's offices.

The problem of lack of services and health-care professionals in their local communities was also acutely felt, as a result of the

distance from larger service centres and of the low density of rural and remote areas.

C'est ça, et on ne peut même plus avoir notre médecin de famille chez nous. On n'a même plus accès à un médecin de famille. Rares sont les personnes. Je dirais qu'il y a peut-être 25 pour cent seulement de la population de notre région qui a un médecin de famille. Là, aujourd'hui, tu vois lui et demain, tu vas aller voir l'autre et puis là, ils te disent, bien tu iras à l'urgence. Mais là, à l'urgence, c'est quatre heures d'attente.

That's it and we can't even get a family doctor at home. We don't have access to a family doctor any more. Rare are the people. I'd say that there's only about 25 % of the population in our region that have a family doctor. Today you see him and tomorrow you see another and then, they'll say that you should go to the emergency. But then, at the emergency, it's a four hour wait.

... parce qu'on a déménagé puis ça nous a pris presque trois ans avoir un médecin de famille. Puis même avec les médecins qu'on voyait ici qui essayaient de nous en trouver, ils avaient pas les moyens de [nous trouver quelqu'un].

...because we moved, it took us almost three years to get a family doctor. And even the doctors that we saw here that tried to get us one didn't have the means to find us one.

Moi, je te dirais qu'il y a un manque de services. Il y a des listes d'attente si tu veux te faire voir en santé mentale. Nous autres, on ne prend plus de clients en santé physique. On est à capacité. (...) Si tu veux des services, surtout un service—comment je pourrais dire ça—des services spécialisés, que ce soit un spécialiste que tu veux voir, tu ne peux pas le voir en dedans de deux semaines. Donc, il faut que tu attendes, être sur une liste d'attente. Tu vas attendre ton rendez-vous. Tu veux avoir un scan : tu vas attendre six semaines ou deux mois, trois mois avant d'avoir ton rendez-vous.

I'd tell you that there is a lack of services. There is a waiting list if you want to see someone in mental health. We don't take any more patients in physical health. We're at top capacity. If you want services, especially a service—how can I say that—specialized services, whether it be a specialist that you want to see, you can't see him within two weeks. So, you have to wait, be on a waiting list. You'll wait for your appointment. You want a scan: you will wait six weeks

or two months, three months before you get your appointment.

Et moi, ça me fait peur parce que nous, on arrive et le monde sont vieillissants. Les enfants sont aux prises. Et là, tu arrives et puis des fois, moi j'y pense. Je me dis « Q'est-ce qui nous attend? Qu'est-ce qui nous attend? » Parce que veut, veut pas, ça ne sera pas facile. (...) Oui, je suis à la retraite. Mon mari aussi. Et puis c'est un autre stage. Et quand tu es en santé, ça va bien. Mais là, et quand tu es aidante puis tu vois tout, tout, tout ce qui se passe, tu dis « Ah, qu'est-ce qui nous attend, nous autres, au point de vue... » À tous les niveaux, au point de vue aidante, aider et puis aussi au point de vue médical. Il manque de tout, là. Il manque des infirmières, il manque de spécialistes, manque de médecins.

And me, it scares me because we are all getting older. The children are caught. And then, you get there and sometimes, I think about it. I tell myself, "What is going to happen to us?" Because whether we want to or not, it's not going to be easy... Yes, I am retired. My husband too. And it's another step. When you're healthy, everything goes well. But when you are a caregiver and you see everything that is going on, you say "What's it going to be like for us ..." In every way, as a caregiver, help and also medically. Everything is missing. Nurses are missing, specialists are missing, doctors are missing.

The issue of distance is compounded by the problem of lack of alternative modes of transportation.

Many women also evoked the problem of distance in terms of distance from family members and particularly their children who leave rural and remote areas to work and live in cities.

Deuxièmement, je pense que l'autre aspect négatif, c'est qu'en vieillissant, il y a moins de famille autour. Nos enfants ne peuvent pas rester dans les communautés rurales. Alors, eux manquent le lien familial. Mais nous, je fais juste me comparer, moi, je suis dans la même communauté que ma mère et puis c'est moi qui s'occupe de voir que les choses se fassent pour sa santé. Mais j'ai six enfants puis j'aurai pas un enfant dans ma communauté qui va faire le suivi vraiment parce qu'ils vivent ailleurs. Peut-être que je vais être chanceuse puis il y a

quelqu'un qui va revenir. Il y a toujours des possibilités parce qu'il y a quand même des choses qui pourraient les ramener, mais c'est pas probable. Et puis ça, c'est un élément qui manque. Alors, il y a l'ennui je pense surtout des femmes âgées parce qu'elles vivent plus longtemps. La seule chose qui sauve, c'est le réseau d'amitié et de communauté.

Secondly, I think that another negative aspect is that as we get older, there is less family around us. Our children can't stay in rural communities. So they lack the family ties. But we, I am just comparing myself, I am in the same community as my mother and it is me who looks after her health needs. I have six children, but I won't have one in my community to follow up because they live elsewhere. Maybe I'll be lucky and someone will come back. There's always a possibility because there are some things that could bring them back, but it's not likely. And that is a missing factor. So there is solitude I think, mostly for elderly women because they live longer. The only thing that saves is the network of friends and the community.

Éloigné de vos enfants. Ils sont jeunes. Ils partent à 17, 18 ans.

Oui, et il n'y a pas vraiment... j'ai pas d'espoir de les revoir à ###. Y'ont tout fait des métiers que je pense pas qu'ils peuvent revenir à ###. (...) Il n'y a pas d'occasion pour les jeunes de revenir, même s'ils font les métiers qu'ils pourraient œuvrer dans la région. Il n'y a pas de travail pour eux.

Far from your friends. They are young. They leave at 17, 18 years of age.

Yes, there is not really... I don't have any hope to see them again in ###. They all have careers that I don't think that they will be able to come back to ###. ... There is no opportunity for youth to come back, even when they have careers that they could do in the region. There's no work for them.

Conservative attitudes regarding sexuality prevent young women from accessing health services.

Si je peux encore rajouter quelque chose, je pense qu'il y a les problèmes des tabous un peu parce que tout ce qui touche à la santé de la femme aussi, la contraception, les maladies vénériennes, juste ce côté-là. Et ce que j'entends des jeunes femmes, c'est que dans une communauté rurale, tu ne sens pas que tu as l'anonymat puis la confidentialité que tu

as en ville où tu peux aller dans une clinique où ton médecin le sait même pas. Tu vas quelque part qu'il n'y a pas nécessairement dans la communauté rurale. Elles n'iront pas, ce qui peut causer des gros problèmes. Ou elles n'iront pas nécessairement chercher certains services. Puis elles n'ont pas les moyens ou elles n'ont pas la disponibilité de pouvoir se déplacer pour aller chercher. Et quand elles y vont, des fois il est un petit peu trop tard. Donc, il y a cette inquiétude. Elles ne seront pas prêtes à organiser quelque chose non plus, une session d'information, justement à cause de ce tabou encore à parler de certains sujets.

If I can still add something, I think that there are problems, taboos a bit because everything that touches women's health, also, contraceptives, venereal disease, only that aspect. And what I hear from young women is that in a rural community, you don't feel that you have the anonymity and the confidentiality that you have in the city where you can go to a clinic and your doctor doesn't even know about it. You go somewhere that does not necessarily exist in a rural community. They won't go, which can cause big problems. Or they won't necessarily get certain services. And they don't have the means or they don't have the possibility of going to get it. And when they go, sometimes, it's a little bit too late. So, it's a worry. They wouldn't be ready to organize something either, an information session, because it's still taboo to speak about certain subjects.

Rural and remote areas are often marked by economic hardship, often associated with the fact that these are single-industry communities.

L'économie, dans les régions rurales et éloignées, l'économie n'est pas bien, bien... Par chez nous, on

vit du tourisme et de la pêche. Deux industries qui fonctionnent juste à l'été. L'hiver, c'est la majorité, la grande majorité des personnes sont sur le chômage.

The economy in rural and remote regions, the economy is not very, very... In our region, we live off tourism and fishing, two industries that only operate in the summer. In the winter, the majority, the large majority of people are unemployed.

In such areas, there are limited employment opportunities for women and when they can join the workforce, their incomes are low. Women are thus less autonomous and more dependent on their husbands and partners. In such economic and family situations, problems of violence against women/family violence can develop.

Smaller communities with limited services and programs do lead to rural women's more frequent community involvement, but this is in the context of need and pressure to take on more responsibilities because if you do not do it, no one else will and the service/activity will not exist. In these circumstances, women's higher participation in organizing community services and events is also associated with social expectations of women. As a result, volunteers experience burnouts.

C'est très vrai. Puis spécialement dans des milieux minoritaires, il y a beaucoup, beaucoup, beaucoup de bénévolat. Puis encore là, le bénévolat est

For a community that works a lot on volunteers and their involvement, it's even harder for the women of these rural regions because they know that if they don't get involved, it means that there won't be any services.

souvent pas valorisé. Puis dans presque trois-quarts du temps, c'est des femmes qui mènent ces organismes. Si je regarde comme les levées de fonds qu'ils ont faits ici pour bâtir le foyer pour les personnes âgées, le trois-quarts des personnes sur le comité, c'était des femmes qui travaillaient pour ça. Beaucoup des choses, des regroupements, toutes les églises, les comités de bien-être et toutes ces choses, c'est toutes des femmes qui sont membres de ces organismes pour aider les organismes de charité. Pour une communauté qui marche beaucoup sur le vouloir des bénévoles puis la participation des bénévoles, c'est encore plus taxant pour les femmes dans des milieux ruraux comme ça parce qu'elles savent si elles ne s'impliquent pas, ça veut dire qu'il n'y aura pas de services. Puis pour faire des levées de fonds en milieux ruraux, c'est beaucoup plus difficile. Encore là, pour les femmes qui veulent des services pour leurs enfants ou des choses, c'est souvent que ça veut dire des efforts additionnels pour avoir accès à un service que des gens dans les villes prennent, ce qu'ils peuvent avoir gratuitement.

En conclusion, c'était si on regarde nos communautés, tout ce qui a affaire avec les services à la famille ou le bien-être de la famille en général, c'est les femmes qui mènent les dossiers. Quand on parle de décision politique, c'est encore mené par les décideurs principaux qui sont encore les hommes dans les dossiers, là. Mais quand on parle de bien-être de la famille en général, c'est les femmes qui sont impliquées.

It's true. Especially in minority environments, there is a large need for volunteers. And even then, volunteers aren't considered important. And three quarters of the time, it's women that lead these organizations. If I look at the fundraising that they have done to build the nursing home here, three quarters of the people on the committee were women who were working for that. Many things, networks, all the churches, the well-being committees and many other things, it's all women who are members of these organizations to help these charities. For a community that works a lot on volunteers and their involvement, it's even harder for the women of these rural regions because they know that if they don't get involved, it means that there won't be any services. And to do fundraising in rural regions, it's much more difficult. Even then, for women who want services

for their children or things, it often means that additional efforts to have access to a service that people in the city take, that they can have free access to.

In conclusion, if we look at our communities, everything that has to do with services for the family or the well being of the family in general, it's the women that take the lead. When we speak of political decisions, it's still led by main decision makers that are still men in these fields. But when we speak of the general well being of the family, it's women that are involved.

D'abord, les personnes qui font beaucoup de bénévolat sont de notre âge. Veut, veut pas, on s'épuise à faire du bénévolat. Pourquoi? Et nous autres, on le vit et les autres organismes aussi. Le monde ne veut plus... Il n'y a plus de monde qui veut s'impliquer et prendre des postes et tout ça. Pourquoi? Parce qu'ils ne sont plus capables. Ils sont épuisés. Tu as tout le phénomène, tu es aidante chez vous puis autant que tes parents, tes enfants aussi qui te demandent beaucoup. Bon bien là « Pourrais-tu venir garder? Il faut que j'aille avec une chez le dentiste. Il faut que j'aille... » Tu as tout ça. Moi, ce que je dis souvent à ma mère, je dis à l'âge que j'ai aujourd'hui, toi, tu partais avec papa, tu nous appelais : « Bon, je pars pour deux, trois jours. Inquiétez-vous pas. » Mais là, nous autres, on peut pas le faire, ça. Tu le fais, mais tu te sens toujours coupable parce que tu sais que ta mère a besoin d'aide.

First, the people who volunteer a lot are our age. Whether we like it or not, we burnout by volunteering. Why? And we live it and other organizations too. People don't want to There are more people that want to get involved and take positions and everything. Why? Because they can't any more. They are burned out. You have the whole phenomena, you are a caregiver at home and as much as your parents, your children ask a lot of you too. Well, "could you come babysit? I have to bring one to see the dentist. I have to go..." You have all of that. What I often tell my mother, that at the age I'm at, you would leave with dad, you would call us : "Well, I am leaving for two, three days. Don't worry." But now, we can't do that. You do it, but you always feel guilty because you know that your mother needs help.

Rurality

Table 10 Responses to the question: When you think of living in a rural area, what comes to mind?

Rurality: Small communities—low density	Examples	Further explanation/detail
Positive aspects	Simple life	
	Own home	House paid off, elderly stay longer in their house
	Freedom	
	Peace	Compared to noise, sirens, traffic and people in the city
	Serenity	
	Tight-knit communities	Cooperation Community life/feeling
	Fresh air	
	Open or green space	Countryside, fields, open land Ocean Big yards Forest Distance between houses and neighbours
	Security	Compared to rate of crime and violence in urban areas
	Different mentality/experiences than in the city	A place to raise kids where they will not be exposed to “urban problems”
	Farms	Real cows, animals
	Negative aspects	Lack of privacy
Less services		Water, sewers, etc.
Having to get involved		Volunteer burnout If you don’t do it, it won’t happen
Compromises		Compromise easy access to a wide variety of services in order to gain the positive aspects of rurality

Distinction between rural and remote regions

Rural: Less populated areas (villages, small towns). Less services.

Remote: Geographic distance from major service centers/specialized services.

Nous autres, quand on part de [notre village], on a juste une direction à aller. Nous autres, à côté du village, c’est les montagnes. Il y a des montagnes et des montagnes et des montagnes. Puis de ce côté ici, c’est la mer. Puis de ce bord-là, c’est le parc

national puis on n’a pas accès au parc national. Quand on part, on peut toujours aller par-là. Le sud-ouest, tout le monde va par là. Puis c’est dispendieux pour nous autres qui avons une famille parce que si on a des enfants qui jouent du hockey, il faut toujours voyager loin. Si on se déplace pour des réunions, c’est loin. Les médecins, c’est loin. Nous autres, la vie nous coûte toujours deux et trois fois plus que les personnes qui vivent dans la région urbaine, par exemple, où leurs enfants peuvent jouer au hockey dans un petit rang de peut-être 10, 15 minutes de tous les côtés. Puis ça peut aller à l’université une heure au plus,

Table 11 Responses to the question: When you think of living in a remote area, what comes to mind?

Remote: Distance from service centres	Examples	Further explanation/detail
Positive aspects	All the same as for rural areas	
	Beautiful and pristine region	
Negative aspects	Isolation*	Far from services
		Far from services in French (or from other Francophones)
		Only one place/direction to go
		Everything is too far
	Cost of living is more expensive	Car pooling or other arrangements otherwise can't work
	Children leave	Have to travel for everything: sports, university, health services
		When kids leave for university, they don't come back

*Relative: depends on the characteristics of the woman (does she drive, does she have access to a car, etc.) and of the felt/perceived needs

puis c'est rendu à l'université. Nous autres, moi, les miens, c'est à l'université de Moncton, Mount Alison à Sackville, Halifax. C'est deux jours. C'est une journée pour y aller et une journée pour s'en revenir : les hôtels, les restaurants, c'était très dispendieux. Nous autres, la vie [dans notre village], c'est dispendieux.

When we leave our village, there is only one direction to go. Beside the village there are mountains. There are mountains and mountains and mountains. And on this side, it's the ocean. And on that side, it's the national park and we don't have access to the national park. When we leave, we can always go that way. Southwest, everybody goes that way. And it's expensive for us that have a family because if we children that play hockey, we always have to travel far. If we travel to meetings, it's far. Doctors are far. Life always costs us two or three times what it costs people that live in the city, for example, where their children can play hockey on a road 10, 15 minutes away in every direction. And they can go to university an hour at most, and they're at the university. Mine are at Moncton University, Mount Alison in Sackville, Halifax. It's two days. It's a day to go and a day to come back: hotels, restaurants, it was very expensive. Life in our village is very expensive.

In some cases, remoteness can be experienced in larger communities (population of up to 10,000), even if those who live there do not consider themselves rural, because of the limited available services and the long distance one must travel to obtain specialized services.

Mais même le rural, dans ma tête à moi, a complètement une différente connotation parce que pour moi, tu es rural même si tu es dans un village qui est rural parce que tu es loin des services. Même je dirais que si je prends ma ville, tu as des services de base. Mais l'effet que tu es moins de 10 000 de population ou si tu es dans la ville voisine, qui est à environ 6 000 de population, souvent tu as un chirurgien mais pas d'anesthésiste ou tu as un anesthésiste mais pas de chirurgien. Ça fait que ça, ce sont des réalités de milieu semi-rural qui n'a pas assez de monde pour faire vivre tout ce beau monde-là. Parce que c'est pas comme quand tu es proche d'un grand centre, il va faire trois jours chez vous puis trois jours dans son grand centre. Mais là, tu es assez rural qu'il ne vient pas chez toi.

But even the rural, in my mind has a different notion because for me, you are rural even if you are in a village that is rural because you are far

from the services. I would even say that if I take my city, you have basic services. But really, if you have a population of less than 10,000 or if you are in the neighbouring city that has a population of about 6,000, you often have a surgeon but not an anaesthetist or you have an anaesthetist but no surgeon. And that is the reality of a semi-rural region that doesn't have enough people to support all these specialists. Because it's not like when you are close to a big city. But here, you're rural enough that he doesn't come to you're place.

For Francophone women, it appears that even women in urban areas consider themselves remote when speaking of health-care services because they must travel longer distances to obtain services in French (i.e. Greater Vancouver Area, large urban areas). Therefore, the concept of remote in this case is conceptualized by these women in relation to French-language services, as this is their predominant preoccupation. It depends on access to Francophone services, organizations or at a minimum, interactions in French. In the Western provinces, if remote is defined with regard to access to French-language services, most Francophone women are remote, whether they live in urban or rural areas. It is interesting to note as well that in some provinces, a Francophone woman living in a rural community—where Francophones represent a strong majority of the population and where a number of Francophone institutions have been

established—is more likely to get services in French than a woman living in an urban area that is predominantly English-speaking. Thus urbanity for Francophone women is not necessarily an advantage if their concern is obtaining services in French and living healthily in French. And rurality can be more advantageous when the Francophone population represents a strong majority or is highly concentrated, but only as regards to basic health-care services, when they are provided. Any specialized health service is provided only in English in most Western provinces, and mostly in English in other provinces to the exception of Quebec.

Rural and remote regions share the same environmental and social benefits with regard to health (fresh air, social support, community involvement, etc.). However, rural and remote communities are further disadvantaged in their access to health-care services because of their geographic distance from major service centers and their low population density.

The remoteness of communities is, according to participants, relative. It largely depends on women's access to transportation (driver's permit; access to a car; available buses and/or trains; cost of flights) and on their needs (childcare, days off from work, etc.) or the difficulty or ease of transportation.



For instance, the Confederation Bridge linking PEI to New Brunswick has certainly made a big difference in facilitating access by limiting travel time and providing more opportunities. Thus women in PEI do not feel as remote as they did when the only

way to get off the island was by airplane or ferry. The frequency with which women engage in social interactions, either face to face or over the telephone or the internet, also influences the subjective feeling of remoteness.

Table 12 Responses to the question: Do you think of yourself as a rural woman? As someone who lives rurally or remotely? Both?

Type of community	Total # of participants
Rural	18
Rural and remote	6
Urban	6 (but some as remote with regard to access to services in French)

One distinction some participants made in declaring themselves rural rather than remote was the idea that they did not feel isolated because they were involved in the community, they had access to a vehicle, to the internet, they lived in a Francophone environment...

Moi, je ne me sens pas vraiment éloignée parce que je suis en contact avec du monde partout sur mon ordinateur. Puis je vois du monde et je suis un petit peu partout. Mais s'il y a une femme qui est là-bas, la seule Francophone, souvent les Francophones qui ne demeurent pas dans notre région doivent se sentir beaucoup plus éloignées parce que tes voisins ne sont pas des Francophones. Mais en tout

cas, je ne me sens pas vraiment éloignée. C'est juste à cause que je suis beaucoup impliquée. Mais ça peut être différent pour les femmes qui n'ont pas d'auto, qui ont pas de moyen de transport...

I don't really feel remote because I am in contact with people from everywhere on my computer. And I see people and I am a little bit everywhere. But if there is a woman over there, the only Francophone, often the Francophones who don't live in our region must feel much more remote because your neighbours aren't Francophones. But anyways, I don't really feel remote. It's just because I am very involved. But it can be different for women who don't have a car, who don't have transportation...

But if there is a woman over there, the only Francophone, often the Francophones who don't live in our region must feel much more remote because your neighbours aren't Francophones.

Policy Framework

Table 13 Responses to the question: If you could have the undivided attention of key health-decision makers to talk about the state of women’s health in your community, what two most important issues would you raise?

Issues	Examples	Further explanation/detail
Accessibility	Increase number of health-care providers	Allow more foreign physicians and professionals to practice Encourage semi-retired physicians to contribute
	Encourage health-care professionals to stay in rural and remote areas	Improve salaries for professionals
	Increase use of nurse practitioners	
	Reduce cost of medication	
	Rotating services to increase accessibility	
	Provide services in rural and remote communities	Create regional service centres
	Provide home visits/services	
	Provide services in French	Proactive services in French Improve quality
	Provide transportation	Public transportation or other to allow women to get to the services
Provide financial help to those in need	Stop cutting or reducing social services and programs	Help the poor
Improve the economy and economic conditions	Increase revenues for families, the elderly, single mothers, etc.	
Information/communication	Inform specialists on the situation of people from remote areas	
	Different agencies should better communicate among themselves to know what services each one provides	
	Women get information through their own organizations, but women not in these organizations do not get the information	
	Promote exchange of information between generations; pass knowledge from elderly to youths	
	Educate women so that they can help their families	Networks of exchange of information



Table 14 Responses to the question: If you could have the undivided attention of key health-decision makers to talk about the state of women’s health in your community, what two most important issues would you raise? (continued)

Issues	Examples	Further explanation/detail
Increase services	Increase funding for health-care system	
	Mental health services	
	Home care	Provide services Help the caregivers
	Better support for victims of violence, social assistance	
	Health prevention and promotion activities/ services	Create women’s health centers across the country
		Services for the family and for early childhood
		Plan for the long term (not short term)
		Maintain/increase specialized prevention services, i.e. speech therapy
		Policies, programs and services to improve lifestyle and culture shift
		– Prevent burnout; change actual working conditions since people are now overworked (one person doing the job of two or three) – Shorter working weeks to help working parents take care of kids, cook nutritious meals – Diet – Physical activity – School physical education and interscholastic programs – Quit smoking

Table 15 Responses to the question: If you could have the undivided attention of key health-decision makers to talk about the state of women’s health in your community, what two most important issues would you raise? (continued)		
Issues	Examples	Further explanation/detail
Multidisciplinary health clinics	Centers with integrated health services	To provide services for the person as a “whole”
Inform politicians and decision-makers about the specific realities of women and of Francophones		
Fund and do research on Francophones’ health in rural areas	The assessment of the health status is needed to plan and provide adequate services	
Re-evaluate funding priorities	Specialized and expensive services vs. prevention	
Improve women’s equity	Financial	Wage equity
		Remunerate stay-at-home mothers, caretakers
		Provide childcare
	Social	Recognize contribution of women’s work
	Political	Wanting a stronger voice (corporations and pharmaceutical companies have too much weight) – Make decisions with grass-roots input, from women and from women’s groups – Have more women in cabinet to influence decision-making but these women need to be critical of the system, not just reproduce it
Change discourse	From a medicalized discourse focused on disease to a more holistic perspective that includes prevention and alternative health	Provide alternative health services; stop the conflicts between physicians and alternative health providers (i.e. chiropractors)

Participants stressed the need to act now to improve the health-care system. There was a sense of urgency about an impending health-care crisis (if it did not already exist) and women felt it was important to act now on the Romanow Report and other recommendations.

The two most important issues women raised were obtaining better access to health services and increasing access to and the quality of social and health services. Access meant on the one hand, finding solutions to provide specialized services in the rural and remote community rather than imposing the

problems of travelling on the sick and vulnerable. On the other hand, access also referred to providing better means of transportation when travelling is inevitable.

Le financement, mais je me dis que quand même qu'on serait bien financé, il y a quelque chose aussi où je me dis qu'on paie tous le même montant de taxes, qu'on soit éloigné, rural éloigné ou n'importe quoi. On a droit à nos services sur place. C'est ça que je me dis. On paie les mêmes taxes que les personnes des grandes villes. Pourquoi est-ce qu'on n'a pas droit aux mêmes services que ces grosses villes? Quand tu tombes à 3 000 ou 4 000 personnes de population, je me dis que le gouvernement devrait gérer un peu le programme santé aussi pour qu'on puisse avoir nos services sur place.

Funding, but I say to myself that even though we would be well funded, there is something where we all pay the same amount of taxes, whether we are remote, rural and remote or anything else. We have a right to services where we are. That's what I tell myself. We pay the same taxes as people in the city. Why don't we have the same rights to services as the cities? When you fall to 3,000 or 4,000 people in the population, I say to myself that the government should manage the health system a bit so that we can have our services where we are.

Je pense que c'est plus facile de déplacer un médecin que de déplacer 20 patients qui vont devoir faire cinq, six heures de route pour aller voir le même médecin. Ça serait peut-être beaucoup moins onéreux et puis ça rendrait bien plus service, puisqu'on est en milieu éloigné, que le système prévoit, que les services vont être donnés proches ou à moins de deux heures de route.

I think that it's easier to move one doctor than to move 20 patients who have to travel five, six hours to go see this same doctor. It would probably be a lot cheaper and it would be much more helpful, as when we are far away, the system is set up so that you will have services at least two hours travel time.

Les médecins aussi et les infirmières, tout ce qui touche à la santé, quand ils arrivent ici, ils ne reconnaissent pas leurs diplômes et tout ça. Mais moi, je me dis qu'ils leur paient une formation et puis leur fassent passer tout un examen puis qui les acceptent. Je me dis « on est en pénurie ». C'est quoi là de toujours bloquer et bloquer? Tu as de bons

médecins, ceux qui arrivent de l'extérieur [de la province, du pays] seraient prêts à venir travailler ici.

Doctors and also nurses, everyone involved in the health system, when they get here they don't recognize their diplomas and all of that. But I say to myself that they pay for their training and make them pass their exams and they accept. I say to myself, "we've got a shortage". What's the idea of blocking and blocking? You have good doctors, but they come from outside (of the province, of the country) that would be glad to come and work here.

The need for better prevention and for health promotion was also underlined and prioritized by participants. In focusing on prevention, women were also calling for a larger safety net and better socio-economic and working conditions. The latter play a large role in ensuring an improved health status.

Mais il y a de la prévention, puis la prévention de santé à faire. Et si tu regardes où est-ce que l'argent est mis tout de suite, il est pas mis sur la promotion de santé. Puis la promotion de la santé en milieu rural est encore plus importante qu'elle l'est en milieu urbain parce que les gens en milieu rural n'ont pas accès aux services que les gens des milieux urbains ont accès. Donc, je vois que s'il y avait plus d'argent d'investi dans la promotion de santé et la prévention de la maladie, d'ici à 30 ans de sûr, on serait pas dans le pétrin qu'on est. On n'aurait pas à verser autant d'argent pour le système de santé qu'on met actuellement. Puis ça s'empire.

But there is prevention, and health prevention that needs to be done. And if you look at where the money is being put right now, it isn't being put on health promotion. And health promotion is even more important in rural regions than it is in urban regions because people from rural regions don't have access to the services that people in urban regions have access to. So I see that if more money was invested in health promotion and the prevention of disease, in 30 days for sure, we wouldn't be in the mess that we are in. We wouldn't have to put the money we do now in the health system. And it's getting worse.

Moi, je pense qu'il y a un autre aspect qu'il faut que le gouvernement regarde, puis c'est la charge des

travailleurs et des travailleuses. Pas rien que dans le domaine de la santé mais dans tout. Je regarde les coupures qu'on fait dans les institutions d'éducation, de la santé. Les entreprises où on coupe le personnel. Alors, les personnes qui restent font le boulot de trois personnes parce (...) qu'on n'a pas réduit l'output. On avait huit employés puis on est rendu à trois, puis on est supposé produire autant, si pas plus. Plus avec moins. Mais moi, je pense que quand même, il y a énormément de stress dans le domaine du travail des gens. Et puis ça, ça affecte la santé. Il y a plus de journées de maladie de prises. Il y a plus de burnouts et puis c'est quelque chose qu'on a de la misère à reconnaître. C'est que souvent les gens se font laisser aller avant qu'ils puissent embarquer sur les plans de santé qu'ils ont payé parce qu'on interprète d'une différente façon et puis après ça, nos gens sont...

I think that another aspect that the government needs to look at is the workload of the employees, not only in the health sector, but in everything. I look at all the budget cuts done in educational institutions, in health, in the businesses where they fire people. So the people left behind do the job of three persons because... we haven't reduced the output. We had eight employees and now we are three and we are supposed to produce as much if not more; more with less. But I still think that there is lots of stress in people's work. And that affects health. More sick-leave days are taken. More burnouts and it's something we have trouble recognizing. It is often the case that people are laid off before they can join the health plans that they have paid because it was interpreted in a different way and that, our people have...

Improve the quality of care available in rural and remote areas.

On n'a pas le choix des spécialistes. S'il y en a un qui décide, je ne sais pas comment c'est arrangé au Collège des médecins, mais s'il y en a un spécialiste qui vient en région, bien c'est lui qu'il faut aller voir. Si on veut en voir un autre, c'est nous autres qu'il

faut qu'on y aille. Et puis souvent, ils sont obligés d'en faire de la région. Je pense qu'à un moment donné, au niveau de la loi, quand ils sortent de l'école des médecins, ils sont obligés. Ils ne sont pas toujours intéressés, ces médecins-là, à nous servir.

We don't have the choice for specialists. If one of them decides, I don't know how it's organized at the CMA, but if a specialist comes to our region, it's him we have to see. If we want to see another one, we have to travel to him. And

often, they're obligated to practise in remote regions. I think that at a given time, the law gives new doctors the obligation. These doctors aren't always interested in serving us.

Provide a voice for women in decision-making processes since women are concerned about these issues and they in fact have much knowledge and experience since they are the professional healthcare providers and the caretakers as well. Women are pushing for a change in the discourse of health so that a more holistic perspective will be encouraged and alternatives to simply focusing on the treatment of disease will be provided.

C'est un peu inquiétant—et je sais que je sors du sujet—mais c'est un peu inquiétant ce qui se passe présentement parce que les études qui sortent dans la francophonie, c'est toujours le même modèle. Puis nous autres, on est toujours à la traîne en arrière, en train de dire non, c'est pas ça qu'on veut. C'est que les femmes, c'est elles non seulement qui utilisent les services mais on travaille dans le milieu et puis on n'a pas de crédibilité dans ce qu'on dit et puis c'est inquiétant parce qu'on va être encore en train d'essayer de défaire ce qui va être mis en place, si on n'a pas notre place.

It's a bit worrisome, and I know I'm getting off topic, but it's a bit worrisome with what is going on now, because students who leave the Francophone community always follow the

I think that another aspect that the government needs to look at is the workload of the employees, not only in the health sector, but in everything.

same model. And we are always lagging behind, saying no, that's not what we want. Women, it's them that use and work in the health services field, but we aren't credible in what we say and it's worrisome because again, we'll have to undo what is being set up if we don't have our place.

Je pense qu'il y a encore un problème. Ils ne comprennent pas, mais ils pensent qu'un groupe de femmes représente seulement les femmes et ne réalisent pas que les décisions qui sont prises, qui affectent les femmes affectent la société au complet. Je pense qu'il y a encore cette image-là de libéralisme féministe et ils ne réalisent pas jusqu'à quel point que l'impact des décisions des opinions des femmes affecte la société au complet, la famille, leur conjoint, l'éducation—ça affecte absolument tout. Et je pense qu'ils ne comprennent pas encore ça. Je ne sais pas ce que ça prend, mais ils ne comprennent pas. Ça fait que c'est vraiment vu comme une perspective d'un groupe cible et puis pourquoi prendre ces décisions pour représenter la communauté au complet.

Moi, je suis tannée qu'on se fasse voir comme un interest group. Viens pas me dire que Bombardier n'est pas un interest group! Ne viens pas me dire que Ipsco est pas un interest group. C'est vraiment... C'est pareil comme si à cause qu'on est des femmes ou qu'on est un groupe de Francophones, on est un interest group puis on est des sangsues. On suce juste le sang de la société et on ne contribue pas, et que c'est vraiment l'inverse.

I think that there is still a problem. They don't understand, but they think that a women's group only represents women and do not realize that the decisions that are taken, that affect women affect the whole society. I think that there is still this image of liberal feminism and they don't realize to what point the impact of the decisions of women's opinions affect the whole society, family, husbands, education, it has an effect on absolutely everything. And I think

that they still don't understand this. I don't know what it takes, but they still don't understand. So it's still seen as the perspective of an interest group and why take decisions that will represent all of the community.

I am tired of being perceived as an interest group. Don't tell me that Bombardier isn't an interest group! Don't tell me that Ipsco isn't an interest group. It's really... It's as if because we are women or that we are a group of Francophones, that we are an interest group and bloodsuckers. We only suck the blood of society and do not contribute, and it's really the opposite.

Puis surtout en milieu rural, ces femmes ont encore moins de voix. Les communautés sont petites. On le voit. Ce que tu disais pour ce qui était dans les situations où il y a de l'abus, les femmes ne veulent pas parler. Bien, c'est la même chose. Quand les femmes sont dans des couples exogames ou tout simplement dans une petite communauté, elles n'iront pas revendiquer rien en français. On va se faire pointer du doigt. Être Francophone minoritaire, ça veut pas dire qu'on est des activistes puis qu'on est des militantes. Puis déjà d'être féministes, on se fait pointer du doigt. S'il faut qu'on aille au bureau de poste en plus puis commencer à demander un service en français...

And especially in rural areas, these women have even less voice. Communities are small. We see it. What you were saying about women in abuse situations, women don't want to talk. Well, it's the same thing. When women are in exogamous relationships or simply from a small community, they won't advocate for nothing in French. We'll be finger pointed. To be Francophone and minority, doesn't mean that we are advocates and lobbyists. And already to be feminists, we get finger pointed. If on top of

that we have to go to the post office and ask for services in French....



Table 16 Responses to the question: How satisfied are you with the quality of health and health care for women and girls in your area?

Level of satisfaction	Examples	Further explanation/detail
Satisfied	Fairly easy to get an appointment with local doctor (if one has a family doctor!)	
	Information provided in the community	
	Health professionals are sometimes more dedicated, they know the people	
	Introduction of nurse practitioners where they do exist has been a good improvement	
	Health status has generally improved	
	Basic services and information available	
	More services and programs are now available in some rural areas (rather than having to travel to larger centre)	Mobile mammography services
	Not satisfied	Lack of services and lack of quality of existing services
Information		
Lack of services, never mind the quality!		
Younger generations are leaving the rural and remote communities partly due to the lack of quality in the services		
Services in French are inexistent or not of good quality		
Errors in making diagnostics		
Lack of health-care professionals		Mental health
		Burnout among health-care professionals
		No access to a family doctor
		Introduction of nurse practitioners means physicians come even less
		Health professionals positions not filled
		Specialist and professionals are too busy
Not enough financial support	Of Francophone groups To ensure services in French	
Waiting lists		
Lack of prevention services and resources	Diet, exercising, smoking	
Specific health problems on the rise	Obesity	

Healthcare providers are too busy and do what they can with what they have (to provide good services) but it is not enough.

Ça fait que quant au service de santé, bien, moi, je trouve qu'on fait du mieux qu'on peut avec les ressources qu'on a. Mais on ne donne certainement pas des soins de santé qui sont Cadillac, bien loin de là. (...) Je regarde, on travaille et on a une pleine charge de patients puis j'ai six infirmières sur la route à chaque jour. J'ai du travail pour sept à huit infirmières. J'ai des filles qui sont en train de se brûler parce qu'on n'a pas suffisamment de ressources. J'ai une ergothérapeute qui a

60 patients. Imaginez-vous avoir 60 patients à desservir dans des maisons et les écoles.

It means that for health services, well, I think we do the best we can with the resources we have. But we certainly don't give Cadillac health services, very far from that ... I look, we work and have a full load of patients and I have six nurses on the road each day. I have work for seven to eight nurses. I have women that are burning themselves out because we don't have enough resources. I have an occupational therapist with 60 patients. Imagine having 60 patients to care for in houses and schools.

Table 17 Responses to the question: Do you think the quality of health care for women in your area has changed in the past two years? In the past five years? For better or worse? Please give examples.

Level of satisfaction	Examples
For better	More programs targeting women (i.e. mammography)
	More clinics and information (i.e. sexual education)
	More services (new machines/technology for diagnostic purposes; nurse practitioners)
	New Francophone health centers
	Some people are adopting healthier behaviours (stopped smoking, better diet...)
For worse	Lack of prevention (Dealing with problems too late)
	More informed but behaviors are not changing (exercise, diet, smoking...)
	Less health-care providers
	Funding cuts, less services (what used to be regional services are now provincial services and no longer anonymous, i.e. telephone info line; reduction of services in French; cuts in physiotherapy services)
	Lack of Francophones or bilingual health-care providers
	With an aging population, there is a need for increased services
	Waiting lists

The creation of Francophone or community-health centers has been identified by participants in some regions as an improvement in the provision of health services.

L'accessibilité disons pour le moment aux soins de santé, en ayant le centre de santé même dans la région, dans le local. Et puis ce qui rassure beaucoup les femmes c'est que nous avons une infirmière et un infirmier praticien sur place continuellement. Aussi, il y a des activités qu'on fait et puis il y a une infirmière qui vient prendre la pression

des personnes et ça rassure beaucoup, beaucoup les femmes. Nous autres, c'est plus les femmes. Moi, je travaille avec les personnes âgées plus et puis c'est ça pour le moment qui s'est amélioré dans notre patelin, disons.

Accessibility for the moment to health services, by having the health centre in the same region, in the community. And what really reassures people is that we continually have a nurse practitioner on site. Also, there are activities that we do and there is a nurse that comes to take people's blood pressure, and that reassures

many, many women. Us, it's not just women. I work more with elderly people and that's why it has gotten better in our community

While women recognized some gains in providing new models of health-care serv-

ices and more information about specific women's health issues, it seemed that they also were discouraged to notice a decline in services.

Research Agenda

How would you define “your community”? Are there women’s health issues about which you think more information is needed in order to prompt appropriate action in your community or region?

Table 18 Responses to the question: How would you define “your community”?

Type of community	Examples	
Geographic community	Neighborhood	
	Village	
	Town	
	Region/County	
Cultural/linguistic community	Acadian (provincial or local/regional)	
	Francophone (provincial or local/regional or Prairie Francophone community)	
Interests	Kids' Soccer	
	Work	
	Women's community	
Commitment/ties	Family	
Religious	Parish	

The most spontaneous answers of most participants referred to the geographic community (which is sometimes the same as

the parish in case of villages), the Francophone community and family.

Why is that with all the information, all the knowledge that we have let's say on smoking, why in a rural area is the number of people, or women that smoke continue to increase, especially amongst young women? Why?

Table 19 Responses to the question: To put it another way, have you ever felt concerned or curious about some aspect of women’s health care in your area and wished that someone would look into it further?

Type of question	Examples
To better provide services	Why, despite all recent information are people not changing lifestyle and behaviors (diet, smoking...)?
	What to do to encourage/help them lead healthier lives?
	Find more creative ways to provide services to rural and remote communities
	How to better reach women and provide them with the information? (Especially those women that are not currently involved)
	Home care and how informed/competent are we as caretakers. More research on our roles as caretakers.
Health problems	Menopause and hormones; Impact of contraceptive pill
	Nutrition (adapted to special circumstances)
	Vitamins
	Cancer (why more in rural areas); Cancers particular to women (i.e. breast)
	Impact of environment on health (i.e. salt on roads, water and air pollution; i.e. allergies, asthma)
	Cardiovascular disease in women
	Impact of medication
	Genetic conditions among populations (i.e. Acadians)
	Effects of recreational drugs and alcohol
	Mental health (women, adolescents)
	Weight gain and obesity
	Alternative medicine
	Bulimia and anorexia
Post-partum depression	
Social and economic factors	Ageism and Access to Services
	Diverse realities of women (age, socio-economic status...)
	Child poverty
	Isolation (how it is experienced by women and its impact on health)
	Impact of language on health and health care (when you can’t get the services in your language or first language)
Comparative	Women/men
	Health of population in rural communities with many health services compared to that of other rural communities with less services

This was not an issue participants had thought about much before this interview. It appeared that women working as health-care providers or involved as volunteers in the social and health service field had more spontaneous ideas about research needs.

And for these women, research topics focused on how to change behaviours and better serve people as opposed to finding cures or gaining more knowledge about specific diseases or health problems.

Pourquoi est-ce que malgré tout l'information, toutes les connaissances qu'on a disons sur le tabagisme, pourquoi est-ce que peut-être dans le milieu rural, le taux des gens, des femmes qui fument continue à augmenter, surtout parmi les jeunes femmes? Pourquoi? Vous avez l'information. Vous savez. C'est quoi qui vous empêche d'arrêter de fumer ou de changer vos habitudes? (...)

Peut-être se pencher sur tout ça.

Pourquoi vous changez pas vos habitudes alimentaires? Pourquoi vous changez pas vos habitudes d'activité physique?

Le comportement, comment changer les habitudes de vie, c'est plus ça qu'il faudrait étudier, plus que OK, on sait que c'est pas bon pour vous à cause de ça, ça, ça, et ça.

Why is that with all the information, all the knowledge that we have let's say on smoking, why in a rural area is the number of people, of women that smoke continue to increase, especially amongst young women? Why? You have the information. You know. What is stopping you from stopping to smoke or from changing your habits? ...

Why aren't you changing your nutritional habits? Why aren't you changing your physical activity habits?

The behaviour, how to change life styles, that's what we would need to study, we know that it's not good for you because of this, this, this and this.

Table 20 Responses to the question: The Centres of Excellence do research that involves community members from the start. Do you have any suggestions on how to improve this model?

Concern with duplication of research studies
Applied research: Research should be "used" or about "usable" topics
Action research, involve women, women groups and communities
Produce reports, documents, books women can read and use; provide concrete outcomes of research
Gather data from more women
Collect data in rural areas
Women's Health Centres of Excellence should provide documentation and services in French
Include Francophone women
Include a greater diversity of women (women not in associations, less privileged women)
Continue with data collection activities that foster interaction
Interviews and focus groups rather than questionnaires
Raising awareness of women through research and such interactions

Some participants stressed the idea of producing applied research that will be useful to women in the communities; to health-care providers in the rural communities.

Moi, j'aurais tendance à faire une recherche appliquée. Ça veut dire que j'aurais tendance à proposer un genre de projet pilote qui aurait comme objectif ce que moi j'ai proposé, mais c'est sûr que beaucoup de gens seraient d'accord avec ça, ce qui est prévention, éducation populaire, échange entre les générations et tout ça, prendre une communauté et se dire dans cette communauté-là, on va appliquer cette approche-là. On va

faire de la prévention, on va faire de l'éducation populaire, on va essayer de créer des échanges entre les générations pour que les expériences se transmettent. On va essayer d'impliquer cette façon de travailler plus sur l'individu que sur le système. Et dans une communauté assez particulière.

I would have a tendency to do applied research. That means that I would tend to propose a kind of pilot project that would have as an objective what I have proposed, but I am sure that lots of people would agree with that, which is prevention, popular education, inter-generational exchanges and all of that, take a community and say in that community, we will apply this

approach. We will do prevention, we will do popular education, we will try to create inter-generational exchanges so that experience can be transmitted. We will try to involve this kind of work more on the individual than on the system. And in a particular community.

Participants profited from the interactive process of the data collection and mentioned that it was more rewarding for them as they felt they could contribute more effectively, but also gain more out of participating in the discussion and hearing other women's opinions. They also felt that a limited number of women were being consulted and that Francophone participants were women involved in their communities. They thus expressed a need for larger consultations with a greater diversity of women.

Il y a aussi, quand les gens, il y a des consultations qui sont faites, je pense que ça suscite en groupe la question d'une ou la réponse d'une va susciter : « ah tiens, oui, j'avais pas pensé à ça. » Mais il y a ça aussi. Ça fait que ça crée automatiquement une sensibilisation dans la communauté. Quand il y a des sondages sur place avec pas seulement les pourvoyeurs de services—si je peux les appeler de même—mais les personnes qui reçoivent ou les usagères. Et je pense que c'est là parce que je me rends compte à cause de comités où je siège qu'on

n'a pas du tout la même interprétation de la santé ou les besoins des personnes selon qu'on est un pourvoyeur de santé ou une usagère. Ça, je pense qu'en tout temps, si on veut avoir quelque chose qui est représentatif, il faut que tu aies les deux groupes assis à la même table et puis il ne faut pas qu'il y ait un groupe qui soit beaucoup plus...

There is also the fact that when people, when group consultations are done, I think that that encourages the question of one person or the response of another will encourage: « yes, I hadn't thought about that. » But there is also that. It automatically creates consciousness raising in the community. When there are local surveys but not only with service providers if I can call them that, but also with the people who are receiving or the users. And I think that it's there because I am realizing that because of committees where I sit that we don't all interpret health in the same way or people's needs whether we are a health provider or a user. That, I think at all time, if we want something that is representative, you have to have both groups sitting at the same table and they have to be about the same size...

J'ai l'impression d'avoir contribué plus efficacement que de remplir nos petits questionnaires puis le mettre à la poste.

I have the impression of having more efficiently contributed than if I had filled out a mail survey and then sent it.

General Comments

1) Women's health issues vs. health issues in rural and remote areas vs. Francophone health issues

What emerged from the discussion with the minority Francophone women living in predominantly Anglophone communities was that the remote (rather than rural) and Francophone issues with regards to health and health-care services were more of a concern for these women than specific women's health issues. They were concerned with problems of constrained and limited access to a variety (not just biomed-

ical) of quality health-care services because of geographic distance and low population levels. This problem seemed so fundamental for the overall population in rural and remote areas that the women were not particularly preoccupied with specific women's health issues. The second issue that arose as highly important was access to quality health-care services in French. As if concerns about women's health can come to the forefront only once so-called basic health concerns are resolved. As if thinking about specific "women's health" problems is a luxury in remote areas.

Il y a aussi une rotation qui se fait. Alors, il n'y a pas toujours un médecin de disponible, ou le médecin qui parle français, bien, c'est pas son tour. La même chose pour les infirmiers et les infirmières. Et ça, c'est tant à l'urbain qu'au rural. C'est très, très difficile d'accéder aux services en français. Puis s'il y a un médecin Francophone, il est tout de suite surchargé. Sa besogne devient presque intolérable. Alors, il y en a qui laissent. Il y en a qui quittent.

There is also a rotation that is done. There is not always a doctor available or it's not the doctor who speaks French's turn. It's the same thing for nurses. And that is as much urban as rural. It is very difficult to access French services. And if there is a Francophone doctor, he is right away overworked. His workload almost becomes unbearable. So some of them quit. There are some that leave us.

Sauf que moi, je suis en région urbaine. Et j'aurais probablement un meilleur service en français dans le village que j'en aurais en ville, ici. Je sais que si je vais à l'hôpital, dans le village, les chances sont que je pourrais avoir une infirmière qui parle français, tandis qu'en ville, c'est une autre histoire. Si on regarde du côté Francophone, c'est complètement différent. Je dirais que c'est l'inverse de ce que c'est normalement.

Except that I'm in the urban region. And I would probably have a better service in French in the village than I would have in the city, here. I know that if I go to the hospital, in the village, chances are that I will get a nurse that speaks French, while in the city, it's another story. If we look at the Francophone side, it's completely different. I would say that it's the opposite of what things normally are.

Si tu demandes je veux parler en français, est-ce que vous parlez français? Ah non, excuse-moi, une minute. Là, elle te met de la musique. Et tu écoutes un beau concerto de je ne sais pas quoi, là. Bien moi, je te dirais que ça me choque, ça. Je ferme la ligne parce que quand je veux écouter de la musique, je ne téléphone pas. J'ouvre la radio.

Quand j'appelle, moi, c'est pour parler à quelqu'un. Puis ça, je comprends que c'est moins dispendieux qu'un employé, mais appuyez sur 1 pour le service, appuyez sur 2 pour tel autre et puis le service en français. Là, tu appelles au service en français et ils veulent savoir quel département. Encore, c'est une boîte vocale. Et puis là, ils te font attendre. Tu es en attente continue. Et là, ne quittez pas pour garder ta priorité d'appel.

Votre appel est important pour nous.

On la sait, cette petite chanson-là. L'autre jour, j'ai attendu 17 minutes. J'ai rappelé et là, j'ai réussi à parler en anglais. Et là, j'ai dit je veux un service en français, dans la même heure, s'il vous plaît...

Oui, mais ton personnel français, quand tu es obligé d'aller le chercher à l'autre bout de l'hôpital, il faut que tu attendes.

Ceux qui parlent anglais et qui disent ah bien, laisse faire. J'attendrai pas une heure, je vais te parler en anglais. Ça, ça fait-tu plaisir aux Anglophones, ça, hein. Moi, ça me fâche, ça. Ah, vous l'avez le service français. On n'a pas à se plaindre, on l'a le service français. Mais ne regarde pas la qualité du service français qu'on a, là.

If you ask I want to speak French, do you speak French? Oh no, wait a minute. And then they put music on for you. And you listen to a nice concerto of I don't know what. Well, I would tell you that that makes me mad. I hang up because when I want to listen to music, I don't call. I turn on the radio. When I call, it's to talk to someone. And I understand that that is cheaper than an employee, but press on

1 for service on 2 for something else and for service in French. Then you call the French-language service and they want to know which department. Again it's a voice box. And they make you wait. You are continually waiting. And then, don't hang up to keep your priority.

Your call is important to us.

We know that little song. The other day I waited 17 minutes. I called back and then, I was able to

***They were concerned
with problems of
constrained and limited
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geographic distance and
low population levels.***

speak in English. So I said I want service in French, during the same hour, please. . . .

Yes, but your Francophone personnel, when you have to go get it at the other end of the hospital, you have to wait.

Those that speak English and who say, well forget it. I'm not going to wait an hour, I can talk to you in English. That really pleases the Anglophones. That makes me mad. Oh, you have the French language services. We shouldn't complain, we have the service in French. But don't look at the quality of French service that we have.

Puis il faut pas oublier la confidentialité parce que quand on demande à une autre personne de traduire pour nous autres, il y a toute la dignité du client. Puis ça souvent, c'est pas pris en considération. Moi, j'ai vu des cas où ils appelaient le concierge parce que c'était le seul Francophone qu'ils connaissaient pour venir faire de la traduction. Moi, j'appelle pas ça un service de qualité. J'appelle pas ça un accès, le même niveau d'accès que les Anglophones peuvent avoir.

We can't forget confidentiality because when we ask another person to translate for us, there is the whole question of the patient's dignity. And that is often not taken into consideration. I have seen cases where they would call in the janitor because he was the only Francophone that they knew to come and do the translation. I don't call that a quality service. I don't call that access, not the same level of access as Anglophones can have.

This did not appear to be the case for women living in rural (without being remote) areas since the distance to specialized and a variety of health-care services was not as great.

For the women living in predominantly Francophone areas, the issue of language did not emerge during the discussion until I raised it at the end of the interview. When prompted on this discrepancy between their answers and those of women living in Anglophone areas, they answered that it was a given for them that health services should, and would, be in French. They had not mentioned it because French-language serv-

ices were available in their community.

They did underline that for other women in other regions of their respective provinces, health-care services were not available in French and that it was a major problem.

The specificity of women's health issues did emerge more spontaneously with these women who lived in rural (but not remote) areas and felt that services in French were available to them because of their proximity to large centers. The rural and remote women living in predominantly Francophone villages felt that in terms of basic needs, they were well served with a variety of health-care services in French in their own remote community, which according to them was an exception. But, in some provinces, they did not have any access whatsoever to French-language specialized services.

Au départ, nous autres, on a un hôpital, puis je peux te dire qu'on a beaucoup de difficulté avec le français. Tout de suite en rentrant, on en a une qui n'est même pas bilingue à l'entrée, à la réception. (...) Mais tout de suite là au départ, c'est une barrière, la langue, tout de suite là. Ça refroidit un malade, ça, qui rentre et qui n'est pas capable de dire qu'est-ce qu'il veut dire. Puis ce n'est pas qu'on ne se bat pas pour ça, mais [maintenant] quand on est malade on est content parce que c'est une française qui est [à la réception]. [La réceptionniste qui ne parle pas français] a eu un bébé et elle a pris son année [de congé]. Aie, imagine-toi que le monde était content d'avoir une française au bureau en rentrant, à la réception. Je trouve ça dommage. Et puis tout de suite là, tu as une barrière là qui est vraiment. (...) Oui, et puis quand tu es souffrant et puis que tu es obligée d'aller courir pour un interprète ou qu'il faut qu'il aille à l'autre bout de l'hôpital pour chercher une garde pour t'interpréter, bien durant ce temps-là, c'est toi qui pâtis. J'en ai fait l'expérience, ça fait que je peux te le dire.

To begin with, we have a hospital, but I can tell you that we have lots of difficulty with French. Right when you come in, we have one that is not even bilingual at the entrance. . . . But right from the start, that is a barrier, the language,

right away. That cools down a sick person that is coming in and that isn't able to say what he wants to say. It's not that we don't fight for that, but (now), when we are sick we are happy because it's a Francophone that is (at the entrance). (The secretary that doesn't speak French) has given birth and has taken a year's (leave). Hey, imagine that people were glad to have a Francophone at the entrance. I find it too bad. And right there, you have a barrier that is really... Yes, and when you are suffering and that you have to run around for someone to translate or that you have to go to the other end of the hospital to find a nurse that can translate, well, during that time, you're the one that is suffering. I have experienced that, so I know what I am talking about.



2) Health as an individual responsibility vs. the impact of the determinants of health (biological, environmental, social...)

One interesting paradox throughout the responses is the concurrent articulation of two different ideas about health. On the one hand, participants expressed much concern over individual behaviors (diet, smoking, sedentary lifestyle...) and individuals' responsibility for their own health. But on the other hand, women also stressed the socio-economic and the biological determinants that impact one's health. They manifested an awareness that health is not merely determined by one's choices and practices, but also by larger social and institutional conditions. Women in focus groups articulated an understanding of health that presumes a complex interaction between

individual, family and community behaviours, practices, values and culture and the determinants of health (social, environmental, biological...). Some action can be taken on these (i.e. social, environment) while others appear to be "inevitable" (but perhaps

"controllable" (i.e. biological determinants).

Themes that arose regarding individual, family and community responsibility for health: nutrition/diet, physical activity, smoking...

Themes that emerged regarding the determinants of health: socio-political (economy, gender equity, values and culture... [government

responsibility: underfunding of health system; need to focus on prevention and promotion of health...) and environment (industrial pollution)

3) Importance of prevention and promotion in fostering a long-term plan for healthcare services as opposed to focusing on disease and immediate health issues.

This concern for a stronger focus on prevention and promotion intersected the two above concerns for individuals' responsibility for their own health as well as the non-behavioral health determinants.

However, this concern for prevention was also manifested through criticisms of the current hegemonic medicalized health discourse focused on treating disease and the call for a more holistic perspective of health,

based on prevention and inclusive of alternative health practices and services. Women repeatedly mentioned the need for a shift towards treating the individual as a whole person, and not strictly focusing on isolated health issues/problems.

On a fait notre AGA de l'année passée, on a fait un atelier santé et ce que les femmes disaient. C'est qu'elles dénoncent le fait que justement, c'est un modèle médical partout qui leur est offert et quand elles demandent un service plus holistique, qu'elles soient traitées comme un tout, ça passe pas. Donc, si elles découvrent la perle qui va le faire, elle serait peut-être prête à faire des distances, je suppose pour ça. C'est ce qu'on essaie, nous autres, de promouvoir au sein de nos organismes puis c'est pour ça qu'on veut être autour des tables. C'est pour le dire et pour que ce soit reconnu.

We had our AGM last year, and we had a health workshop and what the women were saying is that what outrages them is that it is a medical model that is offered to them wherever they go and that when they ask for a more holistic service, that they be treated as a whole, that doesn't go over. So, if they discover the gem that will do it, they will probably travel long distances for that. That is what we try to promote amongst our organizations, and that is why we want to be sitting at the table. It's to say it and so that it can be recognized.

Mais je pense aussi qu'il faut éduquer les médecins à utiliser des soins de santé qui sont autres que les services à pilules.

But I think that we have to educate doctors to use health services that are other than pill services.

Moi, je leur dirais, je leur demanderais et leur dirais de cesser d'investir de l'argent, d'écouter les compagnies pharmaceutiques, d'écouter les fabricateurs de machines super sophistiquées puis de justement d'aller du côté de la prévention. Mais aussi de voir, de cesser de traiter le bobo pour le bobo, mais de voir la personne justement d'une approche holistique, de voir que la personne, c'est un tout et puis de commencer de ce côté-là. Puis en faisant de la prévention par rapport à la santé de la personne, la santé sociale aussi, que d'investir dans le social puis d'investir dans les structures qui font que les communautés sont solides, sont en santé et que les individus qui sont dans ces communautés-là vont être en santé. Qu'on cesse

d'écouter tout le lobby de pilules et puis de machines, on verrait une grosse différence.

I would tell them, I would ask them and would tell them to stop investing money, to stop listening to pharmaceutical companies, to very sophisticated machine builders and to start to go towards prevention. But also to see, to stop treating the ailment for the ailment, but to see the person in a holistic fashion, to see that the person is a whole and to start on that side. And to start doing prevention for the person's health, social health too, investing in the social and then investing in structures that make the communities strong and healthy so that the individuals in those communities will be healthy. If we stop listening to the pill and large machinery lobby, we would see a big difference.

C'est aussi bien qu'il fasse des centres de femmes partout au pays.

Des centres de santé familiale ou des centres de femmes où les personnes peuvent aller et d'avoir accès à une multitude de professionnels qui travaillent sous le même toit, je pense que ça pourrait certainement pas faire tort plutôt que d'être obligé de s'en aller et de visiter silo par silo. On traite pas la famille dans son ensemble, là. Ils sont pas rendus là encore.

It would be better to set up women's centres all across the country.

Family health centres or women's centres where people could go and have access to various professionals who work at the same place. I think that that would be better than having to go visit from silo to silo. We don't treat the family as a whole. They aren't there yet.

Some also claimed that the current health system (if not social system) fosters dependence on professionals and that it is important that women re-appropriate their own health practices, and make their own health decisions.

Mais je trouve que ce n'est pas fou de parler de ça, dans notre monde d'aujourd'hui, c'est les systèmes aussi qui veulent ça, on nous rend de plus en plus dépendant de systèmes, que ce soit le système de santé et autres. Un système de production, par exemple. En ville, on est totalement autonome dans le système de production. Alors moi, je pense que la santé des femmes dans le milieu éloigné,

moins elle doit être autonome de ces systèmes-là, plus elles vont être solides. C'est sûr que des femmes qui vivent dans des milieux éloignés depuis des générations en génération et qui ont conservé ces habitudes de production autour d'elles de santé de suivre sa santé, être capable de faire les accouchements, par exemple, s'il y a des urgences, être capable de soigner les enfants, les femmes qui possèdent ça. Moi, je fais partie des groupes de sages-femmes très anciens. Maintenant, je ne le fais plus parce que maintenant, on se dit récupéré par le système de la santé, mais j'ai déjà fait partie des groupes de sages-femmes. Et moi, faire partie d'un groupe de sages-femmes quand j'étais toute jeune et que j'avais mes premiers enfants, ça m'a redonné ce que moi j'appelle le pouvoir de ma santé.

But I think that it's not crazy to talk about that, in our world today, it's the systems that want that, they make us more and more dependent on systems, whether it be the health system or others. A production system, for example. In the city, we are totally autonomous in a production system. So I think that women's health in a remote area, the less they are autonomous of those systems, the more they will be solid. It is certain that women who have lived in remote regions from generation to generation and that have kept the habits of producing around themselves of health, of following their health, of being able to attend births for example, if there is an emergency, to be able to care for the children, the women who possess that. I am part of the very old groups of midwives. I no longer do it since we say it was "recuperated" by the health system, but I was once part of a midwifery group. Being part of this group of midwives when I was young and that I had my first children gave me what I call power over my own health.

Et moi, je pense que rendu à un certain âge, que ce soit rural ou pas, le système maintient les personnes pour qu'elles soient toujours accrochées

à des médicaments. Quand tu vas voir un médecin—moi, j'y vais souvent, j'y vais très souvent—et à chaque fois que tu vas voir le médecin, il rajoute une pilule. Il en enlève une et il en rajoute une. Tu dis « coudons, là ». Je regarde juste mon mari. Il a 61 ans. Je veux bien croire qu'il est cardiaque. Il a 13 pilules le matin, toutes en ligne, et il les prend.

And I think that at a certain age, whether it be rural or not, the system keeps people so that they will always be dependent on medication. When you go see a doctor, I go often, I go very often, and every time that you go see the doctor, he adds a pill. He takes one away and adds another. You say, "well!" I just look at my husband. He is 61 years old. I agree that he has a heart condition. He takes 13 pills in the morning, all in a row and he takes them.

4) Recognition that we did not talk about particular issues of at-risk populations.

As a final comment, at the end of the focus groups and interviews, participants recognized that they had not specifically discussed issues concerning particular at-risk populations such as the homeless, sex workers, victims of family and/or sexual abuse/violence, seasonal workers (i.e. on fruit farms in the summer) and the destitute. Although issues of poverty did concern their communities, they did not have much close hand experience with those living in poverty. They expressed concern and identified groups that need help and better policies and programs, but there were no suggestions or detailed discussion of what these policies and programs would entail.



Endnotes

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1. With thanks to Ivy Bourgeault , PhD for portions of the Introduction and Methods sections.

Rural, Remote and Northern Women's Health:
Policy and Research Directions

Results from Focus Groups
Conducted in English with Women
Living in Rural and Remote
Communities in Canada

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Project #5 of National Rural and Remote
Women's Health Study

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Table of Contents

Acknowledgements	G3
Introduction	G4
Key Objectives/Research Questions	G4
Methods	G5
Survey and Interview Guide	G5
Recruitment of Participants	G5
Conduct of Focus Groups	G7
Analysis of Focus Group Data	G7
Results	G8
Description of Participants	G8
Other Comments on Participants	G14
Interview Data	G14
A. Impact of Rural/Remote Living on Health	G15
Assets	G15
Liabilities	G18
Physical Environment	G19
Social Environment	G20
B. Impact of Rural/Remote Living on Health Care	G23
Advantages	G23
Disadvantages	G24
Access to Care Issues	G24
Access to Information	G26
Quantity of Health Care Services	G27
Quality of Health Care Services	G30
C. Definition and Experience of Being Rural or Remote	G32
Structural Issues	G33
Social Issues	G35
D. Policy Recommendations	G36
E. Suggestions for Research	G40
Summary and Reflections	G43
Appendix	G47

List of Figures

Figure 1.	Age Distribution of Participants	G8
Figure 2.	Level of Education Completed	G9
Figure 3.	Household Income Distribution of Participants	G9
Figure 4.	Occupation of Participants	G10
Figure 5.	Marital Status	G10
Figure 6.	Participants With Children	G11
Figure 7.	Number of Children Per Participant	G11
Figure 8.	Age of Participant's Children	G11
Figure 9.	Population Estimated by Participants in Each Program	G12
Figure 10.	Live and Work in Same Geographic Region	G12
Figure 11.	Distance to Work	G13
Figure 12.	Travel Time	G13
Figure 13.	Distance to Nearest Health Care Provider	G13



Results from Focus Groups Conducted in English with Women Living in Rural and Remote Communities in Canada

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Introduction

Provisions for rural and remote health care have garnered increasing attention by Canadian policy makers and health-care planners not the least of which has included provisions in the recently released Royal Commission on the Future of Health Canada in Canada. As we grapple with the effects of restructuring and providing equitable access to care to people in rural and remote communities, the consideration of gender and women's health is necessary to complete the picture of health needs, service provision and utilization.

In response to this critically important issue, a National Research Steering Committee on

Rural and Remote Women's Health (NRSC) was created from the network of researchers affiliated with the Centres of Excellence in Women's Health (CEWH). One of the first tasks undertaken by the NRSC was to commission a literature review of the current knowledge in rural women's health. In addition, the NRSC initiated the conduct of several small focus groups with women living in rural and remote areas across Canada from April 2002 to January 2003. This report summarizes the findings from 20 focus groups conducted in English with rural and remote women across Canada.

Key Objectives/Research Questions

The key issues which guided the overall National Study of Rural and Remote Women's Health and Health Care in Canada included the following:

In terms of health ...

- What are the things that promote the health of women living in rural and remote areas of Canada?
- What are the things that threaten the health of women living in rural and remote areas of Canada?

In terms of health care ...

- How satisfied are women with the quality of health care in their area?

In terms of rural/remote living ...

- What is it that makes a woman's life rural and/or remote?

- In what specific ways does living rurally or remotely affect the health of women?

In terms of policy to address the above ...

- What policy issues are women living in rural and/or remote areas concerned about?
- What do they want changed to better promote their health?

Finally, in terms of the need for further research ...

- Are there rural and remote women's health issues about which more information is needed in order to prompt appropriate action?

Methods

Survey and Interview Guide

Following the key research objectives noted above, a short demographic survey (Appendix D) and a focus group interview guide (Appendix E) were developed by Dr. Rebecca Sutherns under the direction of the NRSC. The Research Steering Committee approved the final versions of the guidelines and questions to be used by facilitators in April 2002, after they had been reviewed for plain language and clarity (see Appendix F for full instructions to facilitators).

Ethics Review was provided by York University under application by Marilou McPhedran and Suzanne MacDonald PhD. Ethics reviews were also conducted through other universities with which some of the facilitators were affiliated. Each Centre was responsible for coordinating the ethics processes for the facilitators in their regions.

Facilitators were expected to adhere to the guidelines and the theme areas of the questions provided. Additional questions were provided to facilitators to prompt discussion within a focus group if needed. Some facilitators revised the questions and the format to simplify the language. This kind of flexibility was approved of in principle by the Research Steering Committee, according to the principles of responsive qualitative research; that is, as long as the intent and content did not significantly differ from the parameters approved by the ethics review. Some of the survey questions were also found to be inappropriate for some of the women participating. For instance the original survey sheet inquired about general household income, with the lowest category being “\$15,000 and up”. For many rural and remote women, household income is well below \$15,000 annually.

Recruitment of Participants

Each of the Centres of Excellence for Women’s Health sponsored a certain number of regional focus groups in British Columbia, the Prairies, and the Atlantic coast. NNEWH as a national organization invited La Table Feministe, a community partner of NNEWH to facilitate the focus groups with Francophone minority women (these are discussed at length in *Results From Francophone Focus Groups with Women in Rural and Remote Communities* by C. Dallaire and G. Leclerc¹). Ivy Bourgeault also secured additional funding from the Institute of Gender and Health of the Canadian

Institutes of Health Research in order to conduct additional focus groups: five in Ontario and one in Alberta.

The practical difficulties of getting to rural and remote women or bringing them together for a focus group varied across Canada, and so did the costs. This meant that late in 2002 the Research Steering Committee and the National Steering Committee were able to fund more focus groups, as the budget allowed. A second focus group in Saskatchewan was held in the central farm regions, following a particularly devastating crop year. NNEWH invited the

National Anti-Poverty Organization (NAPO) to conduct focus groups among women in the Northwest Territories. This facilitator advised that the widest diversity of women would be reached through use of teleconference and telephone interviews. For a full

description of the location of the various focus groups and the number of participants in each group, please refer to Table 1 below. For background on the various communities please refer to the Appendix.

Location	Facilitator	Number of Participants
Creston, BC	Lana Sullivan	8*
Port Alice, BC	Lana Sullivan	9*
Tumbler Ridge, BC	Lana Sullivan	5*
Vermillion, AB	Glenna Laing	6*
Clive, AB	Edith McPhedran	13*
Fort Chipewyan, AB	Lynn Skillen	10*
Yorkton, SK	Noreen Johns	10*
Watrous, SK	Noreen Johns	11*
Oakbank, MB	Deborah Barron-McNabb	7*
Lion's Head, ON	Coleen Purdon	4*
Markdale, ON	Ivy Bourgeault	4*
Woodstock, ON	Ivy Bourgeault	5*
Woodstock, ON	Ivy Bourgeault	4*
Cobourg, ON	Ivy Bourgeault	6*
Forteau/Port Hope Simpson/Mary's Harbour, NFLD/LB	Gail Lush	9*
Marystown, NFLD/LB	Gail Lush	6*
Fort Smith, NWT	Aimee Clark	16†
Hay River, NWT	Aimee Clark	9†
Inuvik, NWT	Aimee Clark	15†
Yellowknife, NWT	Aimee Clark	7†

* indicates those focus groups for which verbatim transcripts were included in the thematic analysis.

† there are multiple groups within these categories with group sizes ranging from 2 to 7.

‡Please note that there was one other group conducted in Nain, Nunatsiavut, NFLD/LAB but this was prior to the development of the focus group guide and demographic survey instrument, and thus it is not included for analysis in this report.

Within each of the communities noted above, participants were selected through a variety of methods. In the NWT, for example, the facilitator faxed every health centre in the NWT with the focus group information and asked for interested participants. Faxes were followed up with phone calls. In Fort Smith, advertising for participants was through the CBC North station. Information sheets were also left at the post office for pick up. Notices were also put up on the various community news bulletin boards around town. In many cases, people who were known to the facilitator were invited to participate or asked to recommend participants. In other cases, particular

health and social service agencies were contacted to organize groups. Some of these groups involved pre-existing social support groups, like Heart Health groups. By and large, everyone who was interested in participating was included and indeed, there was a great deal of interest in the project. Many who were interested, however, could not participate due to scheduling or travel restrictions. Thus, our sample is largely one of convenience. Although this may limit the generalizability of our findings, we believe the themes that are raised by the participants are transferable to other women living in rural and remote communities.

Conduct of Focus Groups

All groups began with an explanation of the study both specifically and within the broader context of the national study. Participants were then asked to sign a consent form (Appendix G) and to complete a self-administered demographic survey. No identifiers were included on the survey and participants were told that completing the survey questions was voluntary and that the information contained therein would be kept confidential.

Following the completion of the survey, the facilitator would turn on the tape recorder and start with the focus group interview guide questions. During the conduct of the taped group interview, women could ask for

any of their comments to be stricken from the record. The focus groups lasted from 1.5 to 3 hours. In some cases this was not long enough to cover all theme areas.

All taped focus groups were transcribed for analysis by the same professional with the exception of the Ft. Chipewyan focus group, the Francophone groups and the groups conducted in the Northwest Territories, which were done separately. Please note that transcripts for the NWT focus groups were not received in time for the preparation of this report. Data made available in the Facilitators' Reports for the latter were incorporated in the report where possible.

Analysis of the Focus Group Data

Demographic data presented here were drawn from those tabulations prepared by Karima Hashmani at the National Network on Environments and Women's Health.

The transcriptions from 16 of the 20 focus groups, including 117 out of 164 women, were analyzed thematically using a coding scheme developed from a subset of the inter-

views conducted by Ivy Bourgeault and revised/expanded by members of the NRSC. The coding scheme largely followed the questions set out in the interview guide but reflected broader conceptual categories. This coding scheme was then applied to relevant words, phrases, and sentences within the transcripts by a professionally trained research assistant—Kelly White—with the assistance of the NUDIST qualitative data analysis program. Ivy Bourgeault cross-coded a sub sample of the interviews to help ensure reliability and validity of the applica-

tion of the thematic codes. Where necessary, revisions of the coded segments were undertaken.

The presentation of the data that follows begins with a description of women’s demographic backgrounds. This is then followed by a summary of the key themes highlighted by women in the focus groups organized into five broad conceptual categories including their views on: health, health care, rurality, and their recommendations for policy and research.

Results

Description of Participants

Figures 1 to 4 describe the age, level of education, income, and occupation of the women who participated in the English-language focus groups.

Quite clearly young women (in the 16-25 and in the 26-35 age categories) were significantly underrepresented in the focus groups. The level of education completed by participants was above average for rural

communities. It is difficult to make any comments on the income data in light of the difficulties many participants had in determining whether the question was asking for personal or family income. The occupational categories may reflect the age distribution of participants. That is, the low numbers of students likely parallels the low numbers of young women in the study.

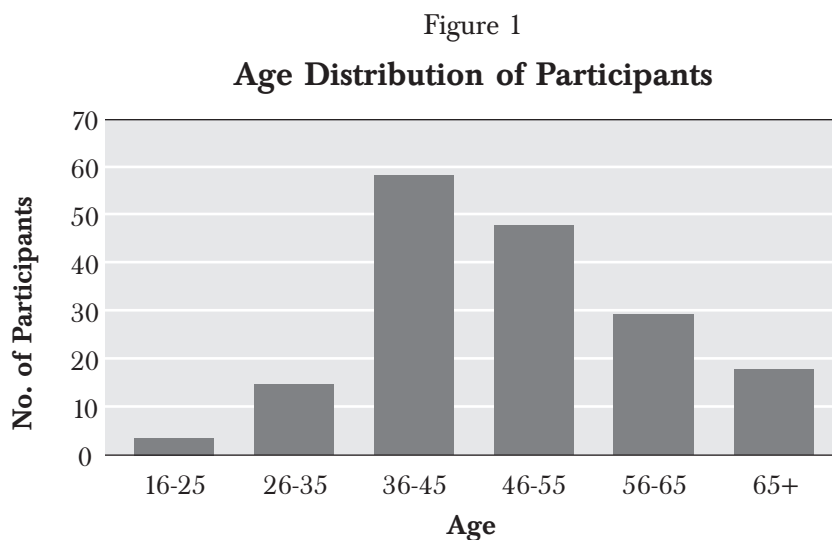


Figure 2

Level of Education Completed

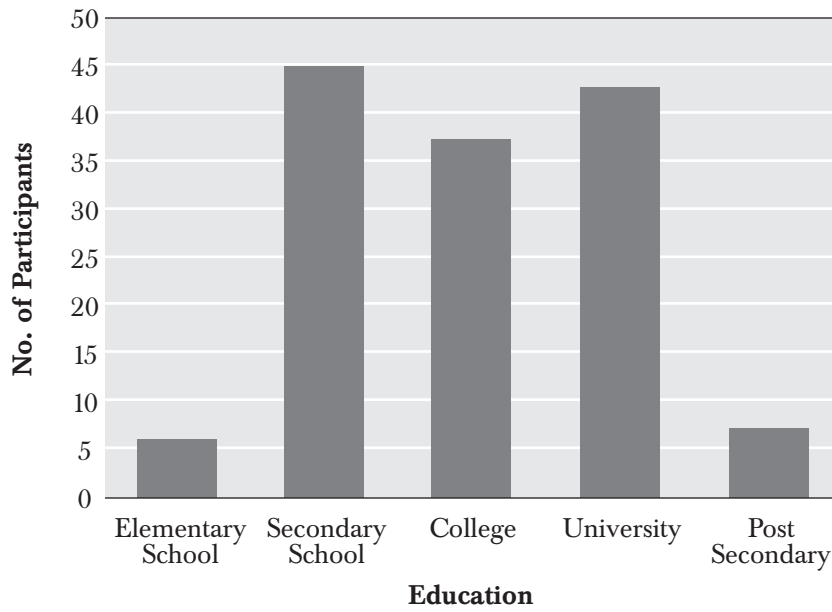


Figure 3

Household Income Distribution of Participants

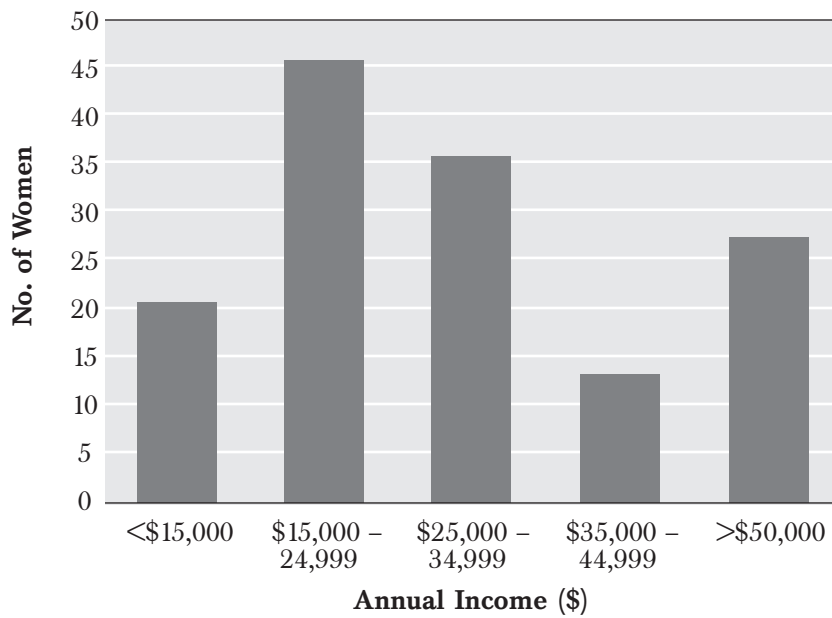
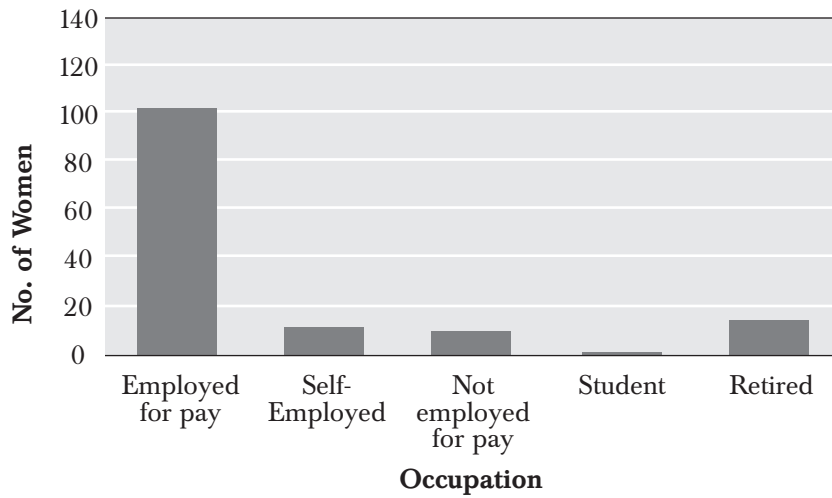


Figure 4

Occupation of Participants



Figures 5-8 present data pertaining to participants' marital status and number and age of children. Most of the women who participated in this study were married (76%) and

had children (87%). The average age of the children these women had was 23.5 years. This is largely reflective of the age of the participants.

Figure 5

Marital Status

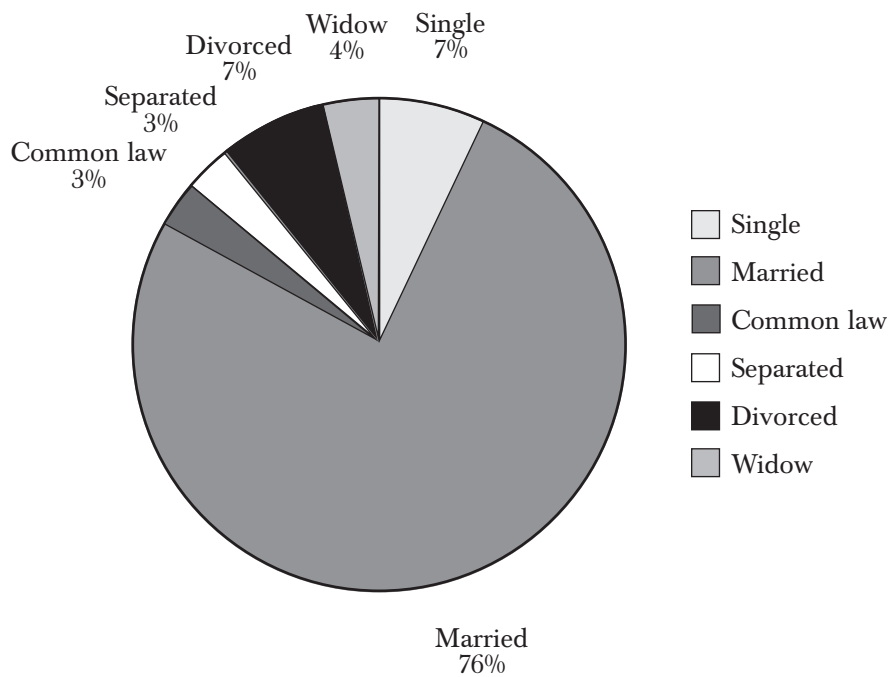


Figure 6

Participants With Children

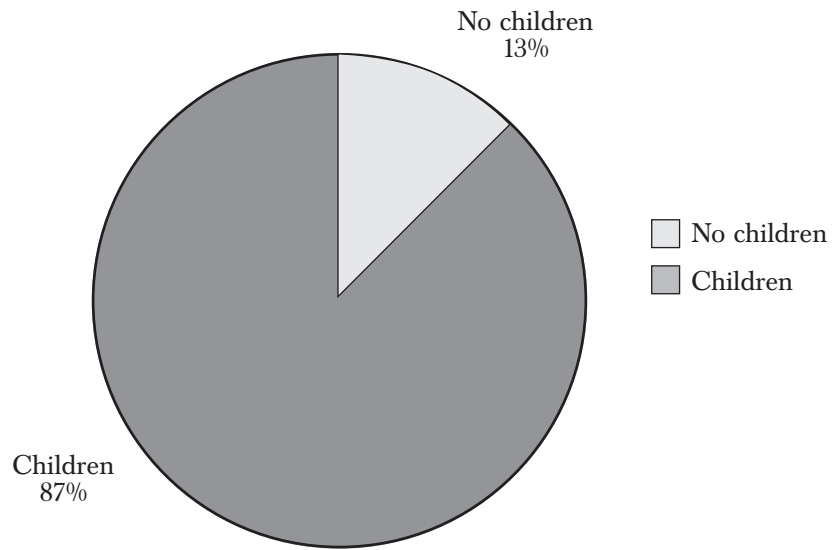


Figure 7

Number of Children Per Participant

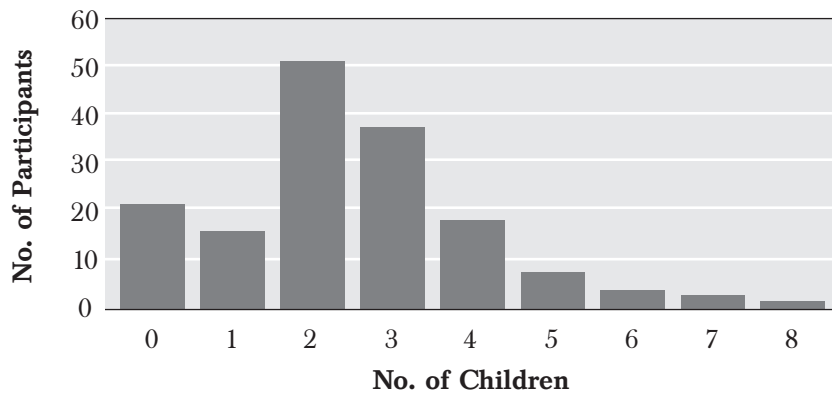
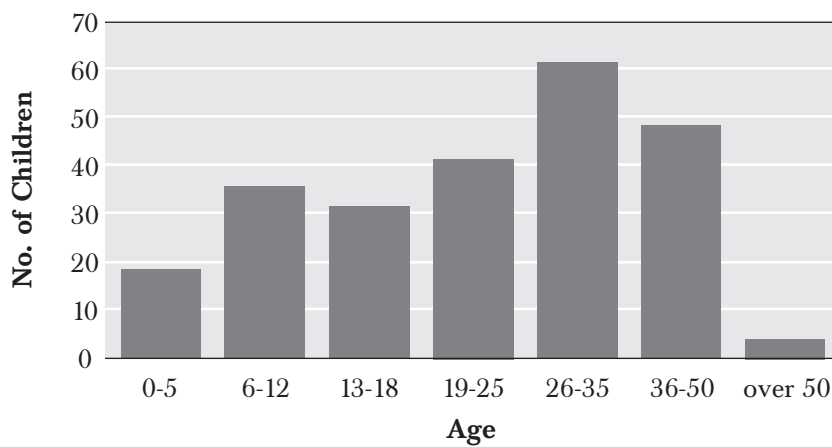


Figure 8

Age of Participants' Children



Figures 9 - 11 illustrate the range of total populations for the communities in which the various participants live, as well as the distance from home to work if they work outside of their community. From these figures we see a wide variation in

“home” populations but most lie beneath the 2,000 range. Most work within their community, but those who must travel outside of their community do not report having to travel far.

Figure 9

Population Estimated by Participants in Each Region

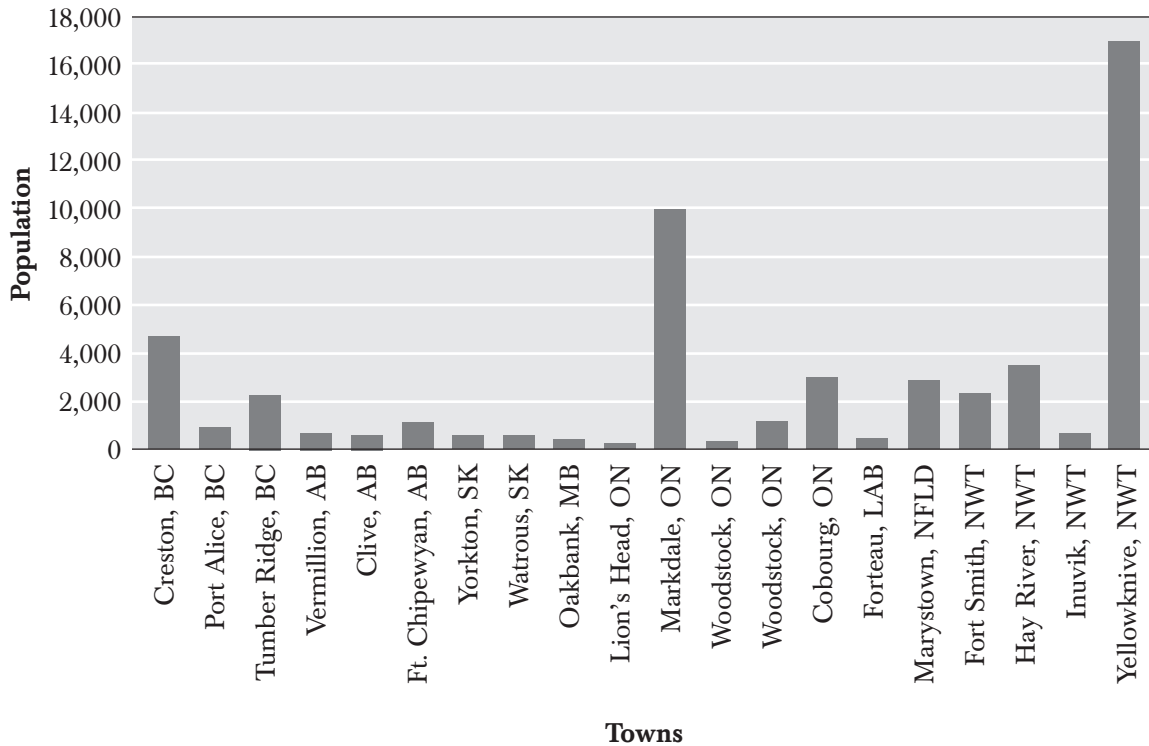


Figure 10

Live and Work in Same Geographic Region

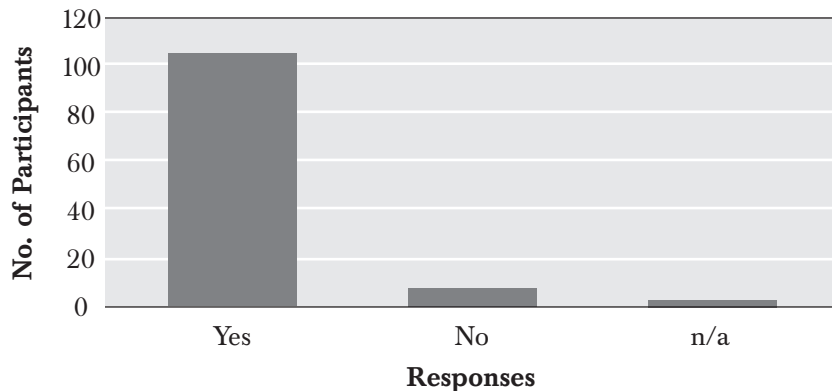
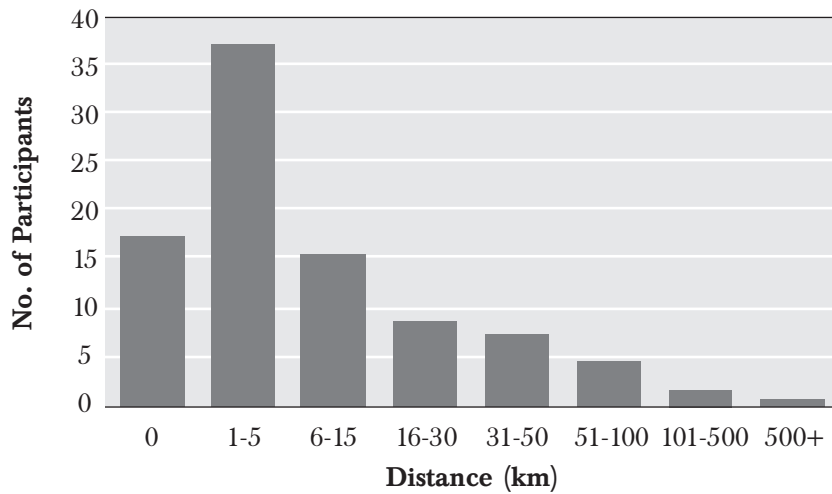


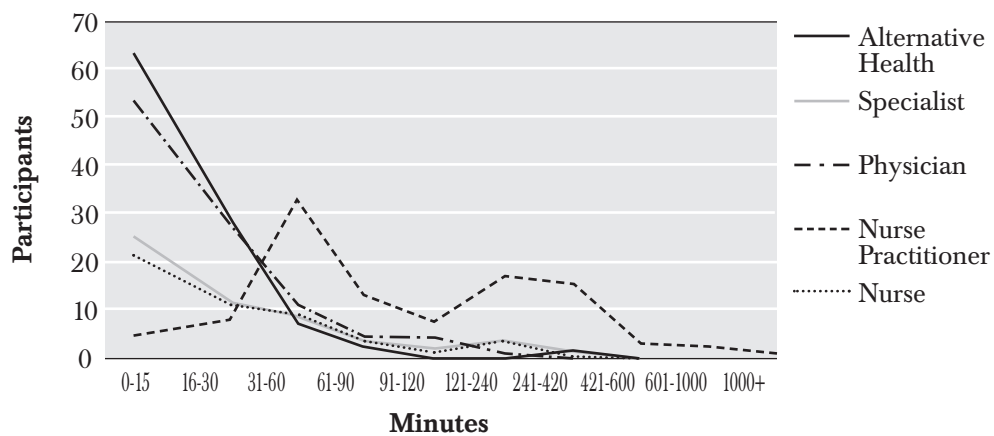
Figure 11
Distance to Work



Participants were asked about the distance and time it took to reach care from a variety of health-care providers including a nurse, nurse practitioner, physician, medical specialist and alternative care providers (broadly defined). From Figure 12 and Table 2 we can see that the order of availability from

most to least available is nurse, physician, nurse practitioner, alternative health-care provider and specialist. We can also see that the least available health-care provider to participants was a nurse practitioner and that to get to medical specialists took more than 2 hours of travel time, on average.

Figure 12
Travel Time



Health Care Providers	Number of Respondents	Average Travel Time
Nurse	104	19.28
Nurse Practitioner	57	42.8
Physician	103	26.38
Specialist	99	148.11
Alternative Health Care Provider	77	87.17

Figure 13

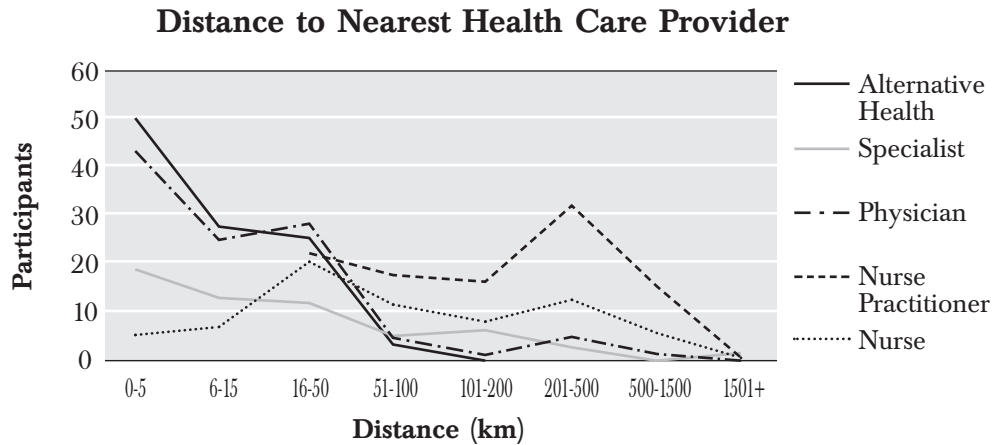


Table 3 Distance to Various Health Care Providers

Health Care Providers	Number of Respondents	Average Travel Time
Nurse	106	12.97
Nurse Practitioner	60	69.86
Physician	109	39.35
Specialist	106	285.18
Alternative Health Care Provider	70	206.35

As indicated in Figure 13 and Table 3, travel time is a function of distance to health care practitioners.

Other Comments on Participants

Although accurate data pertaining to the ethnic background of participants were not gathered, the members of the Research Committee actively sought the participation of Métis women, who came to the Fort Chipewyan and Oakbank groups. Many of the NWT interviews included First Nations women. The first focus group held by Pauktuutit (Inuit Women’s Association) at their Annual General Meeting in Nain

Labrador included Inuit women from across the high arctic, but their data are not addressed in this report because the focus group occurred prior to the development of the standardized focus group interview guide.

It is also important to note that although no systematic data were collected in this regard, some of the participants in the focus groups were both recipients as well as providers of care (hence some of the wording of the questions in the structured focus group interview guide mentioning clients).

Interview Data

As noted above, the presentation of the transcribed focus group interview data will follow the broad conceptual categories of views on health, health care, rurality and

recommendations the women highlighted for policy changes and future research. Within each of these categories, the presentation of the data will begin with a summary

table of the key themes highlighted by the participants. These tables are followed by selected, representative quotes from the interview transcripts that expand upon the themes. In the presentation of quotes, the voices of women are given primary emphasis. Hence they are only loosely contextualized with supporting text from the author. The authors' comments will be noted in the concluding "Summary and Reflections" section.

A. Impact of Rural/Remote Living on Health

In talking about their views on health, women highlighted both the positive aspects of rural/remote living in terms of health assets, as well as the liabilities to health associated with living in rural/remote areas. In both cases, aspects of both the physical as well as the social environment were noted.

Assets

Table 4 lists the various assets of living in a rural or remote community to women's health. These range from the physical environment issues of better air quality and lack

of pollution to the social environment issues of a caring community.

Physical Environment

Many participants noted the importance of the physical environment in rural and remote communities—often referred to as the 'great outdoors'—for maintaining their good health:

I think just in a small community you have access to the outdoors a lot more. You're not stuck in a big town. — Creston, B.C.

This was related to better air quality resulting from a lack of pollution that was usually associated with urban living:

I think we are in a fairly good spot. We don't have a lot of [heavy] industry right where we live. — Vermillion, Alberta

I find the air is fresher ... there's no smog. — Oakbank, Manitoba

Our environment is really healthy here. We have good fresh air. — Cobourg, Ontario

We do have cleaner air, no doubt, than what they do in the cities and towns. — Yorkton, Saskatchewan

Table 4 Health Assets from Living in a Rural/Remote Community

KEY THEME	SPECIFICS
Physical Environment	Better Air Quality/Lack of Pollution More Trees/Lakes/Natural Beauty/Recreational Paradise Better Access to Exercise Better Diet
Social Environment	More Caring Community Social/support Groups W.I. (Women's Institute) Rural Churches Information/programs Being Involved/Pulling Together Have Time to Spend with Family Crime Free/Safe Less Stress/Peaceful Less Congestion

Proximity to low cost recreational areas with trees and lakes and the general beauty of nature all figured prominently in women's responses:

I think there's a lot of opportunity for low cost recreational opportunities for families and children. The provincial park is a good example. — Vermillion, Alberta

We have all these wonderful trees and rocks and the lake and to me that's an extremely beneficial thing. — Cobourg, Ontario

The related issue of access to areas to exercise were also noted as being health promoting:

You can go for a run or a hike or bike or whatever. — Creston, B.C.

Living in the country and having a park close to where I live, it promotes my health because ... I can go to the park. I can walk around. — Oakbank, Manitoba

Fresh air, exercise. You get that here a lot more than you would in the city. Many of us walk to the store. You walk to the post office because it's not quite far enough to take your vehicle. So it's almost forced on you. It's also safe when you walk. — Forteau/Port Hope Simpson/Mary's Harbour, Nfld/Lb

It is important to note, however, that these responses may be disproportionately from women living in rural/remote towns because, as we shall see below, some farm women commented on how living in rural areas made it more difficult for them to go for a walk.

Better diet was also noted by some participants:

Lots of fruits and vegetables. Less junk food. — Cobourg, Ontario

Again, this may be representative of women who grew their own vegetables. Other women living in remote areas noted that fresh fruits and vegetables are a rarity (see below).

Social Environment

In addition to mentioning aspects of the physical environment, participants also

highlighted elements of the social environment of rural and remote communities that were health promoting. Many specifically mentioned the benefits of a 'caring community':

And that faith community is very supporting, as are many other people. You know, everybody up here is not out for self. Those are things that, it's like getting a hug by the community. — Cobourg, Ontario

The whole community will come to see you [if you] have a heart attack. When something happens like that, it's like one big family anyhow, when tragedy happens. — Fort Chipewyan, Alberta

Membership in close-knit social and support groups was described as being of critical importance for some women:

Traditionally as women we get, we draw our strength when we join together. I mean I think about our moms and tots group that we use to have. There was a lot of support. I actually had ... a lady just a month ago said to me, and her daughter is now 15 years old, say 'you know that was one of the best things for me cause I thought I was all alone, going crazy with my two children; and I found out that I was like everyone else.' ... We have greater opportunities in the country to do that, but I think we're starting to become into a city rat race. — Vermillion, Alberta

When my children were younger, there was a parent and tot play group at one of the churches in town here. And that's a great resource as mothers who have sick kids or knew someone who had this experience. Just sharing your experience with other parents. And you can draw on their experiences to find help if you need it. — Creston, B.C.

And I think that's one thing that's really strong in Port Alice is the community and people helping people. — Port Alice

Community support is great and I'm seeing a lot of that. — Clive, Alberta

One specific example of these kinds of groups was the Women's Institutes:

We've tried running Women's Wellness nights like because the biggest group that's impacted are not the younger women because they're not hesitant about going to family doctors, but the senior

women have been going to like the same doctor for about 20 years. — Marystown, Nfld/Lb

When I joined in '64 there were a number of younger women there, but that dwindled off because people went back to work or they just didn't have time to come when they were younger. — Markdale, Ontario

When you talk women's issues, I'm saying 'Look, apart from gynaecological considerations, everything is a woman's issue.' Women's Institute has given me an opportunity to have a wider vision. — participant from Yorkton, Saskatchewan.

Access to information and programs was one of the benefits of participation in community groups:

We're going to be starting a Health Canada grant in the schools and so we're looking at healthy families and healthy children and so looking at some of those things about increasing healthy eating in the schools, looking at school policy, increasing physical activity, those kinds of things. — Vermillion, Alberta

Healthy Baby Clubs is a really good one that started as a federally-funded project in Marystown and has spread across the peninsula. Mothers are referred from the family physicians or nurses or whatever and then followed through pregnancy with nutritional advice and nutritional support ... And I see something like about 90 to 95 percent of attendees to Healthy Baby Clubs breast feed and they're followed up afterwards when they go out. As a follow up to it, there's a Bright Futures where the mothers still attend and they're given support in child care and that kind of thing. But it's made the biggest impact on prenatal care that I've seen in my 30 years on the peninsula. — Marystown, Nfld/Lb²

We have Headstart. And in our Headstart, we have health promotion as one of our components. So, we do tooth brushing, dental hygiene as part of it. We teach hand washing to the children. We also do nutrition workshops; we just had one last night for parents. And we also provide resources, booklets, books and information. — Fort Chipewyan, Alberta

Groups associated with churches in rural and remote communities were also mentioned as being important for some, but less so for others:

We have fairly strong church groups but we also have lifestyle meetings ... in the evenings. There's

weigh-ins but they also have regular aerobics classes, three nights a week." — Forteau/Port Hope Simpson/Mary's Harbour, Nfld/Lb

I don't think they're involved that much in the community at all except for the parishioners coming to church and that ... they promote spirituality but that's it. — Marystown, Nfld/Lb

A lot of support meetings go on in the basement of the church ... so I guess indirectly they're supporting. — Marystown, Nfld/Lb

Thus, the role of churches in promoting rural and remote women's health appears to vary across communities and among women with differing relationships to organized religion.

Rather than mentioning specific groups for social support, many participants mentioned a general sense of being involved and pulling together that exists in their communities:

People look after each other and maybe part of that is because we know it's only us that's going to look after each other. I don't have the big supports like they do in Edmonton ... So when my neighbour's little boy was burned, she only lived beside me for two years but I'm the person she called and we went together to emergency. And I stayed with her the whole entire time. That's what community is. That wouldn't have happened in Edmonton. — Vermillion, Alberta

Being able to spend more time with family was another source of social support:

Time together as a family. Quality time, yeah is important. ... — Cobourg, Ontario

Women thought of rural and remote communities as safer and more free of crime than urban areas:

It's a lovely community and it's a wonderful place to bring up your kids. So I'm talking in a broader sense of family, but you feel good when you're in a safe place for your family. It's a lovely community. There's not a lot of great places to eat and what not. As far as entertainment, there's not a lot of options there. But I feel very safe. My kids have a lot of friends and it's a clean, healthy place, and we've got a wonderful big back yard. We have space and we have time for each other. It's not rush, rush. — Creston, B.C.

My sister lives in the city and she won't go out at night so that puts a lot of stress on her. She won't go anywhere on her own. Where I am, I have no sense of that. I feel safe and I feel comfortable, like not frightened. And that's also part of the culture of where we are as people living on the land, living with the land, makes you feel more comfortable. — Oakbank, Manitoba

The peacefulness that some associated with the rural/remote physical environments also translated to social environments, making life less stressful in comparison to life for their urban counterparts:

You also have a bit more time for yourself. Like even if it's a few minutes in the day, you can go for a walk with the cows and nobody wants to come with you so you've got time to yourself. — Yorkton, Saskatchewan.

Much better than being in an urban setting where you have all the congestion and traffic and high density of population. — Cobourg, Ontario.

To sum thus far, there were several aspects of both the physical and social environments

associated with rural/remote living that participants highlighted as being helpful in promoting their health. These are important to highlight because the tendency in the literature on rural health and health-care issues is to focus only on the negative aspects. There are important reasons why women choose to live or choose to remain in rural and remote communities, and many of these are related to features they see as promoting their health and that of their families. Having said this, participants also identified several detrimental aspects of rural/remote living for women's health. Interestingly, some of these paralleled aspects other participants saw as positive forces in their lives.

Liabilities

Participants identified liabilities in both the physical and the social environments associated with their communities. These are listed briefly below in Table 5.

Table 5 Liabilities to Health from Living in a Rural/Remote Community

KEY THEME	SPECIFICS
Physical Environment	Poorer Air Quality Poorer Water Quality Farm Chemicals Drought Substandard Housing Diet/high Food Costs Transportation Needs/Lack of Public Transportation Impact of Weather/Seasons Limited Access to Health Promoting Activities
Social Environment	Economic/Farm Stress Impact on Husbands (Needing Care) Isolation Social Expectations and Attitudes Lack of Extended Family Lack of Anonymity Substance Abuse Violence Limited Employment Impact of Restructuring Financial Insecurity/Low Income Low Education Literacy

Physical Environment

Whereas some noted that there was better air quality available in rural and remote areas, others highlighted that some communities suffer from poor air quality:

I'd like to see our air a little cleaner and a few more trees planted instead of everybody knocking them down because they help the environment. — Clive, Alberta.

We have some friends who ... live quite a ways from us, south of town, and they had an incident last summer where the spray plane thought that their land was abandoned even though it wasn't marked as such on the map and their yard where the house is was sprayed. The husband was quite ill afterwards and the family's pet rabbit who lives in a cage outdoors was killed. ... so that to me is a concern, especially with three kids under the age of six, and they like to play outside in the summer and we do have the planes go overhead ... For me I think environmentally that's probably one of the biggest risks that we face. — Vermillion, Alberta

Other threats to health associated with the physical environment include the excessive use of limestone on gravel roads and the spraying of the ditches which affects both air and water quality:

That's a negative thing because, you know, they shouldn't be putting so much of that limestone which creates a lot of dust in our environment. — Oakbank, Manitoba

Some of these concerns were associated with specific industries located in the regions— whether they were agricultural, the local limestone quarry, potash mine, or pulp and paper mill.

Paralleling concerns about air quality were concerns about water quality. In some cases these were directly connected to the tragedy that happened in Walkerton, Ontario:

We have zero-zero water. All the E. coli and the choloform, I mean we kind of taunt each other, the neighbours, "What's your rating this week?" "We're still zero-zero." — Oakbank, Manitoba

We have never had a scare with town water. Like there's never been, we had one 'boil water' I think in about 25 years. So there's never been a really big

problem with it. It's just that it's not good water ... like I don't think there's any contaminants or anything actually in it. But it smells and doesn't taste good. — Marystown, Nfld/Lb

The presence of farm chemicals in both the water and in the air is also a salient concern for some:

I'm thinking in terms of the agriculture, the chemicals, water situations. — Woodstock, Ontario

We used to grow our own food because it was healthier. Whether I plant my own garden and grow organically which I try to and the spray plane comes over the day after, I've had my whole garden killed by spray drift. So the quality of life I guess is not there any more. — Vermillion, Alberta

And I think we'll see in a couple years the result of that will be maybe more cancers, more illness. — Vermillion, Alberta

The longstanding drought on the Prairies also prompted discussions of water availability:

Yes, and on a rainy day the town fills up. People are so much more upbeat. We didn't have that this year. — Vermillion, Alberta

Another aspect of the physical environment that was considered detrimental to health in rural/remote communities was substandard housing:

Believe me, there's not enough housing. — Clive, Alberta

And some young single mothers report living in damp, dank apartments because that's all their income will [allow]; you don't have a choice you know? — Marystown, Nfld/Lb

High costs of good quality food was another important issue highlighted by some participants:

The cost of food is higher. — Clive, Alberta

Access to foods sometimes is a problem for us, to good quality foods. We don't have the same variety or the same cost benefit that the larger cities have, and so that's a real detriment. And I know especially if you're at risk, the social supports around that are very poor here. For example, we don't have the same structure around food banks that they have in the city or soup kitchens or that. So if you're destitute in rural Alberta, you have no family

support here, you are toast. You are toast. — Vermillion, Alberta

Anything that weighs anything. Chips are pretty reasonable, but an apple you can't afford. — Oakbank, Manitoba

Genetically modified foods concerned some women:

Food safety. I think there's a lot of concern throughout the world about the GMOs and the sooner we address it, then we'll know. But by the time we know we may have lost all the stuff because it's too late.

We may have no control over it. That's right. I think we've lost it over Canola. — Watrous, Saskatchewan

In addition to the high cost of food and substandard housing, many women mentioned the added burden of the lack of public

transportation in rural and remote areas:

When you're in a rural area, if you were in Toronto you might be able to walk around and find certain services that you wouldn't be able to find as easily in the country. And that usually needs a car and a lot of women don't have a car. And you need gas and all that stuff. — Woodstock, Ontario

If you have access to childcare and transportation, to the resources and community support then you're more able to make decisions that will help you promote health. — Oakbank, Manitoba

Weather has additional effects on transportation and transportation safety in rural and remote communities:

There's been times here on the Southeast coast where we've had bad weather in many months, for 20 days when there were no flights in or out. — Forteau/Port Hope Simpson/ Mary's Harbour, Nfld/Lb

The weather also limits access to health promoting activities, particularly in winter.

Thus, although the physical environment has many health promoting aspects, it can also be detrimental to women's health. As we shall see in the next section, the social environment in rural and remote communities also has negative as well positive aspects.

Social Environment

One of the most salient detrimental social issues of rural/remote living was linked to economic factors, including limited employ-

ment opportunities and the stress of farm living:

I also think that economic wise we are encountering a lot of stresses with the uncertainty, as we rely on, you know, on weather and pricing and stuff within a farming community, that those stresses, and guarantees to make budget and things where you

have incomes that aren't regular, I think it makes a big difference in how we deal with some economic issues. That uncertainty that we live with; that we don't know if it's going to be ours next year. ... I still think that we have a lot of stresses that other people, they have no idea what it's like to have your whole annual income laying in a field being snowed on. I think that there are some coping skills that we have to draw on that other people, they never even touch. — Clive, Alberta

This quote also highlights the link between stress and social support.

You know the amount of hours that go into work, whether or not it is the farm wife that juggles umpteen roles in the community, and her family and the farming, and her responsibilities, I think that, and it's donated time, you know, for labour that many wives and husbands do not draw a wage. Their whole life is contributing to the farm, but it's not like they have, they don't have the same accomplishment that other occupations have. — Clive Alberta



Taking on the care for or in other ways shielding stress from farm husbands seems to be an added burden of farm stress for women:

I think farm women, I wanted to talk about rural farm women and the fact that they've gone through a really tough year watching their men folk work themselves to death. And I think that's getting hard on the women knowing that their income is going to be reduced because of the tough year and they see the stress in their mates' eyes. — Watrous, Saskatchewan

The flip side of a supportive community can be a lack of anonymity in rural/remote communities. Lack of anonymity can be a source of stress. It can also deter people from seeking help when they need it.

Well St. John's is more, well you can be more anonymous in St. John's because it's a again because you're not anonymous. And you're not, everybody kind of knows your business. — Marystown, Nfld/Lb

There are also social expectations and attitudes that come with rural/remote living. These include such things as respect (or lack thereof) for cultural customs, rituals and spirituality:

I work for the Department of Northern Affairs and they were starting to hire more Native people and one of the fellows they hired wanted to burn sweet grass but when he came in to purify himself, ... our supervisor didn't allow it. She had all kinds of excuses why he couldn't do that. — Oakbank, Manitoba

Isolation is an important social issue associated with rural and remote living.

Communities may be more peaceful, but they can, at times, seem too peaceful:

There are lots of suicides that are happening within communities where they do not experience the support that we do. — Clive, Alberta

Isolation and lack, well with everything centralizing now, particularly in the West. The towns are getting smaller. The services aren't there. You can't go in to all the various services; so people are getting very isolated. — Woodstock, Ontario

Although some noted the proximity of family as an asset to health, others noted the lack of extended family in rural/remote areas, likely due to the outflow of young adults to more urban areas for further education and for employment opportunities:

... [T]here are places like Corner Brook and St. John's where they don't get extended families to take them places because in this area the extended family is still fairly strong. I mean there is always cases where it isn't, but I think overall there's, you know, and the neighbour, the next door neighbour, I mean there's still a lot of caring and a lot of helping people. And everyone knows everyone else ... Forteau/Port Hope Simpson/Mary's Harbour, Nfld/LAB

You are your extended family with your neighbour. There are some working but you have no extended family to help you. You have acquaintances here in town— Tumbler Ridge, B.C.

Some women spoke of substance abuse in their communities.

Last year they were concentrating on fetal alcohol syndrome and making a couple of day sessions ... For to make people aware of the dangers of drinking during pregnancy and had the school guidance people in because some of these pregnancies occur in, it's not the alcoholics as such but it's in young women who are binge drinking on the weekends and who are pregnant a month or two before they realize they are and they've had three or four binges. And then if they admit to that they could lose custody of their children ... so I think there is only a couple, well one identified case of fetal alcohol syndrome in the province. — Marystown, Nfld/Lb

Living here you can't help but be aware of the effects of alcohol and drugs, the sexual abuse, the way in which women are treated. — Inuvuk, NWT

Drugs and alcohol use is big in Port Alice because this is a very rich community. — Port Alice, B.C.

I don't know if you'd call this a threat but there's a lot of alcohol in the rural areas that's hidden or that's accepted. — Yorkton, Saskatchewan

There was some discussion of the prevalence and experience of violence in rural and remote communities:

We don't have a place but there's um, for the most part I have to say there's very little, there's not a great need for a place, a shelter because there's very little violence overall.— Forteau/Port Hope Simpson/ Mary's Harbour, Nfld/Lb

It is difficult to know whether this quote is reflective of reality or whether it reflects a community assumption. Indeed, if the services are not there is it hard to gauge the need. Moreover, a group setting may not have been conducive for such discussions.

I personally wish it could be changed and I know it's everywhere but you know when a woman leaves an abusive situation, the amount of money that she gets is very, very minimum. And I know for myself, personally having moved from a relationship before, when you first move you need, like you need to buy ketchup and a broom and ... they look and they go 'okay, do I starve or do I get beaten?' So they go back. They go back, and it breaks my heart. I feel like saying 'come to my house.' — Tumble Ridge, B.C.

Limited employment opportunities for women in many rural/remote areas were linked to poorer mental health outcomes for women in these communities:

Employment ... would be one of the things that would contribute a lot to health and welfare here. ... and support should be there to allow them to be able to do that. — Marystown, Nfld/Lb

A lot of my friends now are just like 'Oh, I'm not working for minimum wage. I'll just get pregnant and go on welfare and they'll take care of me.' Right, I mean there's no work around here. You can't get work and you don't want to go away. If you don't go away you're stuck. — Marystown, Nfld/Lb

This community has very little ... so we have to drive, depending on whether you drive 20 miles, 12 miles or 40 miles to the nearest place to work. — Clive, Alberta

Employment shortages were particularly salient in communities in transition or undergoing other forms of economic restructuring:

Government cutbacks provincially has made it such a stressful life for so many people. And that is so detrimental to your health. My husband, for

example, got laid off and we are just so stressed out wondering what's going to happen. And every single person that we know has somehow been affected by it, whether their job has been affected or they were thinking about it or their store's going to have to close cause 6,000 people leave the community. — Creston, B.C.

Financial insecurity, low income, low education and literacy rates were several important, related issues mentioned by many of these women:

Most people have to be fed by the government and you have to depend on [it] for funding in order to survive because they can't live off the land any more. — Oakbank, Manitoba

I have another concern too that a lot of our young people on minimum wages aren't living a healthy lifestyle ... not getting the proper recreation ... as well as eating, as well as even vitamins and things. — Clive, Alberta

The main job we need to do is to bring people into that; we better educate a few people in the community so that they can come back and then start up groups. That would be one more realistic possibility.—Forteau/Port Hope Simpson/ Mary's Harbour, Nfld/Lb

[There is] little time for public education. — Yellowknife, NWT

If nothing else, literacy, you can't even read about it if you don't know how to. — Forteau/Port Hope Simpson/ Mary's Harbour, Nfld/Lb

Education, such as low literacy skills which is linked to poor health particularly among seniors because it's not that they weren't educated, they lose their skills over time in terms of literacy. — Marystown, Nfld/Lb

But I've had Grade 11 and 12 students come to me, and I shouldn't say it, but they can't read at the Grade 4 level. — Fort Chipewyan, Alberta

Thus women living in rural and remote areas identified both positive and negative aspects of rural and remote living for women's health. Indeed, the same factor—be it water or air quality or social support—could have both positive and negative effects in different areas and for different groups of women. Similar contradictory relationships,

as we shall see, were also important in these women's views on the effects of rural and remote living on health-care services.

B. Impact of Rural/Remote Living on Health Care Services

Although most of the questions in the focus group interview guide addressed the issue of health, many women responded by discussing health care. Indeed, in some cases facilitators had to probe extensively to get women to talk beyond issues related to getting health care. In light of this, the bulk of the data falls within this category. As before, the data show a dichotomy of positive and negative features in women's views about the effects of rural/remote living on health care. Women were more inclined, however, to focus on what was lacking in

rural and remote health-care services as compared to those available in urban areas.

First, the advantages of living in a rural/remote community for health-care services will be presented, followed by the disadvantages. Interspersed throughout the discussion of disadvantages are references to some programs that have been established to address some of the difficulties experienced.

Advantages

Although the discussion around rural and remote health care focused primarily on its inadequacies, several participants noted some of the advantages associated with living in a rural and remote community for health-care services. These are briefly noted in Table 6 below.

Table 6 Advantages of Living in a Rural/Remote Community for Health-Care Services

KEY THEME	SPECIFICS
Structural Issues	Hospital – Not as busy Some level of services improving
Social Issues	Know health-care provider in hospital/community Easy to get appointment with family doctor

One of the benefits of living in a rural or remote community for health-care services is that if a hospital is available, it tends to be less busy than hospitals in larger urban centres. As a result, some women felt they received better care:

The best care I received was in ... a very small hospital where I didn't feel that either the doctors or the nurses were [over]-worked or over-stretched or whatever you might like to say because you're getting that in the [smaller urban centres] now. — Clive, Alberta

In some communities, available services had improved with increases in the number and range of health-care providers. Sometimes

these improvements were the result of rotating site visits:

I think it has changed for the better. Cause we got one nurse for 600 people... and then we got two and now we finally got the third one so I think it's really increased good now. And we had mental health nurse come through. I'm not sure if it's once a month or every three months, and a physiotherapist comes in, like I said I'm not sure if it's once a month or every three months. And speech pathologist comes in on a regular basis too now. And we see the doctor more regular than before. And we have a nurse practitioner stationed here. So I think we're for the better. — Forteau/Port Hope Simpson/Mary's Harbour, Nfld/Lb

Some women mentioned that living in a small rural or remote community meant

they could get to know their health-care provider and that it was easier to get an appointment with their family doctor:

And with regards to actual appointments, I am from Corner Brook and I find you can get appointments a lot faster via our nurses here than you do at home. — Forteau/Port Hope Simpson/Mary's Harbour, Nfld/Lb

The vast majority, however, felt that it was very difficult to get an appointment in communities that were severely underserved. For example:

They're so crowded you can't even get an appointment. — Clive, Alberta

These and other inadequacies with the system will be discussed further below. It is, however, important to note the few benefits that women in rural and remote communities identify with the health care available to them.

Disadvantages

The disadvantages or inadequacies of rural/remote health care can be classified into access issues of both a social and structural nature, and quality issues. These are briefly noted in Table 7.

Access to Care Issues

One of the most salient physical or structural inadequacies of living in a rural/remote community was the distance women had to travel to get care, especially that of specialists. This was not only reflected in the information from the demographic survey (see Figures 12 and 13 and Tables 2 and 3) but also in the words of our participants:

We seem like we tend to have to go further and further, "you're so far away." — Creston, B.C.

You could drive all the way to Edmonton for this big special appointment and you get there and five minutes later they come out and you say 'what did they say?' 'Oh, just keep like that.' Well you know, we had a list of concerns, waited a month or better for some appointment 'cause he's a chronic arthritic [specialist], and you know, if you didn't get the right doctor that day, you didn't get any answer. You just came home totally frustrated even more. And you wasted a day. — Vermillion Alberta

In some cases this could have serious consequences:

The farther away from Highway 2 you live, the less chance you have of surviving a serious incident. — Clive, Alberta

Table 7 Liabilities associated with Living in a Rural/Remote Community for Health-Care Services—Access Issues

KEY THEME	SPECIFICS
Services	Great Distances to Access Care Require Significant Time off Work for Appointments Additional Cost of Staying Over Limited Access to Hospital Care Poor Hours Reduced Access to Ambulance Services Limited Access to Health Promotion Services/Programs
Information	Difficulties Accessing Health and health-care Information Specifically for Sensitive Women's Health Issues Internet Use/Other Media Telehealth

The greater distances to travel to reach care mean more time (often taken off work for appointments) and more money needed to access care that is more readily available

and accessible in urban areas. In some cases participants also had to deal with additional costs and delays associated with staying over night somewhere else:

And the financial part of it is a big problem for most women ... — Oakbank Manitoba

I mean just to travel to Marystown and back, you're looking at probably \$15 for gas and then \$25 to see your chiropractor, like you know, a lot of people just can't afford doing that. — Marystown, Nfld/Lb

Part of it too is when your health services require you to go to Timbuktu all the time then that adds a real strain. Like, I am very fortunate; I don't have chronic disease in my family. But if I had a kid or my husband had a chronic disease, I think that is huge because of the expense on a rural family. I don't think people in the city have any comprehension that that means you're actually leaving your place of work. You're not just popping into a specialist. You're taking a whole day. You're spending over night. I know when my youngest was flown to Edmonton when she was born, I mean literally I had to pack up suitcases and we moved to Edmonton for two weeks. And that was the only way that we could do it. There were babies at the Royal Alex Hospital that were abandoned. And really they were abandoned because their parents live in Fort St.

*John or some such place.
— Vermillion, Alberta*

These added costs are borne directly by the women and their families—that is, for most part, these are not costs that can be recovered under Medicare.

In addition to the physical distances involved, in many cases access to care in the local hospital was limited because it was not open 24 hours, or did not provide the kind of services needed—be it emergency or maternity care:

Markdale is twenty-four hours. So it does have 24 hours. After nine o'clock, you have to ring the doorbell. Yeah. But it's there. Yeah. Mmhmm. Is the doctor there or do they have to call him in? I think they call him in. I think they're always there. — Lion's Head, Ontario

You can't deliver in Port Alice unless you wait too long and arrive at the doorstep. — Port Alice, B.C.

In many cases, the reduced services available in local hospitals made it difficult to attract or retain health-care providers in rural/remote areas (for detailed discussion, see lack of providers section below).

Some communities have responded to the distance problem by developing a volunteer driving program where community volunteers drive women and/or their families to appointments. This is especially helpful for elderly women who cannot drive. Other programs include travelling specialists:

They travel from one community to the other all over our health district. Travelling specialists. — Yorkton, Saskatchewan

In some communities, ambulance services are relatively inaccessible and often require out-of-pocket funds:

It would seem that we don't even have an ambulance located, stationed right here. There's one in Wiarton and one at Tobermory [communities 30-45 minutes away on either side] I believe. — Lion's Head, Ontario

We've just moved up to 9-1-1 this fall. If someone

should have to have an ambulance, you might as well throw them in a vehicle if possible and take them there before the darn thing gets out there and then take that same time for it to get back. — Oakbank, Manitoba

One of the things I wanted to complain about was the cost for ambulance [includes discussion about how it is paid for if returned but not if one way] ... well can you see somebody on social assistance trying to pay for that? — Oakbank, Manitoba

In addition to concerns about emergency services, women also expressed dismay at the lack of access to health promotion services and programs:

Availability to programs that are offered in the city or anywhere else, they should be offered every-

***Availability to programs
that are offered in the
city or anywhere else,
they should be offered
everywhere.***

where. Programs should be available in all remote and rural areas that are available in Winnipeg. Maybe on a smaller scale, but they should be available. — Oakbank, Manitoba

May have a lot of services but there are barriers to accessing the services, lack of knowledge of what is available, cost of accessing services, inconsistencies in who and when services provided, lack of choice... — Fortsmith, NWT

To sum up thus far, it is clear that there are significant physical and systemic barriers to the availability and accessibility of health-care services in rural and remote communities. Social barriers also exist.

Access to Information

Lack of access to reliable health-care information was an important issue women discussed in the focus groups:

It seems like our whole society is saying 'you have responsibility for your own health' and that has changed. Twenty years ago it was the doctor that was responsible for my health. But now it is me. So the information I need needs to be extended to me. — Clive, Alberta

There are things out there we don't even know about. We have no clue. No clue. Just information about what services are available. Perhaps things that the government offers that we don't know about and maybe the government is hoping we don't find out about it. We might want it. And if we didn't ask, you know, they're saying 'well nobody asked for it so we'll just toss that tone. We'll do something else.' Well if we didn't know, how could we ask? — Clive, Alberta

Our geographic area is so large that we need more information where people can turn for support. We need things like some sort of liaison group. As it is, our communities have liaison groups with the community and mental-health services in our region. If we had some sort of women's liaison group where anyone who has any concerns, even if it's in the medical profession. If I have a client show a need for more information on diabetes or deafness, is there some group, are there groups out there who can help? Liaison committee would know to whom to go, where to look, what to look for. — Forteau/Port Hope Simpson/ Mary's Harbour, Nfld/Lb

I think having access to all the information so that we can educate ourselves about these issues, whether it's mental health or water conditions or social services or whatever. — Woodstock, Ontario

In particular, women wanted to have access to information about more sensitive women's health issues:

If we had a public nurse stationed here, someone who could have some information sessions on women's health issues or start up some kind of a program where we're taught nutritional, and an exercise program that women can take part in, that would also I think alleviate some of the stress in their lives. — Forteau/Port Hope Simpson/Mary's Harbour, Nfld/Lb

Well and certainly someone who is familiar with women's issues first of all. Like, I'm finding that there's just a real lack of knowledge around women's issues and certainly around health promotion. Women need information about menstruation, body parts and functions—how these things can affect young women/adult women. — Hay River, NWT

Access to information about women's health issues was noted by one participant as being especially important for young girls:

My husband teaches as well and he has touched on some issues that are issues for the teenagers. It embarrasses them in the classroom. He's doing it with them and they're very comfortable with him. I have spent a lot of time with teenagers and they will not, many, many of them will not go to the clinic. They don't like asking for help. They, many will prefer to go on information gathered from other teens—incorrect answers. However, when they do listen to Mr. X, for example, in the classroom, he has pointed out many times that the looks on their faces are incredulous. He's giving them information that they had no knowledge of. So there is a lack of education in our community, yes. And I do believe the teens find it difficult to go to the clinic and get this information. — Markdale, Ontario

Some of this discussion of limited access or poorly coordinated access to information was linked to the limited availability to computers and the Internet:

But in your rural areas there is not that access. You may have went to a bigger area and got access,

unless you have a computer now and can research the internet, but not everyone has that. — Clive, Alberta

But I know so many people that I've met in this town who don't even know how to turn a computer on. — Creston, B.C.

Unless you have a computer now and can research the internet, but not everyone has that — Clive, Alberta

There is access now cause libraries have them, most public libraries have them. Do you think people would use them for health information? I think they do. Probably the people that need that information most wouldn't know how to turn them. — Marystown, Nfld/Lb

The digital divide. Isn't that it? Bridging the digital divide. If you don't have the money for a computer or you can't travel five or six hours for travelling or two hours for travelling, if you're in some little place or a smaller community — Woodstock, Ontario

But others were concerned about the quality of information available on the Internet:

When I go on the computer, how do I tell between a good article and a bunk article? How do I tell it's written by someone who is knowledgeable? — Clive, Alberta

Lack of access to information was also linked to literacy levels (noted in the section on health above):

If nothing else, literacy, you can't even read about it if you don't know how to read. You can't find out information. Everyone is now saying 'Look to the internet.' Well if you don't know the computer, if you're not comfortable using the computer then

you can't very well look to the internet to find answers. — Forteau/Port Hope Simpson/Mary's Harbour, Nfld/Lb

Telehealth was mentioned specifically as a service that could help address some of the structural and social barriers to accessing good quality health-care information. But for many, this was not available:

It is not available at the present time, but maybe the time is ripe for coordinating that as we are moving into easy access to resources via the technology that we have, that we need to utilize the technology, whatever way it is, through you know Telehealth or whatever. — Clive, Alberta

In addition to these issues of access to health care and health-care information, women in the focus groups discussed other inadequacies associated with living in a rural/remote community in terms of quantity and quality of services. These are noted briefly below in Table 8 and in the following section.

Quantity of Health-Care Services

Women addressed the drawbacks of living in a rural or remote area related to health-care services, emphasizing the many things they lacked. They usually began with the lack of physicians:

Basically, we just have lack of doctors — Yorkton, Saskatchewan

I have heard of families that have lived here for over six years and still don't have a family physician — Cobourg, Ontario



Table 8 Inadequacies of Living in a Rural/Remote Community for health-care Services—Quantity and Quality Issues

KEY THEME	SPECIFICS
Quantity Issues	Lack of ... Physicians Affects Choice and Ability to Get a Second Opinion Nurse Practitioners Midwives Dentists Optometrists Mental Health Services Rehabilitation Services Home Care Services Special Needs Delays/Wait Lists/Times Funding Cuts/Threats of Closures Negative Impact of Restructuring
Quality Issues	Physicians Too Busy/Burnout Lack of Knowledge of Women’s Health Issues/Too Male Too Insensitive/Stereotypical Attitudes Towards Women/ Patronized as Rural Women—I.e., Not Smart Too Close (i.e., know too well to divulge sensitive information) Concerns with Confidentiality Lack of Commitment to Community Lack of Continuity/Consistency

In some cases, this had serious consequences:

Well I had an experience last month with my miscarriage that just shocked me. I started haemorrhaging on a Saturday and ... my husband took me into the hospital here and the nurse was looking kind of green around the gills looking at me lose all this blood, and the doctor didn't look too happy either so they called an ambulance because there was no doctor here. The doctor was away for the weekend. The anaesthetist was away for the weekend. And then they shipped me off in the ambulance to Lloydminster. And the worst part then was after, well and the nurse and the doctor got me so scared I was asking if I was going to bleed to death. At first my main concern was just losing my baby. And then I thought 'well am I going to die?' and then I get to Lloyd and I sat there from 4:30 until 5:00 on the gurney. — Vermillion, Alberta

Many appreciated the personal reasons behind the shortage of physicians:

It is not necessarily the money they make though, it's the fact that there's no one to relieve them on call. — Creston, B.C.

And the ones that are leaving now, you know, are leaving most likely because others won't come here or some are leaving, others are saying 'well, I'm not going to get study with this huge work load' We're just not very marketable. — Creston, B.C.

At the same time, however, they felt the consequences of the lack of physicians including lack of choice and difficulties getting a second opinion about medical care:

Sometimes not having a choice but to see a doctor that you dislike because there is no other doctor. — Oakbank, Manitoba

If you're not satisfied with what you have, most of the time it's too bad. — Woodstock, Ontario

Others specifically noted the lack of female physicians or nurse practitioners. This was

seen as important, particularly for sensitive women's health issues (see further comments on this below in the section on quality):

Issues which would be raised if "there'd be more female physicians and nurse practitioners" — Vermillion, Alberta

Maybe we could get more nurse practitioners out into the communities and alleviate and relieve the problems, stresses on our medical professions like the doctors' office. — Clive, Alberta

Some were interested in being able to access the services of midwives for maternity care services:

What services do you perceive as lacking? Midwifery. Mhhmm. Midwifery would be wonderful. And it would take so much pressure off the doctors. — Vermillion, Alberta

I do really think that midwives are finally now accepted in Canada. It's been a while to come. And I think they should be pushed in smaller communities more and more because a doctor does a delivery so rarely, whereas a midwife, that's all she really does. — Creston, B.C.

It's obvious that women want more services from midwives and it's not there as yet — Yorkton.

A lack of access to dental services was also highlighted. In this case, access was limited not only by distance but also by the lack of dental plans among rural and remote residents:

I had had to take a whole day off work just to go to the dentist — Tumbler Ridge, B.C.

The fact that there's no dental plans. So the poorest dental problems are with rural children. — Yorkton, Saskatchewan

The dentist is in every second week for two days, and he also has the contract with Nunee health. And you can't get in to see him. ... The line-up is so long. And he'll take the treaty³ over anybody else, because he's going to get paid for that whole week. — Fort Chipewyan, Alberta

Similar comments were made about access to optometrists and other eye practitioners:

What about the people who go without eye care because they can't afford to get an eye exam? — Oakbank, Manitoba

The lack of mental health services was particularly salient for many women in the focus groups:

We have a big lack of therapy here. Somebody does come a couple days, part days a week, but there's too much backlog for you to get in. — Cobourg, Ontario

[There are] very, very long waiting lists for them to get in to see the mental health professionals. ... Mentally ill people need to see someone within the week if not a few days after they leave a hospital or they're going to relapse and be back to the hospital so they become revolving door clients ... Mentally ill people, because they're mentally ill, do not have, for lack of a better word, the know-how to get out and go search for the resources. So they need persons ... reaching out to them in our communities. — Clive, Alberta

The wait list for mental health to see someone on the Burin Peninsula I think is something like eight months or longer. That's the wait list. — Marystown, Nfld/Lb

Rehabilitation services were often considered a luxury. Although some women and their families have limited access to such services on a rotating or visiting basis, even these are severely lacking:

And we do have a physiotherapist but we don't have the equipment and the physiotherapist doesn't have much room to work in. — Yorkton, Saskatchewan

For many of the women who were providing care to sick or disabled family members, the lack of home care services was particularly salient:

The home-care situation is deplorable here. ... The home care is just not there. Right now she's paying for a lot of it on her own, out of her own income. — Marystown, Nfld/Lb

And government won't pay for home care for 24 hours or what they need it. There's no family around to provide it, and they can't afford it themselves. And so you make do. Then obviously both people, both their health suffers. — Marystown, Nfld/Lb

Some of the private nursing care that you can hire yourself don't come out to our rural areas. — Clive, Alberta

Other special needs services were also described as ill-coordinated and lacking in other ways as well:

And it's just like this has been nonsense for years and years, not just with special needs but with all aspects of social services. . . . When I first started dealing with social services in this community for a special needs son, the gentleman came in. He was a really nice guy and I felt sorry for him. But that wasn't my job. My job was to be a client and he was supposed to be there to help our family. And he came into our home and says, you know, he wears many different hats, this day he was Native Affairs and today he's, and this, you know, special needs children thing is all new to him and we may probably might have to help him do it and by the way, we're in the market for foster homes. We really need foster homes. And this was our very first meeting with this guy and it was like by the time he left, I was offering him more answers and so forth. And that was then, and things haven't changed. We're going through the same thing now is trying to get some honesty. And I thought it was just me until the service provider said to me 'This is what they said and I know it's bogus. I know what they just said was bullshit.' And I said 'I thought the same thing.' And it's just like, no, that's what we're dealing with, you know. So social services in the North especially in an isolated community, whether it be Native Affairs, whether it be women's issues, whether it be special needs adults and children, it's totally lacking in the North, totally. — Tumbler Ridge, B.C.

The lack of health-care providers results in significant delays, increased waiting lists and longer waiting times for care:

I've had to sit at the emergency several times in the past and oh, the service is unbelievable — Woodstock, Ontario

Not being able to access care in a timely fashion meant that there was less chance for the early detection of problems:

I think the other problem for rural women, so many of the different cancers are treatable if you catch them early. But we're out here and who is going to catch them? First, I think you have to educate the women so that they know to recognize a possible problem. Then you have to be able to send them somewhere to look after it. And there are a lot of steps in that that just are missing out here. — Vermillion, Alberta

Many also noted that instead of getting better, health care restructuring in the form of funding cuts and threats of closures has exacerbated a bad situation, making it worse:

For those of us in rural areas, we live with the threat that we could lose the services that we have. — participant from Vermillion, Alberta

We live under the threat all the time in the rural communities of our hospitals. — Clive, Alberta

But with these cuts that have come in, further cuts, doctors don't want to come here. And that's frightening. We know we don't have the specialists ... We made those choices. But it is frightening knowing that doctors can't practice their anaesthetics here or surgery. — Creston, B.C.

In addition to the consequences of the lack of health-care providers for access to second opinions, and for waiting times and delays in general, women living in rural and remote communities spoke clearly of the implications this had for other aspects of quality of care.

Quality of Health Care Services

Some women differed as to whether the services available in rural and remote areas were similar in quality to those available in urban areas: For example, one woman noted:

Well the quality is there, it is just being able to access it. — Clive, Alberta

Others felt that the quality didn't compare. For example, one participant stated that:

The quality of the nursing isn't there because there are fewer nurses. — Clive, Alberta

Not having enough providers makes those who are available too busy and this woman felt this has consequences for quality of care:

This guy that's been there for 20 years has a case load of people, I mean he just can't do justice to the amount of people that he has on his list, his patient list, because everybody is trying to speak with him. — Oakbank, Manitoba

Many women also noted the lack of knowledge of women's health issues among

physicians in rural and remote communities, most of whom are male. In some cases, these participants perceived physicians to be particularly insensitive, often displaying stereotypical attitudes towards women.

Many participants also reported being patronized as “dumb” rural/remote women:

I'm finding that there's just a real lack of knowledge around women's issues and certainly around health promotion. It tends to be much more 'well here, take a pill.' or 'it's in your head' that kind of attitude rather than, you know, looking at further causes. — Vermillion, Alberta

[Physicians don't] appreciate the concerns that women are bringing to them. — Vermillion, Alberta

My doctor is brutal. He stands up before I'm finished. He's at the door. He's already dismissed me. He just wants to know maybe physically what your symptoms are ... but anything else that's going on [forget it]. — Woodstock, Ontario

In some cases, women travel great distances to access care from a female provider. One woman recalled how she travelled over four hours so her PAP smear could be conducted by a woman:

For my pap smear I go to Midway of all places cause there's a lady there that took me in, and she's really ... and that's how far I will go because I do not want a man, and that's a choice I make. — Creston, B.C.

I can't think of a male doctor understanding when my ovaries are hurting or whatever. I mean he doesn't know what I'm feeling. At least a woman I feel comfortable with. — Creston, B.C.

I hate to sound prejudiced, but I think that a woman doc/physician or a nurse practitioner would understand our health problems much better. — Vermillion, Alberta

I just find that women doctors understand women's issues a lot better. Where a man, I almost feel like they're sometimes grasping at straws, 'okay, let's try this.' 'Oh yeah, let's try this.' And it's like 'no, I'm not going to be your guinea pig.' — Creston, B.C.

Many felt that they had better care from health-care providers who were women:

My health has always been improved I feel by the services that I've received from other women. There seems to be more empathy and more time involved. — Woodstock, Ontario

Some women seek access to alternative practitioners when they are available :

If the medical doctors are fluffing you off and not giving you the help we need, we have to be able to go to an alternative medicine, alternative practitioner or somebody that will help and maybe give you the help that you do need, that we know it does work. — Clive, Alberta

In addition to concerns regarding the gender of their physicians, some women were also concerned about how well they knew their physician. That is, although some participants in some cases felt that knowing their physician well was one of the positive features of rural/remote living, others felt that this sometimes made it difficult to

divulge sensitive information, particularly if they were the physician for other family members:

You know if you have to see the doctor socially. Like the doctor is a friend of your parents or the social environment. I've had to have a lot of pap

smears because I had cervical cancer in the past. So I just feel I'm so much more comfortable having a woman to begin with, and also out of the social



context. So that's important to me. — Woodstock, Ontario

Others identified concerns regarding confidentiality:

I think confidentiality is a concern in a small town and it isn't brought up — Creston, B.C.

I think the other big problem over the years is lack of confidentiality, because whatever you went to the nursing station for, basically everybody in town knew about it in the next few days. — Fort Chipewyan, Alberta

The high turnover of health-care providers in some communities made some participants question their commitment to the community:

Doctors [are] leaving all the time. — Vermillion, Alberta

I think sometimes with us being a rural centre, some of the doctors that are coming in from other countries are just using our communities as spring boards to get to bigger, larger centres. This is where they land and then off they go to the larger centres. — Vermillion, Alberta

We've had quite a big turnover of doctors whereas the regional nurses for the most part are nurses that have lived there for a number of years and actually belong to the community. — Forteau/Port Hope Simpson/ Mary's Harbour, Nfld/Lb

High turnover raised other concerns relating to continuity and consistency of care:

There was one specialist who was coming in and then something happened and then there wasn't anybody coming in and then there was somebody coming but it was somebody different, and you sort of, you don't, there's not any sort of consistency. You don't know who is available from time to time. — Vermillion, Alberta

We have a problem in some of the communities with continuity of family physicians.... so every six months or so you could have a different doctor. So there's no, you know, facility to carry through. — Marystown, Nfld/Lb

I'd say they go years without having paps done and the things that you were saying because the doctors are turning over every six months, the doctor is not going to suggest to them that they have it done. And most women are not going to

approach the doctor about those things either. So I think a lot of it is being neglected, just not getting done. — Marystown, Nfld/Lb

At the same time, however, they noted that much of the turnover was due to being too busy and a high burnout rate among health-care providers:

The high staff turnover and burnout rate for the front line workers affect the continuity of care — Yellowknife, NWT

In sum, the basic picture that was drawn for us about the state of health care for women in rural and remote areas was rather bleak. They faced a lack of health-care providers across the spectrum and those that they did have available to them were in some cases seen as inadequate and insensitive to their needs as women. The women in the focus groups went to great lengths both in terms of time and money to get care—whether that was for basic services or for those provided by another woman. They understood the reasons behind the challenges, but nevertheless hoped that something better would be available to them. In the next section on women's views of rural/remote living, these experiences of health and health care figured prominently.

C. Definition and Experience of Being Rural or Remote

The women who participated in our focus groups had a very strong sense of what it meant to live in a rural or remote community. Their responses were placed into two categories and as with their views on the impact of rural/remote living on health, within each of these categories, both positive and negative facets were identified. The first category addresses the structural issues including distance to services and other people, the differences between farm-rural and town-rural, and between rural and remote. The second category addresses the

social issues associated with being known to all, having to make do, and dealing with stereotypes of rural women. These are briefly noted in Table 9.

Structural Issues

The issues of distance and driving are important elements of rural and remote living as well as rural and remote health care. Indeed, when asked what living rurally or remotely meant to participants, their first response was often “driving”. In some

remote communities, the women noted the added barrier of having to fly to get anywhere. Either way, living in a rural and remote community meant a lot of travelling:

Everything you do, you have to travel. — Vermillion, Alberta

I think the distance from services. . . . I mean everything isn't available here for you so you have to go to it — participants from Lion's Head, Ontario

It takes a hundred kilometres to go to town to buy groceries. I mean then your kid has hockey. So it's a huge amount of travel. — Yorkton, Saskatchewan

Table 9 Overall Sense of Living in a Rural/Remote Community

KEY THEME	SPECIFICS
Structural Issues	Distance Solitude, Silence, and Space Safety Isolation Farm vs. Town Rural vs. Remote Transportation Options Communications
Social Issues	Everyone Knows You You Own Your Home Poverty Having to “Make Do”/Simple Life Discrimination by Those in the City/south Country “Hicks” Impact on Self-esteem “Transplants” [From City to Farm/rural]

For some women who didn't drive, this posed significant problems:

And a lot of people don't have access to transportation. You take with an older person probably a lot of people don't have a vehicle. — Marystown, Nfld/Lb

You're responsible for getting there. — Clive, Alberta

Like to go to the doctor's even, although it's only less than five minutes away from me, because I don't drive, unless my husband takes time off work, I have to count on someone else to take me. — Lion's Head, Ontario

Related to the issue of distances to others and to services were feelings of solitude, silence and space:

You can't hear your neighbours next door. There's no, you know like all the noise and traffic in the city would just grate on my nerves. I mean it's easier to live with calves during weaning time than it is to hear your neighbours fighting next door. — Clive, Alberta

Being able to go out and walk and not have to worry about the traffic. — Lion's Head, Ontario

The space and freedom for ourselves and our children. — Clive, Alberta

For many this translated into a feeling of safety:

You're safe to walk around the community ... not like in the city where you might have to worry about being mugged or whatever. — Tumbler Ridge, B.C.

The other side of this, however, was the feeling of being isolated, lonely and vulnerable:

A part of the problem too in relation to attitudes and living in a rural community, a lot of people feel lonely or isolated or depressed. — Clive, Alberta

If you don't have a car and can't drive, then isolation can definitely set in when you're in a rural area. — Markdale, Ontario

I think there is an immense need to address loneliness that rural women experience. We talk a lot about community and all of that but the isolation of where we live has great beauty, but it also has great capacity to level us. — Yorkton, Saskatchewan.

Quite clearly the structural issue of distance has implications in terms of social isolation (see below for full discussion of the social aspects of the definition of rural/remote living).

Other issues of a structural nature relate to the difference between farm and town with more women regarding rural living as living on the farm. For example:

But rural is being out in the country and having my own area away from other people. — Clive, Alberta

The fact that we're living in a much more clustered community sometimes give us a feeling of not being as rural maybe we think of some of those large farms. — Cobourg, Ontario

My idea of the country is being able to be a farmer and to touch the earth ... I just like to drive the tractor through the field and look behind you and see that the dirt is turned over and the smell, and the worms and the seagulls and the hawks. One time I was working the field, there were 11 hawks flying over me all day long. And I have one hawk named Margaret. She's named after my mother... in this one field that I work in and she sits right there and waits till my tractor comes and I mean

how can you experience that kind of think you know. And we've all sort of felt down and then been driving or walking in the woods and a deer steps out. Like there is no greater feeling than to know that nature is there to support you when you're feeling down maybe because something comes along, you know. And I think it's the ability to touch the earth. — Clive, Alberta

However, many noted that farms are not necessarily idyllic:

It's a lot easier to get hurt on the farm I think than in your little postage stamp back yard. — Clive, Alberta

Within this discussion the issue of “transplants” from cities to the farm or to rural areas was raised:

A lot of our farms have been bought up by people coming out of the city and what not. ... These farms are bought up for retreats. ... So I think maybe that's why some of us feel yes, we're rural but we're recreational rural. — Cobourg, Ontario

If you look around the community, everyone has come from the city. — Markdale, Ontario.

Participants generally distinguished between being rural and being remote:

I think there is a big difference between rural and remote. We're seven miles from town ... remote to me is when you live hundreds of miles from someplace. — Vermillion, Alberta

I think living remotely also builds responsibility into yourself. That you begin to rely on your own resources and you know that it's you who has to see through the situation. ... You have to be self-reliant. — Clive, Alberta

St. Lawrence is probably remote cause they can't get the internet up there, you know, cause they don't have phone ... lines... That makes them remote. — Marystown, Nfld/Lb

When I think of remote I think of the fly-in communities. — Oakbank, Manitoba

Thus distance, transportation options and communications infrastructure play an important role in participants' definitions of rural and remote.

Social Issues

Women we met tended to link rural or remote living to a feeling of being connected to a place.

How do we define our community? It's our home; it's our home, short and simple. So your community is your home. And we make the best of it. — Fort Chipewyan, Alberta

Feeling connected can mean that everyone knows each other, which can have both positive and negative consequences:

Well I think again what's nice here is I know in the city you're pretty much a number. At least here, you have a name ... and if you've been around long enough and you know other people, you're a name and you're a family and their family has had some sort of association with your family ... but that can be a good or a bad thing. — Vermillion, Alberta

When I lived in XXX I had a son that was killed in an accident and everybody was there, absolutely everybody. I don't think you'd find that in a city — Clive, Alberta

A sense of connection. Being very personable ... there's more of a connection with humanity here. — Creston, B.C.

Everybody knows your business whether it's health care or your financial situation or what your kids did last night. It doesn't matter. But then on the other hand, living in this community, everybody raises your children. — Port Alice, B.C.

Poverty is an all too common social aspect of rural/remote living.

But to be community people and to grow up and be part of a community and we live in poverty to begin with ... to grow off the land and feed off the land. — Oakbank, Manitoba

So a lot of what we learned we associated with being poor, but those values are things that everybody needs to be an independent adult and contribute to communities, to family, and to society. And we've somehow associated all of that with the poverty of our youth and sort of look at being somewhat affluent as a means of not having to do any of those things Saskatchewan is an obvious example of that. It's almost poverty struck now. — Woodstock, Ontario

[We need to] recognize there are some very poverty stricken people that don't even have the facilities or

the ability or the knowledge base. — Yorkton, Saskatchewan

The social effects of poverty, limited local services and other threats to health were sometimes exacerbated by time constraints associated with seasonal work in rural and remote areas resulting in an overall sense of having to “make do”.

What you want isn't always available. And that's just sort of a fact of life and also living rurally for us, because we farm, there are just certain times of the year where you can't go someplace ... we can't do anything in March because we're calving. So if you're sick, it's either the emergency room or forget it. If it's during harvest season, it's the same thing. — Vermillion, Alberta

Some portrayed the lack of services and isolation in somewhat more positive terms as keeping life simple and making it easier to live on lower incomes:

Lack of entertainment, shopping, and you know I guess many factors up here that you would have in most centres. But I think that we more than make up for it in other areas. ... We pick our own berries and we grow our own gardens, you know, stuff like that that you wouldn't do if you were in a larger centre. — Forteau/Port Hope Simpson/Mary's Harbour, Nfld/Lb

It's less money to live here. So therefore, you know, I had to work full time when I lived in Vancouver. And I don't even make as much now as I did then and I work like part time, and you know, it's just a lot slower pace of life which is less stress, more pleasure time. — Creston, B.C.

You're not as stressed and going like you're on a treadmill, then you have better quality of health cause you feel better, you're more at peace. You enjoy life more. — Lion's Head, Ontario

I love gardening. I love our back yard. I love our trees ... and it's exciting for me to take fruit and make jam or pies and things like that. I enjoy that. — Creston, B.C.

Many women pointed out the various stereotypes others had of rural and remote living. Some also talked about the discrimination they or others had experienced when they travelled to “the City” or the “South” for health care and other services:

Rural to me means quiet and the space and my own area where there should be less stress. That isn't always the case because so many elements, if you're a farmer forget that. — Clive, Alberta

They fail to realize that people from the remote communities, who may have never been anywhere outside of the community- feel just like those foreigners and should be given the same consideration and care. — Yellowknife, NWT

I hate to say that, but of my urban experiences in hospitals I would say that they think you're a little dumber, you're a little bit more stupid. — Vermillion, Alberta

They think that because you're here you're not really all that educated. — Markdale, Ontario

We think the woman that goes to work, she goes all dressed up in her nice clothes and when we're at home working on the farm we put on, I've never seen a woman digging in her garden in her high heels yet. So I think that has part to do with the attitudes that people have of us or the perception that other people have of us. They think we only go around cause we're scrubby people, that we look like we're down and destitute and we're really, they think because we don't have fancy clothes on that we don't have any brains as well as no clothes. — Yorkton, Saskatchewan

At the same time, however, some of the rural women had their own stereotypes of themselves:

A rural woman is someone who does a lot of home baking ... lots of quilting. — Lion's Head, Ontario

In all, women's definitions of rural/remote living tended toward an image of self-sufficiency—having to make do with a simpler life, with a lot of driving, with doing more for oneself and one's family and with being misunderstood or looked down upon by those in the City or the South.

D. Policy Recommendations

Following our participants' descriptions of the implications of rural and remote living on health and health-care issues, we asked for their opinions on how policy might be shaped to better address the problems they faced. These are briefly noted in Table 10 on

page G37 and include the broad categories of: improving accessibility; improving sensitivity; improving access to information and its targets; expanding the range of age-related services; providing more support; promoting understanding of the impacts of health-care reform; and improving the overall influence of women in rural and remote communities regarding health and health-care issues.

Many of the comments made by the participants in our focus groups regarding improving access to health-care services focused on increasing the number of physicians available in rural and remote communities. Many linked the lack of physicians with other ills in rural and remote health care, such as burnout and overworked health-care providers:

If you had enough doctors in a community, there wouldn't be a problem about being overworked in a rural area. And if you wanted to go off to the city for a weekend with your wife, there would be other physicians in the community to cover for them. — Vermillion, Alberta

Some suggested that more foreign-trained physicians should be allowed to practice:

We hear that the Canadian government in health is now looking at foreign, the foreign doctors who are coming which is unfortunate they haven't done that years and years ago. — Lion's Head, Ontario

Others wanted to encourage more Canadian-trained physicians to practice in rural and remote communities:

I'd like to see some Canadian trained physicians coming out here. I don't know why they're all going to the cities. Why can't, we're spending big money, we all spend the same tax dollars towards universities and I think a certain proportion of physicians should come out back to us. — Vermillion Alberta

Another suggestion was to encourage semi-retired physicians to contribute:

That's another thing we do have is some retired doctors who come down one day a week or every

second week or something to do special things. —
Lion's Head, Ontario

something that had worked well in their
area.

Indeed, participants in one community in
Ontario (Markdale) noted that this was

Table 10 Suggestions for Policy Change to Improve Rural and Remote Women's Health and health-care Issues	
KEY THEME	SPECIFICS
Improve Accessibility	Allow More Foreign-trained Physicians to Practice Encourage Semi-retired Physicians to Contribute Increase Use of Female Physicians and Nurse Practitioners Rotating/outreach Services to Increase Accessibility/care Closer to Home [Such as Well-woman Clinics] Mental Health Services
Improve Sensitivity	Culturally Appropriate Services More Female health-care Providers More Time
Improve Information (and targets)	Reduced Cost of Education, Services
Expand Focus of Age-related Services	Young Children Childcare Youth/teen Issues Teen Sexuality/pregnancy Substance Use/abuse Young Adults (Out of School) Young/single Parents Middle Age/menopause Aging/seniors Issues
Better Support	Victims of Violence Poor/Those on Social Assistance
Better Understand Impact of Health Reforms	Funding Cutbacks Regionalization Travel Time and Costs
Improve Influence of Rural Women	Wanting a Stronger Voice Decisions Made Without Grass-roots Input

Many participants were not only interested in increasing the complement of physicians, they also stressed the importance of increasing the availability of female physicians and female nurse practitioners:

The first thing is having female doctors so that the women and the girls in the community would feel more comfortable talking to them. — Yorkton, Saskatchewan

To have more women doctors, make a person feel more comfy going and you'd probably go more

often. — Yorkton, Saskatchewan

Others pointed to using services that are already available in rural and remote communities more fully; this was mentioned primarily in relation to community pharmacists:

Lately they've been talking about pharmacists being able to prescribe, you know, independently from the doctors. And I believe that's an experiment that should be tried too. Spread it out a little bit

because a lot of the pharmacists really know their patients. You know, they know the people very well and you know, let's experiment with this. — Clive, Alberta

Another strategy mentioned to improve accessibility included rotating/outreach services, such as well-woman clinics and other speciality care to avoid the long drive and to have care closer at hand:

We need more outreach services in the mental health field as well. ... We need more mental health specialists in the community. — Clive, Alberta

When you are sick it's good to have the availability of good health care close at hand. And for that reason I sometimes don't like the idea of them closing down the smaller community health-care centres and that type of thing. — Clive, Alberta

As noted above, mental health services were mentioned specifically.

In additional to these suggestions to improve accessibility, others mentioned that there needed to be improvements in the sensitivity of both health-care providers and rural and remote communities. Related to the mental health issue, some mentioned that greater knowledge and acceptance of mental health issues is also needed in rural and remote communities:

Acceptance of mental health issues and develop strong programming and services to address. — Yellowknife, NWT

There should be more people trained in compassion when they're dealing with people in crisis. — Oakbank, Manitoba

Related to this issue is the need for more culturally-appropriate services, particularly for Aboriginal women and their families:

They're supposed to be working with Aboriginal clients but they're not allowed to bring culture into their work. My thoughts on what (name) was just talking about culture and ethnicity, I think we can have communities within communities. ## Germans, and those folks probably organized together for their big German day or whatever, so it's kind of a community within a community or maybe in ours, ## Catholics probably were still

there but the Catholics ## organize a community within that community too. — Watrous, Saskatchewan

Other participants mentioned that better access to health and health-care information was necessary including better targeting of key audiences and reducing costs of educational services:

Education which may well be in the form of group sessions, public health nurse but certainly the disease prevention/health promotion model. And education, preferably beginning at the school-age group or even younger. Education involves, I mean not only educating young children but parents as well. I'll give you an example. When I spoke about getting a nutrition program going at the school, the nutritionist at the time and the public-health nurse both said to me there's a lot of opposition from the parents to take the [pop] and chips out of the school. And I said, 'well what does that tell you? That tells you that you should start educating the parents; that we should be educating parents about the importance of good nutrition. — Forteau/Port Hope Simpson/Mary's Harbour, Nfld/Lb

The first responders⁴ are darn good but we need better basic health needs such as education on nutrition and exercise and stress. Those kind of things need improvement through education. — Yorkton, Saskatchewan

Others noted the importance of expanded Age-Related Services for women and girls in rural and remote communities. This began with a discussion of services for young children and their mothers:

I want a children's centre in the community. A children's centre? That would provide what? That would provide — Headstart, daycare, infant care... — Fort Chipewyan, Alberta

Services for youths/teens were also emphasized:

We would like to see extra attention being given, especially when it comes to the youth, because they are the ones we need to reach. — Forteau/Port Hope Simpson/ Mary's Harbour, Nfld/Lb

Part of this related to issues of sexuality, pregnancy and parenting:

Birth control and family planning promotion especially geared towards younger women. — Marystown, Nfld/Lb

They do have, they impact on, the girls [to] stop smoking and pay attention to nutrition and pay better attention to their health and they're educated regarding good prenatal care and breast feeding and what not. But it has a big positive impact on them. — Oakbank, Manitoba

There's all these programs that are trying to teach these young women how to be parents. So that's very stressful on the family. And they have no support. They have to go elsewhere to have support. — Oakbank, Manitoba

Other age-related women's health services some felt needed attention were services for those between childbearing and menopause:

And the ones past child-bearing age and not yet in the menopause. That's a group too that's kind of neglected. — Marystown, Nfld/Lb

In addition to these specific age-related services for women, many mentioned that better support for victims of violence and those on social assistance was greatly needed:

And my second one is how to recognize the early signs of abuse and have places and education for people dealing with these problems. — Yorkton, Saskatchewan

Related to this was the need to better understand the impact of health reforms and other forms of restructuring on the lives of women in rural and remote communities and to begin to address these:

I mean that's affecting me personally, but on a broad level government cutbacks provincially has made it such a stressful life for so many people. And that is so detrimental to your health. — Creston, B.C.

Substance use and abuse was another concern raised not just for teens but for many in rural and remote communities:

For non-medical issues such as mental health, alcohol and drugs, abuse, there is lack of followup services, the waiting time to access services can be long or restrictions to access of services (i.e. can only be in treatment centre for 30 days) are detrimental and senseless. — Yellowknife, NWT

I don't know if you'd call this a threat, but there's a lot of alcohol in the rural areas that's hidden or that's accepted. More that it's accepted. — Yorkton, Saskatchewan

Regionalization of health-care delivery was mentioned in particular (and in particular by women in Alberta) as a policy that needs to be revised:

The policy too. Like the new region might not be as pro like lactation consultants and stuff like that so you end up losing the funding for them. — Vermillion, Alberta

I think they're cutting down on the small hospitals and they're forcing us to go to the bigger centre, and even once you get to Red Deer if they don't have the specialist you need there or even to get into a G.P. there, there's a long, long waiting list and you're having to wait there too and then they can refer you on to a bigger centre yet and it's another six months waiting list to get into them. — Clive, Alberta

They've de-centralized everything and I think that was wrong. I think they should have kept open these smaller hospitals. — Clive, Alberta

Women called for greater sensitivity to and, ideally, compensation for the excessive travel times and costs borne by women in rural and remote communities in order to get access to health care:

The cost of travel back and forth to St. John's every month or couple of months and then you know if you don't have family there, there's hostel and meals, and if that person doesn't have medical insurance, you know, then the cost could be a big factor for them. And I think that's something that's very important to be put in any questions about improvement of women's health. — Forteau/Port Hope Simpson/ Mary's Harbour, Nfld/Lb

I had an experience where I had to go back to the hospital three times a day for, you know, an intravenous, and I was told on the last day that I was going 'where are you from?' and I said "well, an hour and three quarters." "Well we could have got a health-care nurse to come to do that." But that was after we'd gone three times a day for four days. But somehow I don't think they, the urban areas, understand what rural means. They think you live within 10, 15 minutes driving time; that you can pop back and forth. — Clive, Alberta

Finally, one of the key policy recommendations from women who participated in our focus groups was to improve the overall extent to which women in rural and remote communities have influence over decisions that affect their health and health care.

Indeed, many wanted a stronger voice:

The policies are in the way of our voices being what are we doing in our own communities to reduce diabetes and stress and offer support for each other; and equal representation for the North. Political recognition. Right. You want the North to have a voice. A voice. So that voice is heard. Yeah. And I'm sure that's consensus in all decisions made without grass-roots input — Hay River, NWT

The treatment of women—we are not slaves—we are equal. — Yellowknife, NWT

Can help women change and grow but the attitudes prevailing in the communities, the region, the Territories has to be supportive. — Yellowknife, NWT

Women are not relevant and important. — Watrous, Saskatchewan

In sum, for any policy to effectively address rural and remote women’s health and health-care needs, these women need to

have input into the development of this policy and it needs to be formulated based on the realities that they face. Rural and remote women’s health and health-care concerns need to be clearly identified so that we can improve accessibility, improve information and support services and target appropriate services to women of different ages, from different ethnic and cultural backgrounds and with different needs.

E. Suggestions for Research

In addition to asking participants for some direction for policy changes that would effectively address the health and health-care issues they raised in the context of the focus group, we also queried them about possible areas where more research would be needed to better understand rural and remote women’s health and health care issues. Overwhelmingly, most participants preferred action to more research; nevertheless, some very important areas for future research were identified by the women in our groups. These are briefly noted in Table 11 below.

Table 11 Suggestions for Research to Address Rural and Remote Women’s Health and Health Care Issues	
KEY QUESTION	SPECIFICS
Impact of Age on Access to Services	Denying access to older women
Specific Concerns for Rural and Remote Communities	Concern with Effects of Drugs and Alcohol Negative Media Image
Urban/Rural Comparison Of Women’s Health	Does an Urban Approach to Health Care Work for Rural People? Caregiver Issues Value of Women’s Work
Knowledge Transfer/ Dissemination	Research should be “used” or about “usable” topics and made accessible Concern with duplication of research studies Mentoring

Several participants were interested in knowing more about the effects of age on access to services.

Well there's clinics in the city that they won't accept new patients unless you're under a certain age bracket. Like you have to be up to 19. They'll accept anybody under 19. But if you have the same problem as somebody who is 19, and you're 20 or something like that, they won't accept you... Well it's like why should you be denied the same health care for the same issue just because you're a year older. — Oakbank, Manitoba

Some of these concerns addressed older and elderly women's difficulties accessing care:

The only thing that I can say is that I think as people get older, they lose their ability to travel living in the country because some doctor says that you can't drive or your family you're a hazard on the road. And I think that this is maybe a barrier to living in this country. There might be worse barriers in town. — Clive, Alberta

Other specific concerns included redirecting research towards stopping smoking and abuse problems before they started among young women in rural and remote communities:

That's what I'm saying. Maybe the research is not on the impact of smoking on young women. It's more research on how to motivate young women not to smoke, not to start smoking, or when they do, how to quit. And it's not just smoking I think. That's what I say. It's # drugs. All sorts of different — Cobourg, Ontario

Some were interested in research into the negative media image that rural and remote communities seem to have:

It is maybe even more important that you doing the survey realize and recognize the good in rural areas, not only list off the bad. I think we have a lot

of good systems, maybe unofficial organization, but still we have things that work in small towns that would, that big cities would never be able to come close to. And I think in studies like this that has to be recognized because often time all we hear is the negative. We don't hear the positives

and the positive gets dropped. —

*Forteau/Port Hope
Simpson/Mary's
Harbour, Nfld/Lb*

I would say the only time we really get in the media is when there's something negative happening here, and they really blow it up when every student in the high school fails the math test on these provincial achievement tests that they do. —

Fort Chipewyan, Alberta

This discussion also raised issues of a comparative nature between urban and rural/remote women's health and health care. Many questioned whether an urban approach to health care is appropriate for rural people:

They need to know that our health needs as women are just as important as the women in the cities. We're not any different rural women. We need the same facilities. We need the same type of people available. We need the same education. And it has to be available. We have to have it here for us that we don't have to... It's a lot easier to bring one or two people to a hundred than it is to send the hundred to two people. —

*Forteau/Port Hope Simpson/ Mary's Harbour,
Nfld/Lb*

Some other participants mentioned that research should address issues of caregiving as well as valuing the work that women do:

So supporting care givers. Yes, totally. Because we're the ones that are doing it. In a family, it's not the dad that goes 'Oh I think there's a', it's usually the mom. And it's usually when the kid is sick it's usually the mom who is the caregiver who stays home. So if she's working she stays home. If she's not working it still throws a wrench in her life for that time frame. — Vermillion, Alberta

In all, women's definitions of rural/remote living tended toward an image of self-sufficiency—having to make do with a simpler life...

Some of the organizations that are backing this need for research information to get their messages across and we feel that that would be research worth doing. Another one is the true value of farm women's work in economic terms to prove value that justifies financial input by levels of government. We think that's a great unrecognized resource. — Yorkton, Saskatchewan.

Other comments about research needs addressed form in addition to content. For example, participants highlighted how any research that is conducted should be “used” or about “usable” topics and made accessible:

If it makes no difference in the practices and it's not being disseminated in language that is comprehensible for us rural women. — Clive, Alberta

If the research doesn't get implemented at our level it is useless to us. — Vermillion, Alberta

I think the people should fund the research should have the responsibility to distribute it afterwards and make sure it goes into policies and policy-making and is used in health care decisions. — Marystown, Nfld/Lb

Thus research transfer was very important to women. Other concerns with research were regarding the duplication of research studies:

I also think it needs to be like I said disseminated in a manner, share it and let's see some results. And know what's out there so that two people aren't doing the same research at two different ends of the country. Like there's got to be some pool that they can actually do it collectively and maybe speed it up. — Clive, Alberta

If you've already got a study and it's a good study, use the results from that study. Don't go spending money on another study and just run over the same ground. — Vermillion, Alberta

Others, as noted above, wanted to focus more on action as opposed to research:

You can do the research and the papers sit up on somebody's desk. Just because we know that, even if we know what the facts are, if the government or some public agency is not going to use what they found in the research, were are we going with it?

— Marystown, Nfld/Lb

In sum, women in this study had some very important issues to raise about future research on rural and remote women's health and health care issues both in terms of content and form. It is critical for these concerns to be addressed.

Rural and remote women's health and health-care concerns need to be clearly identified...

Summary and Reflections

In sum, we found many commonalities as well as some unique challenges raised by the 164 women in the 20 focus groups that were conducted across rural and remote Canada. Some of the key points can be summarised as follows:

I. Impact of Rural/Remote Living on Health

- The impacts of rural and remote living on women's health can be both positive (i.e., assets) and negative (i.e., detriments)
- Both physical and social features of rural and remote areas can influence health
- The same feature can have both positive and negative impacts
- Thus, rural and remote living yields both benefits and drawbacks for women's health.

Assets of Rural/Remote Living for Women's Health

- *Physical assets:* air quality/lack of pollution, trees/lakes/beauty/recreational paradise, access to exercise and better diet.
- *Social assets:* being part of a caring community, access to social/support groups including the WI (Women's Institute) and rural churches; access to information and programs through these venues, being involved/pulling together, have time to spend with family, crime free/safe, less stress, less congestion, more peace.

Detriments of Rural/Remote Living for Women's Health

- *Physical detriments:* poor air and water quality, exposure to farm chemicals, impact of the drought, substandard housing, high food costs, lack of public

transportation, impact of weather/seasonality, and limited access to health promoting activities

- *Social detriments:* economic stress of farming, the related concern of caring for husband under stress, isolation, social expectations and attitudes, lack of extended family, lack of anonymity, substance abuse, violence, limited employment, communities in transition or suffering from economic restructuring, financial insecurity/low income, low education and low literacy rates.

Reflections

The focus groups identified a fairly good balance of positive and negative aspects of rural and remote living for women's health. Perhaps this is indicative of the importance of these issues for women living in rural and remote communities or it is reflective of the questions posed during the focus groups. Either way, there was good quality data gathered on this issue.

II. Impact of Rural/Remote Living on Health Care Services

- Although most of the questions in the focus group interview guide addressed the issue of health, most women responded by discussing health care. In light of this, the bulk of the data falls within the category of health care services.
- A similar dichotomy of positive and negative features noted in participants' views of the impact of rural/remote living on health was also salient in their discussions of health care but the majority of the discussion addressed the various elements that were lacking in rural and remote health care services. Many women made

direct comparisons with the health services they felt were available in urban areas.

Benefits

- In terms of *structural* issues, hospitals were considered not as busy and therefore better quality of care was provided. Others mentioned that the level of some services was improving.
- In terms of *social* issues, there are better opportunities to get to know one's health care provider in the community. In some cases this can make it easier to get an appointment with one's family doctor

Drawbacks

- *Structural barriers*: distance to services, access to hospital and ambulance services as well as health promotion services/programs.
- *Social barriers*: those mentioned mainly related to constraints on access to information specifically related to sensitive women's health issues and included discussions of internet use and other media.
- Women discussed local initiatives developed to mitigate some of these barriers. These included: volunteer driver programs, rotating specialist visits and telehealth where available (see more details in policy section below).
- With respect to *quantity* of services, there was a lack of physicians, nurse practitioners, midwives, dentists, optometrists, mental health services, rehabilitation services, home care services, special needs, and alternative practitioners. Shortages limited choice and ability to get a second opinion, increased delays/wait lists/times. Recent funding cuts and restructuring

seemed to have exacerbated these inadequacies in the system.

- With respect to *quality* of services, women noted how busy the physicians and other health-care providers in their area are, suggested that this has led to burnout of health-care providers, and to a lack of continuity and consistency of care. Others noted that some of the physicians in rural and remote areas lack knowledge of women's health issues and in some cases are insensitive to women's concerns and even hold stereotypical attitudes towards women making some of the participants feel patronized as rural women—i.e., that they are not particularly smart. Other concerns highlighted how knowing one's health-care provider well made it difficult to divulge sensitive information and others had concerns with confidentiality.

Reflections

The balance of positive and negative aspects of rural and remote living for women's health was not mirrored in women's views of rural/remote health care. Perhaps this is reflective of reality, but it is important to keep in mind that there were no specific questions probing for the positive aspects of rural/remote health care. Indeed, it is interesting that the only formal question which addressed health care focused on the issue of satisfaction. In many cases, women would say they were satisfied but would then delve into a rather scathing critique of the services available to them. This 'satisfied, but' phenomenon requires further exploration. It is likely related to what one expects from living in a rural area (see summary comments below)

III. Definition and Experience of Being Rural or Remote

- These women had a very strong sense of what it meant to live in a rural or remote community.
- Their responses were categorized into structural and social issues and, within these categories, into positive and negative facets.
 - *Structural* issues: distance to services and the differences between farm-rural and town-rural and between rural and remote.
 - *Social* issues: everyone knowing each other (for better or worse), having to make do, living the 'simple' life, and the experience of various stereotypes people had of rural women (i.e., poor, carefree, and unintelligent).

IV. Policy Recommendations

The participants were able to identify several ways in which policy might be shaped to better address the health and health-care issues they faced. These included:

- improving accessibility, particularly to physicians through a variety of measures including recruiting more foreign-trained physicians and encouraging more Canadian-trained physicians to practice;
- improving the sensitivity of rural and remote health-care providers to women's issues and cultural issues;
- improving accessibility to health and health-care information;
- expanding the range of age-related services for women ;
- providing more support to those who are victims of violence and poverty;
- better understanding of the impacts of health-care reform on the health of rural and remote women; and

- improving the overall influence of women in rural and remote communities regarding health and health-care issues.

V. Research Recommendations

The women in our study made several recommendations for future research both in terms of content and form. These included:

- the effect of age on access to health care services
- specific concerns for rural and remote communities including substance abuse and the negative stereotypes of rural/remote living;
- comparative research between urban and rural/remote areas to prevent the transfer of inappropriate urban approaches to care in rural/remote communities; and
- better transfer of research knowledge to the communities that could most benefit from it.

Some Reflections on Future Research

Although the focus groups that were conducted yielded several important findings, there are nevertheless some gaps in our knowledge of rural women's health issues that remain. Specifically, we touch upon some of the more general health and health promotion issues, but we touch very little on *rural women's health and health care issues across the life course*. Perhaps in subsequent questioning we could attempt to have participants draw out issues across the life course so that even though we may not have younger women participate in the group (though we should endeavour to secure participants from these age groups) we could address some of the following issues affecting:

- rural adolescent women;
- young rural adult women;
- young rural mothers, etc.

highlighting issues of sexuality and early reproductive-health issues, workplace-health issues (across the life course), maternity issues—including maternity care and child-care—midlife-reproductive health and sexuality issues, eldercare and later-life issues, and health planning and programming appropriate to women. It would be interesting to get data on whether adult children are located in close proximity (why and why not). This could have important implications for care and sustainability of rural communities.

We would also do well with specific groups that discuss issues of *violence against women in rural communities* because mixed groups in which some have experienced violence and others not (or not wishing to disclose) will not result in the kind of disclosure of information we would find most helpful in a drafting policy and a research agenda related to this issue. The same could be said about *mental health issues* and issues related to *substance abuse*. *Disability issues* should also be addressed—women with disabilities in

rural/remote areas and women taking care of loved ones with disabilities. Indeed, we need to collect more data specifically about caregiving. We know that providing care to a sick or disabled child or parent is quite isolating, but how is this specifically experienced in a rural/remote setting? Is the isolation exacerbated or supported by the ‘caring community’?

Data pertaining to participants’ ethnic background was also not gathered and is something that should be considered for future research. Moreover, more attention should be paid to ensuring participation from key equity groups such as Aboriginal women, women from visible minorities, Mennonite women and Hutterite women who live in rural and remote areas. We should also strive to separate out *rural town*, *rural farm* and *remote* (perhaps also *remote drive* and *remote fly*) as much as possible to help extricate the key differences as well as highlight commonalities. This would necessitate some purposive sampling in follow-up research.



Appendix

A Brief Note about the Locations

Creston, B.C. is located on Hwy..... 3, 28 kms south of Kootenay Lake and 11 km north of the U.S. border. It is home to a diversified set of industries and has experienced population growth in the past decade. Although Creston was officially incorporated in 1924, the first white settlers arrived in the area as residents in 1891. By 1896 it was a well-developed gold-mining town with a population of 1,500. Despite its resource base nature, Creston has always had a relatively diversified economy—tourism, brewery, agriculture, lumber and mining. This has led to increased economic stability, larger populations and a less vulnerable attitude about the future of the town.

Port Alice, B.C. is located on the northern tip of Vancouver Island and is approximately 45 minutes drive from Port McNeill and Port Hardy, and about a five hours drive away from Nainaimo. The village was built initially to house the workers of a pulp mill working for Colonial Pulp and paper Company in 1917. Much of the original townsite was destroyed in fires in 1941 and 1960 and a massive tidal wave caused by an earthquake in Alaska in 1964 and relocated four miles away. Residents have always been dependent on the forest industry. Access in and out is quite restricted. Twelve years ago the last baby was delivered in Port Alice, now expectant mothers travel outside of town to deliver their infants. At the end of February 2002, the services at the hospital were reduced from a 24-hour facility to a 12-hour facility.

Tumbler Ridge, B.C. is located in northeastern British Columbia and is approximately one hour's drive from Chetwynd and Dawson Creek, and about five hours drive away from Prince George. Incorporated in 1981, Tumbler Ridge was built to support the local activities of two coal-mining companies, Denison Mines and Teck Corporation. It was developed as the province's newest resource mega project. As a result, Tumbler Ridge has significantly higher income levels in comparison to provincial averages. With the recent depletion of coal, many believe that a closure announcement is imminent.

Vermillion, Alberta is located 2 hours east of Edmonton (the nearest tertiary care centre) and one hour from Lloydminster, Saskatchewan. Its economy is almost exclusively agricultural, including the local agricultural college. It was chosen to help address the farm/drought crisis issue as well as its lack of medical services. There is a general hospital available in town including emergency and maternity-care services. The physicians are almost exclusively immigrants from South Africa.

Clive, Alberta is situated in central Alberta, ten miles east of the province's main highway corridor between Edmonton and Calgary. It is a two-hour drive to Calgary or Edmonton. The next largest urban centre is Red Deer which is approximately a 45-minute to one hour drive. All specialists are located in Calgary, Edmonton or Red Deer. General practitioners and a regional hospital can be accessed in the town of Lacombe, which is a 20-minute drive. The region has a solid agricultural base that includes large intensive livestock operations. Many of the farms are third and fourth-generation family farms. The oil and gas industrial activity is also very strong, with the local presence of some of the largest gas plants located in North America.

Fort Chipewyan, Alberta is a Métis community located in northern Alberta. No other information about the community was made available in the facilitator's report.

Yorkton, Saskatchewan was chosen as a central location to everyone who had a farm background. No information about the community was made available in the facilitator's report. Included women from Manitoba and from northwest part of province and only one from Yorkton. One from Kelleher which is one hour away.

Watrous, Saskatchewan is one and a half hours southeast of Saskatoon. It has a small hospital which mainly delivers long-term care and respite but also has an emergency room. The main industry is agricultural and potash mines. Historical healing waters of Manitou beach is a spa which attracts seniors. More of a community group. Participants came from 30 miles away.

Oakbank, Manitoba

No information about the community made available in the facilitator’s report.

Lion’s Head, Ontario is located 30 minutes north of Owen Sound and three and a half to four hours north of London, Ontario (the nearest tertiary care centre). Its economy is mixed recreational (being on the Bruce Peninsula of which part is a National Park) and agricultural. Like Markdale, it was chosen because of its distance from care particularly in the winter season.

Markdale, Ontario is located 30 minutes south of Owen Sound and two and a half to three hours north of London, Ontario (the nearest tertiary care centre). Its economy is largely agricultural. It was chosen because of its distance from care which is particularly exacerbated in the winter season as it exists in the “snow-belt” It is also nearby to Walkerton, Ontario and therefore the issue of water safety was most salient.

Woodstock, Ontario is located 45 minutes east of London, Ontario and 90 minutes west of Toronto. It is accessible via Hwy. 401. Within the town itself, there is light industry (auto-parts manufacturing, quarry just outside of town, etc), but there is a significant agricultural community (dairy, cash crops–corn, tobacco...). It houses one of the experimental farm sites for the University of Guelph and is home to the outdoor farm show. It was chosen because of its agricultural connection and also because it is experiencing a dramatic shortage of medical personnel. It also has a sizeable elderly population.

Cobourg, Ontario is located 90 minutes east of Toronto on Hwy. 401. It has a mixed economy including recreational (located on Lake Ontario and with several other lakes within the district), farming, and a fairly large retirement community (from Toronto). Like Woodstock, it was chosen because of its shortage of medical personnel, sizeable elderly population and because of its mix of recreational and agricultural economies.

Forteau/Port Hope Simpson/Mary’s Harbour, NFLD/LB

No information about the community made available in the facilitator’s report.

Marystown, NFLD

No information about the community made available in the facilitator’s report.

Fort Smith, NWT region encompasses the area south of Great Slave Lake–hence it is named the South Slave Region. Fort Smith is a town and has a hospital. All health and social services are contained in the facility. Fort Smith is at the end of the road but sits on the Alberta border. There is road access through Wood Buffalo National Park (straddles the border).

Hay River, NWT encompasses the area south of Great Slave Lake–hence it is named the South Slave Region. The town of Hay River is the largest community south of the Lake. It has a hospital, road access, a train and airport. Hay River Community Health Board serves Enterprise and the Hay River Reserve. The physicians are fee-for-service. Hay River is known for its business community.

Inuvik, NWT region encompasses the area north of the Great Slave Lake, along the MacKenzie River, north to the Arctic Ocean. The town of Inuvik is the second largest community north of the Lake. It has a regional hospital. Inuvik Regional Health and Social Services serves 13 communities:

Inuvik	Paulatuk
Fort Good Hope	Tuktoyaktuk

Tulita
 Holman
 Fort McPherson
 Tsiigehctchic
 Sachs Harbour

Coleville Lake
 Norman Wells
 Aklavik
 Deline

There are three very distinct regions—Beaufort Sea, MacKenzie Valley and the Delta. Inuvik is in the MacKenzie Delta. There is road access from Inuvik across to the Yukon via the Dempster Highway. There is a full-size airport. Water transportation is used to access the other communities in the region. In winter the ice roads are used.

Yellowknife, NWT Region encompasses the area north of the Great Slave Lake. It is sandwiched between the South Slave Region and the Inuvik Region. For the purposes of this project, I included the Deh Cho and Dogrib regions in with Yellowknife. Yellowknife is the capital city. It has a city health and social services board and it has Stanton Regional hospital. Stanton is the largest hospital and is the hub of health and social services—for better or worse.

There are a total of 18 communities in these three regions:

Deh Cho	Dogrib	Yellowknife
Fort Simpson	Wha Ti	Yellowknife
Kakisa	Wekweti (Snare Lake)	Dettah
Trout Lake	Rae	Fort Resolution
Fort Liard	Edzo	Lutsel'ke
Nahanni Butte	Rae Lakes	Dettah
Jean Marie River		
Wrigley		
Fort Providence		



Endnotes

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- 1 Section D of this report.
 - 2 Note that this is a free service.
 - 3 Referring to a First Nations person with treaty status.
 - 4 Emergency measures personnel.

Rural, Remote and Northern Women's Health:
Policy and Research Directions

**Pauktuutit Inuit
Women's Association**

By Pauktuutit with Margaret Haworth-Brockman

Table of Contents

Introduction	H3
Methods	H4
Responses	H4
Appendix	H7



Pauktuutit Inuit Women's Association

Introduction

In October 2001 the Centres of Excellence hosted a Roundtable Discussion¹ on women's health in rural and remote Canada. Women in attendance were invited to comment on the proposal to undertake the national project.

The President of Pauktuutit Inuit Women's Association, Ms. Veronica Dewar, was a guest and participant in the Roundtable Discussion. Following the meeting Ms. Dewar advised the Centres of Excellence

that within a month Pauktuutit would be holding its Annual General Meeting in Nain, Nunatsiavut (Labrador). This would be an ideal opportunity to conduct a small focus group with women from across the high arctic, and to highlight the particular concerns of Inuit women. Women's Health Bureau, Health Canada, provided separate funding to Pauktuutit, to ensure the best possible representation to the Annual General Meeting.



Methods

With so little time to prepare before the Annual General Meeting, only a very crude set of questions could be developed for the focus group². The national research steering committee had not been struck, and so the national management committee devised the guide, in anticipation of the kinds of questions that would eventually be part of the formal focus group protocols.

Because neither the focus group guide, nor the manner of recording the responses matched the format of later focus groups

(which began in April 2002), the findings were not included in the coding or analyses of the other English or French language focus groups (Sections F and G). However, the findings from this first focus group are included in the discussions of research priorities (Section K) and policy recommendations (Section L).

The following is a summary of notes taken over the course of the Pauktuutit Inuit Women's Association Annual General Meeting in November 2001.

Responses

Fourteen participants gave input for each of the questions above. In some cases the questions had to be broken down into several questions and adjusted for clarity.

1. Describe what kind of health care there is available in your home community.

- a. Two out of 14 have a hospital in their community
- b. 12 out of 14 have a health centre
- c. Three out of 14 always have a doctor in the community
- d. each region has regional doctors (in the regional centre)
- e. all 14 communities have nurses

2. Can you get regular check-ups? Do you choose to? Why or why not?

What care is there for emergencies?

- a. 10 out of 14 have regular check-ups
- b. all 14 want to have regular check-ups
- c. 4 out of 14 say that regular check-ups are sometimes not available; sometimes can't have a check-up when menstruating

- d. all 14 can go to the health centre anytime for an emergency
- e. all 14 communities provide medivacs for emergencies that cannot be handled in the community

3. Do you think you get good care?

Do you have good health care (for yourself)? eight out of 14 said 'no'; five said 'yes'; one abstained saying that health-care professionals don't explain things well to her; some people don't speak about their health problems.

4. Has health care become better or worse in your community over the last ten years?

Over the last ten years two out of 14 said that the health care was 'better'; seven said it was 'worse'; four abstained and one explained that she recently moved to another community and rarely goes to the health centre, but that care was good in the regional centre where she lived previously. Those abstaining said that nurses and doctors change often and some were better and some were worse.

5. What changes would you like for health care in your community?

Improvements desired include:

- medical exams occurring more often; implement regular annual check-ups with phone calls to the women to inform them of the appointment;
- specialists available more often because doctors do not train in all specific fields;
- standardize policies in the regions so that programs could be delivered consistently;
- doctors should provide more information especially concerning medications (e.g. a woman and her husband were given the same medication for different conditions);
- investigate terminal illnesses earlier rather than after they have gotten worse;
- make our health more important than the funding
“... the Government of Nunavut says there is a lack of funding—doctors and nurses just say we are ‘under the influence’, but we have to pay taxes—more funds should be allocated to health care...”
- improve oxygen equipment as the masks are sometimes not comfortable;
- provide thorough medical exams
“Since I had children all they ever examine is my womb”;
- show more respect for women’s ability to understand medical information
“They may think we don’t have enough education—we are being left behind”
- provide access to home-care services
“Women are always the caregivers looking after the dying—federal funding is always being cut even to other regions in Canada”;
- better services and health-care facilities for Inuit;
- increase public education—we’re so busy treating illnesses;

- provide cultural orientation for nurses and doctors coming in; screen for long-term commitments; provide information on the past health issues in the community they come to;
- show us courtesy by answering our questions—give us an answer later if they don’t have one at the time;
- improve diagnosis (i.e. there is a problem of misdiagnosis)

Solutions from the women:

- *“Our legislators are the ones cutting the funding—we need to strengthen our voice to the governments; we need to lobby the governments and legislators; the policies are in the way of our voices being heard...”*
- *“What are we doing in our own communities to reduce diabetes and stress and offer support for each other...”*
- *“What things can we do to support more Inuit training in medical fields as we don’t have enough Inuit in training? ...”;*
- focus more on self-care and health promotion;
- provide a women’s health coordinator/specialist in each region.

6. What are your biggest worries about health for you or your family?

Greatest concerns include:

- not enough doctors and specialists;
- not enough care given (i.e. just given pain killers);
- sent away for births; women going to give birth without their spouses for up to a month or more—they should leave closer to the delivery time;
- need more medical exams for wombs and breasts;
- not made to feel welcome or equal when going to the health centre;
- Depo provera shots given to girls up to 15 without their parents’ consent;
- need bigger hospitals with surgical facilities closer to home;

- sending people by medivacs is sometimes upsetting;
- sometimes family members don't want to go to the hospital;
- aging women need to be able to retire due to health problems;
- menopause;
- hysterectomies are a concern;
- we are so far from anywhere else;
- pregnant women using tobacco and alcohol;
- long waiting periods for diagnosis and tests—can have an effect on a person's health (i.e. not having the information to know what to do to look after one's self);
- need to change the mammogram policy as it seems to be only for women 40-year old and up
- need more information given to patients and families about medical procedures done;
- need more research on breast cancer especially in the Qikitaaluk (Baffin) Region;
- coughing from smoke—many elderly people get this and are constantly coughing and only receive cough medication—need more information released on this;
- young people are being more affected by tobacco—it will affect a person's health in the future;
- some elderly patients cannot tolerate the tranquilizers given while on medivacs;
- women need information about menstruation, body parts and functions—how these things can affect young women/adult women;
- patients need to be told beforehand what will be happening to them i.e. before hysterectomy, other surgical procedures—we need to know what we are signing when we sign consent forms and that we have the right to receive specific information before we are discharged from hospitals;
- concerns regarding the mental health and warnings signs of problems of family members; Alzheimers; how family caregivers are doing—their health and well-being;
- need long-term care supports for elders in their homes in all communities, not just in regional centres or the south;
- concerns about the long distances that must be travelled to access health care—must be improved.



Appendix

Questions Guide for Focus Group on Women and Health Inuit Women's Association

The Centres of Excellence for Women's Health have started a small project about the health of women who live in rural and remote parts of Canada. Part of this project includes speaking with small groups of women about their own health and their concerns about health care. We are very grateful for the chance to hear your thoughts on the subjects and we would like to include them in a report that will give direction for new research but also for changes in policy and how health care is provided to women in the North.

Please begin by providing some record of the communities women have traveled from.

These questions are provided as a guide for your discussions.

1. Describe what kind of health care there is available in your home community.
Can you get regular check-ups? Do you choose to? Why or why not?
What care is there for emergencies?
2. Do you think you get good care?
3. Has health care become better or worse in your community over the last ten years?
4. What changes would you like for health care in your community?
5. What are your biggest worries about health for you or your family?



Endnotes

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- 1 See Section C and Appendix A of this Final Report
 - 2 See the Appendix to this section.

Rural, Remote and Northern Women's Health:
Policy and Research Directions

The National Consultation

**By Margaret Haworth-Brockman
and Karima Hashmani**

Table of Contents

Introduction	I3
The Format for the Consultation: Open Space	I4
The National Consultation	I5
Areas of Priority for Improving Women’s Health	I5
Conclusion	I9
Appendix	I10



The National Consultation

Introduction

The original proposal for the Centres of Excellence for Women's Health project, *Rural, Remote and Northern Women's Health: Policy and Research Directions*, included plans for a National Consultation. The intent was to convene a meeting of women from various communities, institutions and governments to strengthen the understandings of living in rural, remote and northern communities and how these circumstances affect the health of women who live there. In March 2003 a successful meeting of more than 50 women from across the country was held for two days in Saskatoon, Saskatchewan, as the final phase of this project.

Citizen engagement and participation was a primary and significant component of the

National Consultation. The Centres of Excellence are grateful for the generous contributions made to the event by the Women's Health Bureau, the Rural Health Office, Health Canada, and the Institute for Gender and Health of the Canadian Institutes for Health Research. Their additional support made it possible for women from isolated coastal communities and the high Arctic to contribute to the discussions and outcomes.

Because the number of focus groups had increased since the original plans, one member of each focus group was invited, as well as all the focus group facilitators. The women came from very diverse circumstances including fishery, forestry and farming-dependent areas, francophone,

Dene, Métis, and Inuit women. For some women, it was their first-ever opportunity to participate in a meeting of this size. Despite, in some cases, having to spend more days getting to and from the Consultation than at it, the women stated repeatedly that they appreciated the chance to attend and the real interest in what they had to say once they got there.

The National Consultation benefited as well from the participation of government and policy officials who could provide expertise from their departments. Finally, members of the National Management and Research Committees attended, providing their own expertise from personal and research related experience.¹

A Draft Summary Report was prepared in English and French for the women who attended the Consultation. It included the completed literature reviews and some early findings from the focus groups. In a non-traditional conference format, the women who came to the National Consultation discussed the findings, but also collaborated to provide new insights. Particularly important to the women was the work they did together to outline possible policy changes and steps to make those changes effective, to improve women's health in rural, remote and northern Canada.

The Format for the Consultation: Open Space

To ensure effective discussions among the women who came to the National Consultation, Open Space was used as the facilitation process². Open Space is an intentional leadership practice in which all participants are invited and encouraged to engage in discussion equitably. Instead of a more traditional format in which there are presenters and then respondents, in Open Space meetings all participants take part in discussion groups (parallel working sessions) around a central theme. "Experts" from all backgrounds, community activists, formal researchers, and policy-makers can feel at ease and contribute to discussions. The process requires participants to consider their commitment to the outcomes and follow-up.³

The goals for the meeting were:

- A strong consensus among participants, and in particular among rural and remote women, about the priorities for them in policy changes and legal changes needed;

- An achievable agenda with a set of shared conclusions;
- A feeling of comfort among the groups that all topics of interest get discussed;
- A sense of the political context within which they are working;
- A clear idea of key changes needed to bring about in health policy and research, and ideas about where and how participants could become involved.

Open Space begins with having participants sit in a large circle, for introductions ("to promote equality for all")⁴. Participants are then asked to suggest topics to discuss. The topics are given schedule times and participants then choose which discussions they want to lead or join. Discussions last for up to one hour and a member records them. Notes from each discussion are entered in computers made available to the participants. At the end of the day, every participant receives a record of all the discussions. After some time for reflection,

the participants reconvene the following day and begin by ranking the topics in order of importance. The facilitator encourages some consolidation of the many topics into

broader categories. Finally, participants consider strategies for the next steps of action. The meeting formally concludes with a closing circle for final comments.

The National Consultation

The National Consultation was held at the Delta Bessborough in Saskatoon, Saskatchewan on March 17-19th, 2003. Simultaneous interpretation was available for all aspects of the two-day meetings. The meeting opened on the evening of the 17th, with introductions and welcomes in both official languages from the co-directors of the study, Margaret Haworth-Brockman and Marilou McPhedran. Barbara Neis, chair of the National Research Steering Committee described the importance of the national project, the Consultation and the goals.

Guest speaker, Marie DesMeules, Health Canada, presented early results from a forthcoming Health Canada project which includes quantitative data on the health profile of women living in rural and remote areas⁵.

Facilitator Kim Martens spoke in both French and English throughout the Consultation. The question posed at the outset of the first full day of the Consultation was, *“What are the challenges and opportunities for ensuring the best state of women’s health in your community?”*

Areas of Priority for Improving Women’s Health

The women suggested 24 topics for working sessions held over the course of the day. Each woman then moved from session to session (held in either language), to participate in any discussion. The discussion notes were recorded on lap-top computers provided, and copies were distributed to all the women at the Consultation at the end of the day⁶. (There was a short disruption after lunch when a burst pipe above the ceiling brought water pouring down over reports and computers. Fortunately, quick thinking and action saved all but one of the session documents.)

- Strategies to increase participation and decisions making of women in rural and remote communities
- Literacy and culture in health service delivery

- Caregiving and Women: How can we help?
- Poverty as a health issue
- Promotion of research in complementary therapies
- Access to health care in Inuit communities
- How to be heard
- Positive aspects of living in rural Canada
- Making policy recommendations
- Diversity
- Advice about the final report
- Education
- Increase access to primary care by non-physicians
- Health—girls and young women in all of their diversity
- Northern/Remote Centre of Excellence
- Empower rural communities to look after their diversity

- Building in the next step
- Mental health of women living in rural and remote communities
- Aboriginal women’s health—holistic, cultural specific models
- Mental health and its relationship to illness: the connecting link
- How do we define the value of women in our society
- Women’s occupational health.

The following day the women ranked the topics they felt were most critical to address within the next six to 12 months to ensure the best state of women’s health. Table 1 illustrates the top ten topics chosen by the participants. ***It is important to note that the issue of greatest concern to the women at the National Consultation was poverty among women, and its effects on women’s health.***

The group then proceeded to bring together related topics. The six, consolidated areas of prime concern for the women, and initial steps for change are summarized below. The comments and key remarks included here come from both the initial working sessions and from the consolidation reports. The recommendations the women made for policy change or new action are also part of the discussion in Section L of this report.

Better Primary Health Care

Women at the National Consultation discussed ways and means to achieve better primary health care with the resources available to their communities, including considering community health centres, improved preventative and promotional health, and alternative practitioners.

Complementary therapies need to be integrated into our present primary care system to allow patient input, choice of treatment and more responsibility for their own health.

(We need) community contributions and investment in finding and implementing strategies to increase access and availability to midwives, nurse practitioners, social workers, health promoters, traditional hearers and community-development workers and complementary therapists

Use the Aboriginal Health Centres in Ontario as (a) model... These Centres use a holistic approach on health, under the same centre there are physicians, nurses, mental health counsellors. They provide workshops on managing anger, family violence, suicide prevention, also cooking groups, grieving support groups.. yoga and thishi courses.

Next steps include:

- Making use of existing resources to improve education and understanding about community-health centres;
- Encouraging the Centres of Excellence to evaluate primary care and primary-health care models for women;



- Making alternative (non-medical) therapies more affordable;
- Increasing research in complementary therapies.

Concrete Steps to Influence Policy

The women of the National Consultation emphasized the value of this national rural and remote women's health project to developing strategies for the future.

Don't assume the existence of a voluntary sector that has time to communicate this message... [work with] others who will endorse and accept this message—who else owns pieces of the story?

There is an urgent need for policy makers to reach down to the roots of the community—to ask women what they need and not to tell them what they need. We need to work with the [policy-makers] to ensure they see issues at the community level.

[Give] examples of where things are working well. Policies need to be linked, effective and accountable to communities and include an action plan for implementation.

Clarify messages, identify audiences, use alternative formats, develop specific dissemination plans.

Bring together both the qualitative and quantitative evidence for policy makers.

Women agreed that good dissemination of the results of this Study and the community discussions will require adequate resources and funding. “Core groups could work in partnership with the Centres of Excellence to develop future policy proposals at various government levels.”

Next steps include:

- Creating lobbying strategies for recommendations identified by the research;
- Developing a final report [this Summary Report] which is as specific in its recommendations as possible;
- Producing user-friendly information and dissemination kits for local advocacy and education;
- Disseminating and communicating the policy recommendations from this report

through some form of central coordination;

- Enlisting the support of appropriate provincial government representatives.

Empower Local Communities

Participants at the National Consultation highlighted the need to work from the grass-roots level to improve women's lives in rural, remote and northern communities.

The women emphasized the need to find for themselves and provide for others the necessary skills and platforms to encourage greater participation by women in decision-making.

Women's groups in rural, remote and northern areas are less connected than they used to be and have fewer resources, if they even still exist. We need information about how our tax money is being spent—what portion benefits women and how? ... Get our elected leaders to respond.

Find ways to involve the community, especially young people.

Next steps include:

- Training for women;
- Educating and supporting women for decision-making and involvement in the health-care system;
- Developing models for mentoring, design community workshops and create awareness about them;
- Recruiting and supporting women to take part in political activities;
- Providing federal support for community training in gender based analysis;
- Providing new resources for rural women to fund community based research projects.

Health Services and Systemic Issues

Although now part of this final topic heading, **women at the National Consultation were clear that the most overriding systemic issue affecting women's health is poverty.** Enfolded with poverty issues, the women at the National

Consultation also included their earlier discussions of violence against women, women's value and diversity within the health system. In doing so, the women highlighted the inter-connections of these in women's health.

One of the determinants of health is the social and economic level, but we are not answering to the basic needs of women and families for food, housing, access to education and training, and a decent quality of life... There is an enormous reluctance to address poverty in a holistic way, and there are not strategies to make necessary changes to improve the lives of poor women and their families.

Women's contributions to the care of their families, volunteer work in their communities is not valued in a wage-based community

Women routinely ignore their health needs to go back to work in order to provide for their families.

When [government-funded] projects are successful, there is no longer term funding to make a difference to women and their health. ... Services are devolved to the local level without the financial support to uphold high levels of services.

Need to have a national and public review of income support programs and minimum wage policies to examine how they can meet basic needs, and how these programs can fit effectively with other social support programs.

Issues other than region and language need to be built into the analysis in order to really avoid the "one size fits all" approach to policy making. If we don't ask appropriate questions and approach diverse groups of women, we run the risk of perpetuating misconceptions, .. of helping to formulate policies that help some women in rural, remote and northern locations while exacerbating the disadvantages facing other women.

There is a lack of mental-health services in rural areas and those that do exist have been greatly affected by "cut-cut-cut backs" (sic). What impact do these cuts have on the community: petty crime increase? Increased addictions? Increase in violence and abuse?

The prevention of violence towards children and women is a priority-health issue, as is proper identification and support for victims.

Health care providers have a critical role to play, but require much more education and protocols on how to respond.

Access to health promotion and disease prevention in a user-friendly format and in Inuktitut is still a problem in Inuit communities... Often health-care personnel cannot explain medical issues and problems in an understandable language to Inuit women... Inuit women want more birthing centers in their communities, which would integrate traditional Inuit practices and modern-health care services.

To make sure that these systemic issues are given sufficient attention, the women proposed the dissemination of the information at local, provincial and federal levels by using a social-justice platform. Next steps include:

- Lobbying governments to raise awareness about the direct link between systemic issues and health;
- Establishing long-term funding for programs and preparing communication materials for media campaigns and training sessions.

Northern/Remote Centre of Excellence

The last group discussed the possibility of a Northern or Remote-based Centre of Excellence for Women's Health. The women felt there is a need to better represent the women and issues from the Territories and to expand the existing centres' mandate to include remote, rural and northern communities. This would make the Centres more accountable and responsive and have the Centres include accountability and responsiveness to northern, First Nation, Inuit and Métis women in their mandate. The goal would be to strengthen partnerships between organizations that were doing similar work, and use to develop networks to share information.

There is a need for Inuit specific services for women and children and for abusers, who in most cases are members of the community

Research the effectiveness of Aboriginal community-health centres.

There is currently no Centre of Excellence [for Women’s Health] serving the North or in the North. There is no central depository for research findings, resources and materials. The people of the North are tired of being researched especially research that is done without their consultation, without their involvement and never comes back for comment or discussion. Policy makers are removed from the realities, barriers, of the

communities, clients/patients, culture and language. For example there are communities in the North that are 99% francophone, the government is totally oblivious to their language issues. The perception is that the francophones live in Quebec.

The next steps discussed were:

- Initiating discussion for a new centre;
- Establishing working groups to provide status updates;
- Creating strategies, and develop a contact list for new partners to be involved.

Conclusion

The National Consultation concluded in the afternoon of March 19th, following a closing circle in which women expressed their pleasure in attending and participating, their appreciation of new information and their optimism that the rural, remote and northern women’s health project can develop further. The National Consultation was a clear demonstration of diverse women working together to create strategies for

changing the health system for the future. The participants were able to draw from their own experiences and knowledge when developing priority areas for rural, remote and northern women’s health. The information shared over the two days gave women the chance to be involved in developing the methods to change the status of rural women’s health.

Table 1 Top Ten Ranked Topics from Highest Priority

1. Poverty as a health issue
 2. Strategies to increase the participation in decision making of women in R&R areas
 3. Making policy recommendations
 4. Mental health of women living in rural and remote communities
 5. Aboriginal women’s health—holistic, cultural specific models
 6. Increase access to primary care by non-physicians
 7. Healthy girls and young women in all their diversity
 8. Education
 9. Caregiving and women: How can we help?
 10. How to be heard.
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Appendix

Participants at the National Consultation, Saskatoon, March 2003

Julia Allen	Chandra Hovde
Colette Arsenault	Noreen Johns
Deborah Barron-McNabb	Catherine Kulisek
Madeline Boscoe	Glenna Laing
Aline Bourgeois	Guylaine Leclerc
Nancy Caron	Lisa McCallum
Francine Chenier	Molly McCracken
Amanda Chirico	Carolyn McDonald
Aimée Clark	Edith McPhedran
Barbara Clow	Marilou McPhedran
Rose Colledge	Marielee Nault
Christine Dallaire	Barbara Neis
Marie DesMeules	Wendy Nelson
Bernice Dubec	Mary (Mae) O'Hagan
Janet Dumaresque	Madeleine Paquette
Marie Dussault	Ann Pederson
Gail Erickson	Colleen Purdon
Mary-Anne Gauthier	Charline Roy
Avis Gray	Lilliane Sabiston
Lorraine Greaves	Lynn Skillen
Winnie Greenland	Lana Sullivan
Faye Grose	Rebecca Sutherns
Paule Giguere	Helle Tees
Karima Hashmani	Sylvie Thauvette
Joanne Havelock	Annette Willborn
Margaret Haworth-Brockman	



Endnotes

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- 1 See the Appendix for a list of the National Consultation participants.
 - 2 Salters, M. Mega Space Consulting. November 17, 2002.
 - 3 Ibid.
 - 4 Starfield Consulting. Leaderships tips for the event. March 2003.
 - 5 DesMeules, M., C. Lagace, R. Pitblado, R. Bollman and R. Pong 2003. Assessing rural women's health as part of the national research program "Canada's Rural Communities: Understanding Rural Health and its Determinants".
 - 6 Copies of the original reports from the discussions are held at the National Network on Environments and Women's Health.

Rural, Remote and Northern Women's Health:
Policy and Research Directions

Synthesis of Themes

By Rebecca Sutherns, PhD

Table of Contents

Introduction	J3
The Big Picture	J3
What do Rural, Remote and Northern Mean in Canada?	J4
Living Rurally	J6
Health as Health Care	J8
Variations in What Was Said	J10
Summary	J11



Synthesis of Themes

Introduction

This section synthesizes the findings that emerged from all of the data sources for this project: both literature reviews, both focus groups summaries and the national consultation. The two following sections outline the research and policy recommendations emerging from these findings.

Overall, there was a high degree of consistency both among the focus groups and between the focus groups, the national consultation priorities and the literature review findings. Where an issue was emphasized particularly strongly, and/or was highlighted in one area of data collection but not in others, this is pointed out in the text.

The Big Picture

Regarding general issues of health and rurality, women spoke of “juggling acts” and tradeoffs they face as they grapple with the personal consequences of structures and systems that have failed them. The women who participated in the focus groups raised four main issues, also echoed in the litera-

ture reviews, which provided the backdrop for more detailed observations:

1. *Rural women are largely invisible to policy makers.*

Participants felt ignored and misunderstood by policy makers who are used to

operating in urban contexts. Similarly, research on rural women in Canada is scarce in the literature.

2. *The health-care system is perceived as under-funded and deteriorating.*

Women around the country described the health-care system as strained, vulnerable, unreliable and insufficient to meet their needs. This parallels the preoccupation in the literature with poor rural access to health services.

3. *Efforts to restructure that system have exacerbated rather than improved an already vulnerable situation.*

According to participants and the literature, cutbacks in services inherent in health reform have led to more travel, more stress, and less personalized care for rural and Northern residents.

4. *Financial insecurity, primarily as a result of unemployment, job insecurity, low wages or seasonal work, is a key determinant of health for rural women and their families.*

Many rural places are single industry towns and/or rely heavily on seasonal primary resource production such as farming and fishing. Income streams are frequently limited or inconsistent, and the implications on health are far reaching. These include, but are certainly not limited to, greater stress and isolation and poorer access to health services.

Despite grave concerns about the state of rural-health care, participants did stress the health benefits of living rurally. As one participant in Cobourg said, “We have all these wonderful trees and rocks and the lake and to me that’s an extremely beneficial thing.” Rural-health care may be in crisis, but for many women rural health is not. In either case, rurality is an influential determinant of women’s health, often functioning both positively and negatively in their lives. Specifically how that happens differs according to the wide diversity of rural people themselves.

What do Rural, Remote and Northern Mean in Canada?

Definitions

In much of the literature on rural and remote health, there is considerable debate over definitions of terms. There is no standard definition of rural, remote or northern used in policy, research or planning, because different criteria, levels of analysis and methodologies are used. This is further complicated because how rural is “defined” in research studies and policy documents is often implied and not explicitly stated.¹

Largely in response to this ongoing debate, this project did not start with a glossary containing firm definitions for concepts such as rural, remote, northern and health. This was an intentional element of the design,

emerging from a desire to learn from participants’ understandings of what it means to be a rural, remote or Northern woman. This approach caused some difficulty for the women, as they seemed to be expecting to be told what the researchers’ definitions of terms were.

In the end, women did not craft precise definitions of rurality and health, though they had a clear, “common sense” understanding of what those terms meant to them. In the case of one group of Métis women, they resisted the labels “rural”, “remote” and “Northern” altogether, preferring to be identified only as “Fort Chipewyan women.”²

Many of the other women considered themselves rural, although some excluded themselves from that category since they did not live on farms. Few self-identified as remote. “Remote” places were seen as totally isolated, often fly-in communities with limited road access and no telephone service. “Rural” in many cases was equated with travel time and having to drive to get anywhere. It was also variously associated with low populations, dispersed or limited services, closeness to the land and knowing and being known by one’s neighbours. The distinction between “farm” and “town” was notable within the category of rural, as it often shaped women’s experiences of rural life. “Northern” was talked about less often, but in some cases described places that are neither rural nor remote, but that nevertheless present their own challenges for women’s health.

Upon further reflection, participants began questioning the idea of remoteness, asking “remote from what or whom?” Many Francophone participants, for instance, felt remote because of their distance from French-language health and social services.³ Others talked about feeling remote when friends and family were not living nearby, or when Internet access was not available. Remoteness was therefore not always similarly understood in relation to a fixed [urban] point of reference.

In Search of a Rural Culture

Although precise definitions of rurality proved elusive, participants did demonstrate having a clear sense of what rurality meant to them. Throughout the country, women consistently described a rural culture, although its characteristics varied. For some, living rurally meant being self-reliant and “making do” without complaining. For others, rural people were either “hicks” or “transplants.” For still others, rural culture

was indistinguishable from their ethnic or linguistic heritage. In all cases, women highlighted the need for culturally specific and appropriate health-care provision. So is there a rural culture in Canada? Yes and no. There are rural *cultures*. What are they like? It depends. Analyses must be context specific, and further research is needed into the factors that influence how rural culture affects women’s health.

Contradictions by Another Name

This understanding of rural culture as both important and varied is key to understanding the findings of this project. At first, many of the findings appear to be at odds with one another; every observation has its corresponding contradiction. What one person describes as peaceful, another describes as isolated. What one woman perceives as helpful support from family and friends, another perceives as meddling. Living rurally may be safer in some ways, and riskier in others. Rural doctors’ knowledge of their patients may result in care that is perceived as inferior and superior at the same time. Some rural families get better access to nutritious food; other more remote families report having very few affordable healthy-food choices. For some women, living rurally means walking everywhere, whereas for others rural distances make walking anywhere virtually impossible. In some provinces, living in the North means “more of the same but colder,” whereas in other places, Northern living is markedly different from life further south.

What to do with these tensions? They obviously present a challenge to policy making. They should not, however, be seen as a flaw that makes these findings less convincing. Quite the opposite is true. These apparent contradictions point to the diversity of rural Canada. Rurality does have an identifiable

culture, but that culture varies according to its context. Rural life is not the same, for example, for Métis women as it is for Francophone women or for women living on Baffin Island or within commuting distance of Toronto, nor is it necessarily the same even within any of those groups. Rural

culture must therefore always be taken into account, but these findings underscore the need for that culture to be explored at local levels so that its distinctive characteristics can inform appropriate policy. When it comes to rural research and policy making in Canada, one size clearly does not fit all.

Living Rurally

Women in this project spoke at length about the positive and negative aspects of living in rural areas. In this section, their observations will be discussed according to the physical and social environments of rural places.

Positive Features

In the focus groups in both languages, as well as at the national consultation, women spoke frequently about the positive influence living rurally has on their health. Their comments stand in sharp contrast to the published literature on rural health, which focuses almost exclusively on rural deficits.

Many of the participants' positive comments addressed the physical environment. They spoke, for example, of living where it is "pretty", "clean", "peaceful", "safe" and "quiet." They reported enjoying more time and less traffic than their urban counterparts. They specifically affirmed having less busy hospitals. They praised their ready access to fresh air, wildlife, beauty, recreation and the outdoors. One woman from Creston, British Columbia put it this way, "It's a lovely community...I feel very safe. My kids have a lot of friends and it's a clean, healthy place and we've got a wonderful big back yard. We have space and we have time for each other. It's not rush, rush."

Many participants were similarly positive about the social environment in rural places. They spoke of lower stress, strong commu-

nity spirit, and the benefits of close ties with one's neighbours. As one Métis woman said, "When tragedy happens, it's like one big family here." They also talked about the benefits of participating in rural community groups. According to one woman from Vermillion, Alberta:

Traditionally as women, we draw our strength when we join together. I think about our moms and tots group we used to have. There was a lot of support. I actually had a lady just a month ago say to me, and her daughter is now 15 years old, 'You know, that was one of the best things for me, 'cause I thought all along I was going crazy with my two children, and I found out I was like everyone else.'... We have greater opportunities in the country to do that, but I think we're starting to become a city rat race now.

For some, this positive social support translated into higher quality health care, due to providers knowing their patients and having a long-term commitment to the community.

Negative Features

Some of the negative features of living rurally that appear prominently in the literature were echoed by the women participating in this study, although tempered by the positive descriptions outlined above. Their concerns related to the absence or fragility of community infrastructure: insufficient childcare services, no public transportation, inadequate housing (especially for seniors and the disabled), limited local-educational opportunities and few jobs. The lack of health-care

services was frequently mentioned and will be addressed separately. As an Oakbank, Manitoba resident explained, “If you have access to childcare and transportation, to resources and to community support, then you’re more able to make decisions that will help you promote health.”

Other concerns addressed the physical environment, including concerns about air and water quality, severe winters and drought. One Alberta farmer described it this way,

We live with uncertainty... I still think that we have a lot of stresses that other people don't. They have no idea what it's like to have your whole annual income laying in a field being snowed on. I think that there are some coping skills we have to draw on that other people never even touch.

Participants also spoke negatively about social dimensions of rural life. Some mentioned drug and alcohol addictions, as well as family violence. As one woman from the Northwest Territories put it, “Living here, you can’t help but be aware of the effects of alcohol and drugs, the sexual abuse, the way in which women are treated.” Others talked about the loneliness of seeing their extended family members leaving the area, usually for educational or employment reasons. Some felt socially isolated because of not being “from there”, in some cases despite having lived in a place for many years. Many women reported feeling invisible, but at the same time never anonymous in a small community. This lack of confidentiality was linked to stigmas or taboos, particularly among young people, that result in people leaving the community or failing to access services within it for fear of being seen or talked about. Coakes and Kelly (1997) have

described these tensions this way, “as a way of coping with being too close [in small communities], individuals create emotional distance, in turn exacerbating any feelings of isolation. In effect, individuals are simultaneously too close and too distant.”⁴

Gender issues were highlighted as another negative feature of rural life. Rural society was repeatedly characterized as conservative in their expectations of women. Stress, role strain and burnout

They have no idea what it's like to have your whole annual income laying in a field being snowed on.

among rural women were emphasized again and again. Women reported fatigue from having to work multiple jobs, both inside and outside the home, or frustration at being limited in what roles they were allowed or forced to perform. They specifically mentioned “volunteer burnout”, and the pressure in a small community of “having to get involved or it won’t get done.” This juggling act was linked to being “too busy to be sick” or to seek health care. One Francophone participant addressed women’s role strain this way, “It boils down to voicing our expectations, the expectations society puts on us, the expectations we put on ourselves, the expectations our husband puts on us, the expectations our children put on our shoulders. Some days, I ask myself how women manage.” Another woman specifically highlighted the stresses on caregivers:

The women who take care of their parents end up putting their own health in jeopardy because they are doing work they are not trained for... These women end up getting sick themselves because they don't have the necessary tools and they don't have the necessary training. They work ridiculous hours without getting paid... and they end up living in poverty.

Health as Health Care

Another of the most consistent findings was the tendency for women to equate health with health care. On its own this may not be surprising, as this trend is strongly echoed in the rural health literature and popular media. What is more striking is the way in which rural women characterized their health and lifestyle as positive but rural health care as sorely inadequate. To the extent that researchers and the media focus exclusively on health care, at the expense of broader understandings of health, they miss the positive health features of living rurally.

Amount of Care

Poor access to health services was mentioned without exception in every focus group, as well as at the national consultation and in the literature. Women were aware of the difficulties facing health-care workers and policy makers in meeting the needs of rural people. They therefore often seemed reluctant to communicate dissatisfaction without qualifying it with expressions of appreciation for the efforts being made to provide care. On the whole, however, participants were very concerned with the level of service they can readily receive.

Within this theme, what stood out was women's lack of emphasis on physicians. They spoke of the need for more dentists, optometrists, midwives, home-care workers, mental-health workers and physiotherapists. They wanted easier access to complementary or alternative-health practitioners. They talked about ambulance services being scarce or expensive. They discussed the stress they experience when local health services are no longer available, or closures are threatened. They reported frustration at their lack of access to health information. They acknowledged the lack of physicians, but moved the conversation quickly beyond that.

When they did talk about doctors, participants frequently lamented the lack of access to family physicians in Canada.⁵ They mentioned the scarcity of specialists in rural areas, and long waiting lists. Perhaps more interestingly, women talked about the implications of doctor shortages on their lives: in addition to having to travel, which will be discussed in a later section, physician scarcity limits choice. Many women spoke passionately about preferring to be in the care of a female doctor, a preference clearly echoed in the literature⁶, but they rarely have that option in rural places. Others spoke of their desire for a second medical opinion, but when finding any doctor is problematic, consulting a second one is nearly impossible.

Quality of Care

The availability of health-care services is closely tied to the perceived quality of those services. For many in rural Canada, satisfaction with health care quality is seen as a luxury when basic access to primary care is unavailable. When you have no choice of doctor, there is little point in thinking about whether or not you are happy with the services that doctor provides.

Nevertheless, women did widely report four main concerns with the quality of their health care services. The busyness of health-care workers was the first concern. This busyness has many implications, including long waits, rushed care and burnout of health professionals. As woman from Alberta recounted, "The best care I ever received was in a very small hospital where I didn't feel that either the doctors or the nurses were over-worked or over-stretched." Second, women reported concern over the lack of female health care providers and its impact on care quality. They spoke, for

example, of their reluctance to discuss sensitive issues with a male physician. They also recounted experiences where male doctors were insensitive or patronizing. A third concern had to do with being known too well by local physicians. Although some women felt that being known by their physician led to more personalized care, several others expressed concern about potential breaches of confidentiality and/or doctors becoming careless. In some rural places, women reported a perceived lack of commitment by physicians who were not planning to stay long in the community, resulting in a lack of continuity of care.

At a broader level, some women reported concerns with the quality of rural-health policy. They spoke of being too far away from urban-based decision makers, who do not understand how health-care delivery models need to adapt to rural realities. They stressed, for example, that “mapping distance as the crow flies” is not an adequate tool for rural-health planning. Because distance emerged as such a frequent recurring theme, it warrants a separate discussion below.

When women spoke of being satisfied with their health care, that expression of satisfaction was frequently followed with, “but...,” or it seemed to reflect low expectations rather than high-quality care. The one notable exception to the concerns raised about rural-health care quality was the community-health centre model. It was mentioned in numerous groups, and was spoken of very highly in terms of its holistic approach and its rootedness in rural communities.

In contrast, the literature on rural women’s health in Canada speaks very little to issues of quality beyond the ability to access services. There is considerable research on health-care quality and reports of satisfaction, but it does not deal explicitly with rural women’s concerns.

Implications of Distance

One of the characterizing features of rural life is the need to travel away from home to obtain services of any kind. Women spoke at length about the far-reaching implications of what some might see only as an inconvenience. They talked about the financial, emotional and social costs of travelling to obtain health care. Gas or flights are expensive, as are hotel rooms, parking, food, childcare and forfeited income. They also reported high levels of stress associated with being away from their family, especially during health crises, and having to make complicated arrangements to help family members and employers cope with their absence.

These multiple costs and inconveniences are largely borne by women, as they are often responsible for scheduling activities, maintaining the home and monitoring the emotional climate of the family. As one Francophone participant put it, “Obviously, it’s often women that give the support needed. They take time off work, they pay the babysitter, they travel. So it always ends up falling on the woman’s shoulders, financially or socially.”

Moreover, the costs of distance are incurred regardless of whether the appointment proves helpful or not. Some women reported having appointments cancelled once they got there, or taking a whole day to travel to a five-minute appointment. They felt their time was considered less valuable than that of health-care providers, most of whom did not take into consideration how difficult it had been even for the women to get there. For example, one Vermillion, Alberta woman told her story this way:

You could drive all the way to Edmonton for this big special appointment, and you get there and five minutes later you come out. ‘What did they say?’ ‘Oh, just keep it like that.’ Well, you know, we had a list of concerns and had waited a month or

better for that same appointment...and you didn't get any answer. You just came home totally frustrated even more. And you wasted a day.

Another woman described chronic disease as “a huge expense on a rural family.” She went on to explain:

I don't think people in the city have any comprehension that it means you're actually leaving your place of work. You're not just popping into a specialist. You're taking a whole day. You're spending overnight. When my youngest was flown to Edmonton when she was born, I mean I literally had to pack up suitcases and move to Edmonton for two weeks. That was the only way we could do it.

The implications of these costs are clear, and they extend beyond financial costs. Many times women reported not bothering to seek care until they were very sick, just to avoid the hassle. Appointments for preventive measures are therefore rarely made.

Other dimensions of distance had to do with weather and transportation. Although a regional centre with health services may not appear far away on a map, at certain times of the year it may be virtually inaccessible

due to winter weather. Since public transportation is rarely available in rural places, if women do not have a vehicle, they cannot get to services even if they are not very far away. As one focus group participant put it, “To go to the doctor's, although it's less than five minutes away, because I don't drive, unless my husband takes time off work, I have to count on someone else to take me.”

Seasonality of work also affects health-care access in rural places. Since many rural residents are employed seasonally, they try not to leave home to seek health care during peak work times such as harvest so as not to miss the opportunity to earn income at that time. If services were available locally, seasonality would have less of an influence on access.

These findings point to the importance of qualitative data in helping to understand health utilization behaviour. Space and distance are clearly social as well as physical phenomena. Currently, Canadian literature on rural health-seeking behaviours and the social geography of health remains limited.

Variations in What Was Said

Overall, there was a high degree of consistency in what was said during the various phases of data collection for this study. There were, however, moments where emphases differed so dramatically that they warrant separate mention. Reasons for these inconsistencies are offered as possibilities only.

For example, the topics ranked of highest importance at the national consultation included the impact of poverty and of violence on health. Although these structural determinants of health figure prominently in the literature also, they did not emerge out of the focus group data strongly at all. This likely reflects the composition of the focus-

group participants and the safety they felt to disclose sensitive information more than the actual salience of those issues.

Similarly, in the literature and the focus groups, scarcity of physicians was a common theme. At the national consultation, this was not mentioned at all. Again, the absence of the issue is not likely a reflection of its lack of importance. In this case, it may be attributable to the participants at the consultation focusing their energy on changes they felt were both more fundamental and more achievable. Physician shortages have been well documented; it is time for some new ideas and perspectives on rural health to emerge.

The literature on rural health, although not primarily biomedical, is heavily focused on specific diseases and conditions. Very rarely did those come up in the focus groups or at the national consultation. It could be that in a group setting, participants did not feel that a particular health condition of importance to them would be as relevant to the group as a whole. The discrepancy may also reflect the desire of women to deal with root causes and larger contextual issues relating to rural health rather than taking specific diseases as their starting point; an approach consistent with the models of health care women most often report preferring.

The research literature also spends much more time on definitional issues than did the women themselves. Participants had a strong, almost intuitive sense of what was meant by rural and remote and were inter-

ested in moving beyond definitions quite quickly.

Conversely, the rural-health literature in Canada has little to say about the positive aspects of living rurally. The focus group and consultation participants spoke much more freely and at length about what is attractive to them about life in rural places. Some women were quite explicit about having deliberately chosen rural life, fully aware of the tradeoffs and compromises that entails.

Finally, the need for a research centre that focuses on the concerns of remote and Northern women was raised at the National Consultation. There is limited research literature on remote and Northern women in Canada, but the need for a Northern research centre was only briefly mentioned in any focus groups.

Summary

The key messages of this study can be summarized as follows:

- Rurality is a significant determinant of women's health. Its influence must be explicitly considered in health research and planning.
- Rurality is more than a geographic concept. It is also a cultural one, and that cultural influence can be far-reaching and powerful in women's lives.
- Rural Canada is highly diverse. The specific influences of rural spaces and cultures on health must therefore be studied in context, and care models adjusted accordingly.
- Rural health has both positive and negative dimensions. Women feel strongly that both sides should be taken into account.
- Women understand that health is more than health care, yet the two are often seen as synonymous. Rural-health care is viewed overwhelmingly negatively, particularly in terms of access to services.
- Income security, social support and gender intersect with rurality as influential determinants of health.

The themes described here will be revisited in the following two sections, first in terms of their influence on research priorities and finally in terms of their implications for policy making.

Endnotes

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- 1 See www.hc-sc.gc.ca/english/ruralhealth/paper.html for a paper published by the Office of Rural Health in Health Canada that addresses definitions of rurality.
 - 2 Skillen L. (2003). "We're Fort Chipewyan Women" Reflections of Métis women on health and health care. Final Report (unpublished). University of Alberta. Conducted as a focus group for the national study.
 - 3 Because not all of the Francophone focus groups were held in rural locations, and some of the participating women no longer lived rurally, they may not have been as isolated from services as other women were who lived in more remote locations, regardless of the language spoken. Their isolation was therefore based more on language than geography.
 - 4 Coakes, S. J., and Kelly, G. J. (1997). Community Competence and Empowerment: Strategies for Rural Change in Women's Health Service Planning and Delivery. *Australian Journal of Rural Health*, 5, p.27.
 - 5 Participants were not directly asked if they had a family doctor, so it was not clear if they were reporting personal experiences with lack of access to primary care. This information will be explicitly gathered in the next phase of this project.
 - 6 See for example Thorne, S. (1994). Women Show a Growing Preference for Treatment by Female Physicians. *Canadian Medical Association Journal*, 150 (9), 14667.



Rural, Remote and Northern Women's Health:
Policy and Research Directions

Research Priorities

By Rebecca Sutherns, PhD

Table of Contents

Introduction	K3
Research Topics	K4
Use and Usefulness of Research	K6
Research Designs	K6
Summary	K7



Research Priorities

Policies and strategies for improving health and health care in smaller communities have not been based on solid evidence or research. Until recently, Canadian research on rural health issues has been piecemeal in nature and limited to small-scale projects. To make matters worse, despite the wealth of health-related data at the federal, provincial and territorial levels, most data collected or released are frequently not presented in a manner that supports meaningful rural-health research and analysis. Furthermore...there is little connection between decision makers and researchers. As a result, rural-health policies, strategies, programs and practice have not been as effective as they could have been.

– Roy Romanow,

Commission on the Future of Health Care in Canada Final Report, 2002

Introduction

One of the objectives of this project was to develop a research agenda for rural and remote women's health in Canada. Research gaps were identified in two ways: through comprehensive reviews of existing Canadian literature in English and French on rural women's health issues, and through direct solicitation of women's opinions regarding

research needs during the focus groups and national consultation. The literature tended to focus on topic areas warranting further research, while the participants were more interested in the types of research being conducted and the uses to which the findings are put.

Research Topics

In this section, broad areas for further institutional and community-based research are outlined. Specific topics that emerged as salient are offered as suggested starting points within each. They are roughly presented according to the priority given to them in discussions with participants.

1. Anything about rural women in Canada

It was widely recognized that rural women in Canada have been largely invisible to researchers and policy makers. Most health research tends to ignore women, or rural realities, or both. Where rural populations are addressed at all in Canadian research, their input is rarely separately analyzed and gender analysis is rarely conducted. Even this project can only be considered exploratory. Virtually any aspect of rural women's health in Canada that explicitly analyzes the importance of place, culture and gender would therefore be a suitable topic for additional research.

2. Creative models of rural health service provision

Participants were interested in "thinking outside the box" to solve problems of access to health services in rural areas. They were also committed to rural-specific solutions to health-care challenges. They therefore affirmed any research aimed at developing models of health-care delivery with rural populations clearly in mind. Specific ideas include health-care models that reduce dependency on medical practitioners, models of mobile care, the value of telehealth to women, and new approaches to health promotion and disease prevention among rural populations.

3. Impacts of isolation on health

Geographic and social isolation are common features of rural life in Canada, and they have powerful effects on personal and community health. Currently the specific positive and negative influences of place on health are undervalued. Specific research ideas in this area include rural women's mental health, health effects of the lack of proximity of adult children, health effects of scarce health services, and social geography of distance.

4. Importance of cultural values for health

With the possible exception of Aboriginal health, where exploration of the intersection between culture and health is just beginning, research into the characteristics of diverse Canadian rural cultures is rare. More specifically, the ways in which cultural values enhance or undermine good health and models of delivering culturally appropriate health care in rural contexts warrant further investigation.

5. Factors influencing the impact of rurality on health

This project has made clear that rurality is an influential determinant of health, often in contradictory ways. Further research is needed to explore why living rurally operates simultaneously as a positive and negative determinant of health. What factors or mechanisms determine how rurality is likely to affect someone's health? A related topic area would be research into the cumulative impact of or interplay among rurality, gender and other health determinants in women's lives.

6. Moving from information to action

Participants were passionate about the need to get beyond information to action,

both in terms of putting policy research into practice and translating health knowledge into changed personal behaviour, especially in the areas of addictions and inactivity. There was interest in further research into how to bridge the gap between information and action among policy makers and rural populations.

7. Health issues across the life course

More research is needed into women's health experiences at particular stages of their lives, and how those experiences related to ones they had or will have at different ages. Research about children, adolescents and young women in rural contexts is especially scarce.

8. Health issues relating to specific rural populations

There are obvious gaps in current research aimed to address the health concerns of specific sub-groups of rural women. These include but are not limited to: young women, immigrants, coastal women, Métis, Inuit and First Nations women, Mennonite or Hutterite women, women with addictions and women experiencing violence. Research about rural health practitioners who are not doctors or nurses is also very limited.

9. Getting beyond reports of satisfaction

There is a considerable body of literature on client satisfaction in health. It calls into question the validity of many client satisfaction surveys, because of their tendency to elicit only positive responses. Similarly in this project, when asked about satisfaction, most participants said they were satisfied with their health care. The interactive methods chosen for this project,

however, allowed women to continue their comments, and most added, "but..." Understanding this phenomenon of "Satisfied, but..." would be a fruitful research area in rural health. Similarly, the links between reported satisfaction, care quality and expectations of care in rural contexts need further exploration.

10. Rural Definitions and Depictions

In existing literature, rurality is either not defined, defined inconsistently, or defined but not analyzed. Rurality is frequently treated as a homogeneous, straightforward, usually negative influence on health. Similarly, participants expressed concern about the negative, stereotypical ways in which rural people and rural life are portrayed in the media and other areas of popular culture. There is a lack of attention to the diversity that characterizes rural Canada, and a need for more careful analysis of the impacts of that diversity on healthy living. As Howatson-Leo and Earl (1995) have said,

Non-metropolitan areas in Canada are often simply referred to as rural Canada, without enough attention paid to their inner differences. It is clear that non-metropolitan Canada is anything but homogeneous. More research is needed to bring out this diversity so that social policies can be better tailored to the needs of non-metropolitan Canadian populations.

11. Rural occupational health and safety

Rural-specific occupations held by women, especially outside of farming and fishing, have not been well researched in Canada. The experiences of women juggling multiple roles, including those of caregiver, parent and paid worker, also warrant further attention.

Use and Usefulness of Research

Both implicitly and explicitly, the non-academic participants in this project expressed that research was of limited interest to them. Many had participated in research projects, but few were aware of the difference the research had made. Findings were not communicated or locally implemented. Women saw research as a means to an end; they wanted research that has clear results that lead to social change. They were more interested in closing the gap between knowledge and behaviour than in generating new knowledge. As one woman said, “We know enough! It’s time to do something!”

In contrast, many researchers see research as beneficial for its own sake, in the creation of new knowledge, and not just as a tool for

immediate change. This perspective sets the tone for much of the literature on rural women’s health in Canada.

When they did comment directly on research needs, women spoke of the need for research to be applied and useful. It should avoid duplication and should be effectively and accessibly communicated to diverse populations. One indication that this has not yet happened sufficiently appeared when participants’ suggestions of specific research topics reflected areas already relatively well researched, suggesting that rural-health researchers have not gone far enough in reaching community-based populations with their findings.

Research Designs

Participants applauded the project’s commitment to community-based research that actively seeks out women’s involvement. They affirmed the need for research designs that allow women’s voices to be clearly heard and that offer women opportunities to be engaged, to work together and to hear one another’s perspectives as part of the research process. As one participant said, “When group consultations are done, the question of one person or the response of another will encourage someone else...It creates consciousness raising in the community.” Another said, “I have the impression that I’ve more effectively contributed this way than if I had filled out a mail survey and sent it in.”

On one level, the literature reviews echoed this need for women’s direct participation in research. Much of the existing literature is generated by governments (especially in

French) or by health care workers, with women’s voices being largely left out. Yet at another level, the Canadian rural-health literature is full of small-scale studies that allow individual stories to be told. What are missing are national statistical or epidemiological studies on rural-health status, as well as longitudinal work. That “big picture” gap will be filled in part by an ongoing national research program entitled “Canada’s Rural Communities: Understanding Rural Health and its Determinants”. This multidisciplinary study is a partnership between Health Canada, the Canadian Population Health Initiative of the Canadian Institute for Health Information, and the Centre for Rural and Northern Health Research at Laurentian University. It examines health status, health determinants, and health services utilization among rural Canadians in comparison to those living in urban settings.

The program is intended to make a major contribution to our understanding of rural health in Canada, particularly from a population health perspective.

The current project also underscored the benefit of combining academic and community-based research expertise. Academic rigour, access to resources, and exposure through indexed databases of research abstracts were brought together with the grassroots practicality and accessibility of community-based research in what proved to be a rich exchange, both in person and in the literature reviews. Valuing of multiple ways of knowing is another important priority for future research designs in rural women's health.

Women also affirmed the need for research to be designed in ways that take the whole

of women's lives into account, rather than exploring one small dimension in isolation. For instance, they were supportive of research that sees health broadly, and not just in terms of disease and mortality.

Related to that, participants were interested in research questions that do not imply that living rurally is somehow a deficit. They encouraged exploring the full range of rural experience in research.

Participants recommended that terms be defined more clearly in follow-up research so that issues relating to rural town, rural farm, northern, remote drive-in and remote fly-in could be disaggregated.

Finally, in order to capture rural diversity adequately, multidisciplinary and multicultural approaches to research are required.

Summary

Rural health research in Canada is gaining momentum, both within and outside of the Canadian Institutes for Health Research. The topics listed here provide a strong starting point for researchers interested in filling the many gaps in current knowledge about rural women's health.

Perhaps even more important than the topics, however, are the assertions regarding research designs and applications. Women's voices must find a place in the rural-health research strategies currently being developed in Canada. Women should be involved in designing the strategies and in informing what those strategies ultimately teach us.

The new quantitative work on rural health status is to be applauded, as it will clearly augment our knowledge. Qualitative descriptions such as those presented here are essential, however, to ensuring that the

quantitative surveys are meaningful and that policy recommendations stemming from them are relevant to the fabric of women's lives.

Although there is some value in research done for its own sake, participants in this study were clear that they are interested in research that leads to social change. This underlines the importance of research findings being communicated clearly and quickly at local levels so that research can be seen as relevant to the lives of the women who made it possible in the first place. Those same findings need to be communicated effectively to decision makers who have the power to use them to inform meaningful policy changes that benefit rural women. Suggestions for such policy directions will be discussed in the next section.

Rural, Remote and Northern Women's Health:
Policy and Research Directions

Policy Recommendations

**By Marilou McPhedran
with Rebecca Sutherns, PhD**

Table of Contents

Policy Précis	L3
Introduction	L4
Influencing Public Policy	L5
Why Care?	L9
Priorities	L10
Building a “GPA”–Gender Place Analysis	L10
Understanding Poverty as a Major Determinant of Women’s Health ...	L11
Policy Priority #1. Factor Gender, Place and Culture into All Health Policy	L11
Policy Priority #2. Define Health Policy as More than Health Care Services	L12
Policy Priority #3. Improve Health by Improving Access to Diverse Services and Power	L13
Implementation of the Policy Priorities	L18

Policy Précis:
**Mainstreaming Women's Health in Rural,
Remote and Northern Canada**

This Study, *Rural, Remote and Northern Women's Health: Policy and Research Directions*, reflects investment in a highly consultative process with women to produce clear, achievable goals for change by harvesting knowledge from women who have built their lives in rural, remote and northern Canada. Such emphasis on "process" can be seen from two distinct perspectives: as a cumbersome problem or as an essential methodology that is part of a solution. This Study provides essential qualitative data that can only be gained through a process of appreciative inquiry. Refreshed by evidence that will continue to be generated by the Centres of Excellence for Women's Health and other research initiatives, we must create policies and strategies to improve women's health in rural, remote and northern Canada if we are to revitalize these regions. The oft-heard question, what do women want? now has this answer: **create a "GPA–Gender Place Analysis" policy change network of collaborative, mutually respectful partnerships between Canadian women in rural, remote and northern Canada and policy makers, at every level of government.**¹ The overarching priority of the participants in this Study's National Consultation is to be truly engaged in policy change based on "Gender Place Analysis", using data on the social determinants of women's health in these regions. **Three main policy priorities, with eleven related strategies, inform our recommendations for action:**

1. **Factor Gender, Place and Culture into All Health Policy**
2. **Define Health Policy as More than Health Care Services**
3. **Improve Health by Improving Access to Diverse Services and Power.**

Introduction

Current policies and practices affecting health do not clearly reflect the knowledge and expertise of women living in rural, remote and northern areas of Canada. *Rural, Remote and Northern Women's Health: Policy and Research Directions* (Study) was designed to provide useful information for policy changes needed now, to provide the foundation for a next phase (which is underway²), and to complement other research initiatives. In this Study with women living in rural, remote and northern Canada (and in other research) the Centres of Excellence for Women's Health examine how factors such as culture, race, income and education interact with gender and sex to affect health. The result is clear, achievable goals for change generated by harvesting knowledge from women who have built their lives in rural, remote and northern Canada.³

This section of the final report on the Study is directed to policy makers at every government level and it has also been written to serve as a resource for women leaders in rural, remote and northern Canada, to assist in making the **pivotal change identified as a top priority** through women's direct engagement in the policy change and implementation process.

Adding Women's Wisdom

By using a combination of research methods we were able to collect data from a diverse range of women and communities. The

Study began with a literature review and gaps analysis presented at the invitational national roundtable in October 2001. This was followed by thematic bibliographies in French and English. From November 2001 to January 2003 28 community-based focus groups were held in rural, remote or northern communities. A preliminary report was prepared for the National Consultation in March 2003 held in Saskatoon, Saskatchewan, which brought together women from the focus groups, as well as policymakers and researchers specialising in this field. Midway through this journey, the National Research Steering Committee held a session on policy development and uptake with policy experts to identify areas of opportunity for communicating the findings from this Study to a policy audience⁴.

Our National Consultation in Saskatoon was like a crucible into which participants poured content and subsequent reflections from the focus groups, reviewed the early findings and assessed them from national, regional and community perspectives. The egalitarian "Open Space" process served as a catalyst producing six "convergence reports", from which this Study's policy priorities and strategies to improve women's health have been derived. (For a more complete description of our process and the recommendations please see Section I of this Report.)



Influencing Public Policy

Including Community Women

When the Centres of Excellence for Women's Health jointly convened the National Consultation, one of the participants captured the sentiments of many by raising this fundamental question:

Just what is 'public policy' and how can women like us influence it?

There is no legislated system for policy development, yet for decades the power dynamics behind policy development in the Canadian governmental context have operated to maintain the general nature of public policy process, which has been likened by one expert to "as much a chaotic marketplace as a planned system."⁵

Inputs, Outputs ... Real Life

Although they tended not to use policy terminology, some participants in the Study noted that their previous attempts at "political inputs" were seldom successful in producing "policy outputs". They also described how needed policies had been facilitated—or undermined—by momentum of governmental decisions that had already been made. To be successful, desired changes need political and institutional support to maintain "momentum in policy direction and spending patterns."⁶ Women at the Consultation identified a variety of policy inputs such as public opinion research, personal relationships, partisan politics, networking and coalition power brokering by individuals and communities. A consensus emerged that most of these inputs are seldom readily accessible to women in rural, remote or northern Canada. This in turn led to recommendations linking power and policy development. Some of the groups explored how policy outputs come in three basic forms:

1. direction and leadership provided by federal and provincial cabinet ministers, municipal leaders and their agencies;
2. new or changed programs and special projects; and /or
3. laws and regulations.

And then the discussions circled back to what changes were needed to bring momentum and increased political influence for the policy priorities they identified. From this discussion, another query emerged: how can women get more power to influence their health options?

Women in Rural, Remote & Northern Canada as a "Policy Community"

The intuitive emphasis on power in the questions quoted in this chapter highlights a central challenge for women in Canada generally, and specifically for women living in rural, remote and northern parts of Canada, because it echoes what political scientists have been saying for some time: policy has a lot to do with "community." The unfortunate truth is, women as a group seldom fit the description of an acknowledged "policy community" which has been defined as a "dominant voice in determining government decisions...by virtue of its functional responsibilities, its vested interests and its specialized knowledge."⁷ Individuals and groups within the policy communities that are close to those who control resources needed to implement policy have been referred to as "sub-government", while those who are actively concerned and or affected by particular policies, but who do not have "insider" status or influence, have been described as the "attentive public".⁸

Participants in the National Consultation mostly described their level of participation in terms closer to the “attentive public” label but they were certainly not content with marginal positions. Many of the women at the Consultation, and in the 28 focus groups held throughout Canada before that, demonstrated strong interest in building or strengthening this policy community by investing their skills and energy to generate greater policy influence than they currently wield. The need for women-centred reforms and increased engagement of women as leaders in governmental processes came out of the recognition that women’s life circumstances are different from men’s, and that not all women have the same needs or the same access to resources.

To be effective, policy needs to look at differences between genders and differences within each gender. For example, community profiles by Statistics Canada can yield helpful information about social determinants of health, such as domestic violence. In a biennial “snapshot” on a particular day—April 15, 2002—taken as part of the federal government’s Family Violence Initiative, transition homes in Northwest Territories reported that 80% of the women

residing in shelters on that day were victims of abuse and the rest were admitted for reasons other than abuse, such as housing problems. Of those admitted for abuse, twice as many were fleeing physical abuse as were escaping psychological abuse and 67% of those fleeing both kinds of abuse were admitted with their children; 71% of these children were under 10 years of age.⁹

Evidence-based decision-making on policies like “reduction of domestic violence” need to start with research and facts, as we have in this Study. Our participants valued the research component and moved quickly to looking at how to integrate the research with policy, which raised questions about what information needs to be provided to policy makers to “move up” on their agenda.

Invisible Women: Gender and Health Planning

Although women occupy a unique place in our health system—they make up 80% of the healthcare workforce and (along with children) are heavy consumers of health-care—preparatory work for public policies affecting the health of Canadians lacks attention to women, keeping many

...any way the population pie gets sliced, women account for a major, if not majority, of the population of rural, remote and northern Canada—in numbers big enough that, to be effective, policies and implementation strategies need to take women, and their diversity, into account.

women, and women-centred analysis, out of the more influential “sub-government” echelons of policy influence. Statistical profiles of “rural” women vary somewhat. For example, using rural postal codes (just one of the six definitions of “rural” referenced by Statistics Canada) 28.7% of the Canadian population is rural and women make up 50.8 % of that.¹⁰ However, the “numbers game” should not be played to justify little or no gender-based analysis in policy development because, any way the population pie gets sliced, women account for a major, if not majority, of the population of rural, remote and northern Canada—in numbers big enough that, to be effective, policies and implementation strategies need to take women, and their diversity, into account. Unfortunately, recent analysis of provincial and federal policy efforts show otherwise.

In November 1999, the Prairie Women’s Health Centre of Excellence (PWHCE) released a research report entitled *Invisible Women: Gender and Health Planning in Manitoba and Saskatchewan and Models for Progress*¹¹ in which a review of policy documents and transcripts of interviews conducted at the regional and district levels of policy development showed little evidence that gender analysis was used to inform health planning at these levels.¹² Information on health needs was rarely disaggregated by sex, and consultations with women’s groups as key stakeholders were the exception, rather than the rule. When women’s health needs were identified, they were often focused quite narrowly on women’s reproductive health, or on what were assumed to be the women’s responsibility for the health and care of their families. This is not to say that officials and departments within the Manitoba and Saskatchewan agencies were hostile to women’s health issues. Indeed, the report is

a better illustration of how strong personal interest on the part of policy makers often cannot overcome systemically entrenched oversights in policy development¹³.

Decision Time: What Gets Excluded?

In order to implement policy effectively, we know that choices have to be made from among genuine, achievable policy options and it is clear that the three policy priorities identified through this Study meet that standard. However, decision-making on two levels will determine if any progress can be made because if policy makers cannot get past the first level decision then women’s priorities will be effectively removed from the list of policy options for rural, remote and northern health initiatives.

The first decision has to be whether to make policy from an evidence base that excludes gender-based analysis and excludes qualitative data from and about women.¹⁴ Only if policy and law makers choose to pass beyond the first level and then choose to insist on specific policy options and connected strategies that include “gender place analysis” with gender-specific data will it be possible to consider the policy priorities from this Study. Action on the overarching priority articulated in this Study—a “GPA” policy change network—necessitates that our policy makers move to the second, higher level of decision-making. Thus, the recommendations arising from this Study are situated in the context of policy development, before more detailed discussion of the recommendations themselves under each of the three policy priorities.

Federal Oversight

At the federal level, the two most recent reports funded by Canadian taxpayers—one

chaired by Senator Michael Kirby and the other by the Honourable Roy Romanow—released near the end of 2002, made virtually no mention of women’s health needs and neither purported to include gender-based analysis in the development of their policy recommendations.¹⁵ Indeed, not one of the background papers commissioned for the “Romanow Report” contained a rigorous gender-based analysis. While Mr. Romanow articulated a vision echoed by participants in our Study when he recommended “innovative ways of delivering health care services to smaller communities and to improve the health of those communities,” he had little more to add on innovation.

However women in this Study, who are community leaders and specialists in rural, remote and northern women’s health, were able to enhance and deepen the Romanow suggestions. Women in our Study valued doctors and nurses in their communities, and went further to identify innovative, realistic approaches that they concluded will produce better results in rural, remote or northern communities: mobile screening and treatment programmes, nurse practitioners, and midwives for example.

In the focus groups, at the roundtables and the National Consultation, women described the stress and exhaustion caused when they are “sandwiched” between generations that need their care, for little or no monetary compensation. Although Mr. Romanow recommended “training and support should be given to informal caregivers to support the role they play in rural settings”¹⁶ he was silent on the fact that these “informal caregivers” are usually women. In its analysis of the Romanow Report, the National Coordinating Group on Health Reform voiced a concern that recurred in this Study:

Is the Romanow Commission suggesting that we transform these women into paid caregivers or, as seems more likely, that we train them to provide a wider range of skilled services while continuing to withhold financial compensation?¹⁷

In response to concerns about similar gaps in their October 2002 report, members of Senator Kirby’s Committee have committed to preparing additional reports after more senate committee hearings in 2003 and 2004 on Aboriginal health, mental health and women’s health. This will be a forum where the relevant results from this Study can be taken into account.

Attaining National and International Standards

Ironically, these gaps in publicly funded policy development contradict international, federal and provincial commitments to employ gender-based analysis in public programs, policies and laws. Widely criticized for similar inattention, the president of the World Bank recently wrote:

Effective action requires that policy-makers take account of local realities when designing and implementing policies and programs. There can be no one-size-fits-all formula for promoting gender equality. Identifying what works requires consultations with stakeholders—both women and men—on key issue and actions. ...to enhance development effectiveness, gender issues must be an integral part of policy analysis, design and implementation.¹⁸

Another international perspective comes from *The Convention on the Elimination of All Forms of Discrimination Against Women* (CEDAW), the only major UN human rights treaty focused on women, activated by the

United Nations General Assembly more than 20 years ago.¹⁹ Article 14 of CEDAW is dedicated to rural women and it resonates with the vision and values articulated by

participants in our Study in emphasizing social determinants of health, including equitable access to services and power.²⁰

Why Care?

A vital question was raised at the National Consultation: Who cares and why? Policy-making is about the allocation of scarce resources among competing priorities. The motivations and values of policy makers vary, and in the context of limited resources, policy makers may question if rural, remote or northern women's health issues are sufficiently worthy of priority attention. Consider the following:

- As slightly more than half of the population of Canada and of rural, remote and northern Canada, women are far more than a “special interest group.” They are the majority of voters, health care providers, caregivers (paid and unpaid). Because women are underrepresented among elected politicians and other decision makers, their “political capital” is often not valued.²¹
- Women's health concerns differ from men's, for biological and social reasons. While the biological reasons seem self-evident, policy makers must also consider the chronic under-representation of

women in many past health studies. Although there is definite improvement,²² much of the necessary information on good health care for women does not yet exist.

- Nearly one-third of Canadians—more than nine million people out of 31 million—live in rural and remote areas. These Canadians significantly contribute to the country's wealth and prosperity through their participation in Canada's primary resource-based sectors (including fishing, forestry, mining and agriculture), the tourism industry and small business enterprises.²³
- Despite the federal *Canada Health Act* promising accessibility and universality of health care provision, rural, remote and northern Canada remains chronically under-serviced in terms of acute primary (disease) care and primary health (well-being) care that includes disease prevention, health promotion and community health care. The rural/urban divide is exacerbated in a number of

Women in rural, remote and northern areas of Canada often experience triple disadvantage, because of their gender, their location, and the interactions between the two.

ways. For example, the geography of income disparities appears to have shifted slowly but steadily from a provincial to a rural/urban divide, with clusters of persistently low-income census divisions in marginal and northern areas that reflect greater disparity in 1999 than in 1992.²⁴

- Women’s productive and reproductive work, as well as their health concerns, are frequently subsumed into larger categories by policy makers, and often by women themselves. Women’s health issues are addressed as family issues. Although “farmers” are no longer

assumed to be men, women’s contributions to rural households are under-valued, either literally in statistics of wealth or productivity, or figuratively in terms of their social value.

- Women in rural, remote and northern areas of Canada often experience triple disadvantage, because of their gender, their location, and the interactions between the two. Their voices are rarely given an opportunity to be heard. For Aboriginal women, and women facing additional barriers of racism, economics or education, the negative health effects can be multiplied further.

Priorities:

Building a “GPA”—Gender Place Analysis—Policy Change Network

Results from decisions made by governments and the decisions by governments to do nothing are just as much policy as are decisions to do something²⁵

A policy network has been described as groups of people who interact on a regular basis and who participate directly in the policy process. People in policy networks are distinguished from the larger community by a shared focus on material or observable interests, such as budgets.²⁶ One of the Focus Group facilitators in this Study captured an overarching message to law and policy makers when she concluded:

Whether or not “GPA” [Gender Based Analysis] is being done before policies and laws get made, for those of us who live beyond the urban centres, it’s really “GPA” (Gender Place Analysis) that’s needed!

The idea of a “policy change network” that has arisen from this Study is reflected in many of the “convergence reports” produced through the Open Space process

at the National Consultation for this Study in Saskatoon.²⁷ For example, Report #2 from a bilingual group, entitled “Ensuring the best state of women’s health in our communities,” gave the following steps for building and sustaining a network. The approach needed for focusing on the particular and diverse health needs of women in rural, remote and northern Canada was widely accepted in the final plenary:

- make clear recommendations in order of priority
- make sure there are actions associated with each recommendation
- produce a user friendly kit and user’s guide that would include: press releases, briefing papers, background sheets, presentation notes, a list of strategic people and organizations to contact and include
- create a central office with 1-2 staff to implement the action plan, oversee the

dissemination strategy and continue the work.²⁸

The Centres of Excellence and the Canadian Women's Health Network

(CWHN) have produced much of the evidentiary base needed to launch a "GPA (Gender Place Analysis) Network".

Understanding Poverty as a Major Determinant of Women's Health

The territories /provinces have all been given choices over so many things, but the claw back of the national child benefit is unequally imposed across Canada. Even though it is shown to be discriminatory (for example, working poor, low income families benefit but stay at home moms or students don't—where the claw back exists) and indeed harmful to the health and well-being of the women and children. There are some territories and provinces that are refusing to ban the claw back. Is this a health issue? You betcha!
—A. Clark, Focus Group Facilitator

Participants at the National Consultation insisted that poverty be considered a major determinant of women's health. These women spoke of the dramatic "trickle down" effects of a decade of major cuts in federal support of education and social services. The decision-makers have infused consideration of health policy options at all levels of government (regional, provincial and federal), which are now keyed to quite a narrow fiscal framework, with emphasis on cost recovery or "revenue neutral" programs. This Study documents that women living in rural, remote and northern Canada are profoundly affected as a result. While revitalization of rural, remote and northern economies and gender equality are current policy priorities (with the latter being entrenched in the Constitution), hard realities remain, such as the fact that economic conditions constrain full-time employment for rural women working part-time and wishing full-time work.²⁹ The recommendations for change coming out of this Study serve as the platform for gathering further information on the effects of

re-structuring on women in rural, remote and northern communities.³⁰

Affecting and Effecting Policy Change: Three Policy Priorities Identified

As we know, Health Policy occurs at a variety of governmental levels in Canada, but in this Study, women were clear that many of the policies outside the "healthcare silo," including finance, labour, social services and transportation, can have as much influence on health and health status. Other policy arenas were also mentioned: research councils, professional associations, academic institutions, and health care facilities. The first policy priority is to "Factor Gender, Place and Culture into all Health Policy" and the recommended actions highlight the importance of explicitly and systematically taking rurality and gender into account in health policy and planning. The second policy priority is to "Define Health Policy as More than Health Care Services" and the recommended actions stress that economic and social investments are themselves investments in the health of Canadians. The third policy priority, "Improve Health by Improving Access," addresses actions to improve access to health care in four inter-related dimensions: information, services, appropriate care and decision making.

Policy Priority #1: Factor Gender, Place and Culture into All Health Policy

When policies are touted as "place and gender neutral," decisions that are likely to favour urban, male stakeholders get made.

For more than thirty years, health literature has stressed the importance of factors

outside of the health care sector in determining the health status of individuals and communities.³¹ Despite this knowledge, much health policy remains directed at disease care.³² This Study has helped to illuminate the significance of gender, place and culture as determinants of women's health, but now they must be taken into account in policy making. As one focus group participant said, "One size does not fit all."

What is seen depends on the lens used...

One way of ensuring that gender, place and culture are taken into consideration is to use specific "lenses", "filters" or "tools" that help to take gender, culture and place (rural, remote and/or northern locations) systematically into account when considering policy alternatives.³³ Gender-based analysis helps to identify and give priority to those areas where gender-sensitive interventions will lead to improved health.³⁴ The federal Rural Secretariat defines a rural lens as "a way of viewing issues through the eyes of Canadians living in rural and remote areas."

Consider deciding on the location of a family planning clinic. Locating the clinic a "reasonable distance" from rural residents may not in itself ensure that the target populations use the clinic. A rural lens might take into account factors such as seasonality of work and of road access, as well as ways to ensure confidentiality in small communities. A gender lens might consider the availability and cost of transportation and childcare to women, at various times of the day, week and year, alongside issues of confidentiality and appropriateness of care. Without paying attention to gender, spatial and social factors, services that appear to be accessible may have severely limited use.

Actions 1 and 2: Gender/Place/Culture Lenses; Involve Women

1. Use gender/place/culture lenses in policy development, health planning and programming, at the federal, provincial and municipal levels, so that the impacts of policy outcomes are systematically considered and more accurately assessed for effectiveness.
2. Involve women in rural, remote or northern Canada in gender/place/culture based analyses to accurately assess the impact and effectiveness of policies and practices which are designed to increase social and economic capital.

Policy Priority #2: Define Health Policy as More than Health Care Services

Women and their families cannot maintain their health in the absence of financial security.

Participants in this Study stressed that their lives are not sorted into discrete boxes that can be dealt with independently by different government departments and that, if policy development were to be citizen-centred, then intersectoral, collaborative policy development, grounded by "gender place analysis" (which of course includes gender based analysis), would be required. Despite clear evidence otherwise, *health care services* still dominate thinking, media coverage, decision making and budgeting for *health*. Women's experiences of healthy living extend far beyond visits to health care providers, just as barriers to good health often have little to do with the provision of health care services. For example, women are disproportionately burdened with poverty and domestic violence in Canada, with certain groups such as Aboriginal women and elderly women being particularly disadvantaged. The strong correlation between poverty, income inequality and

health has been well documented,³⁵ and was supported by the findings of this Study.

It's time for health policy to reflect health research: economic and social investments are investments in health.

Similarly, a lack of community infrastructure, both social and physical, undermines good health. Many women praised the health benefits derived from the social capital in their communities, including service clubs, community spirit, proximity to family and supportive interpersonal relationships.³⁶ Yet many others reported feeling lonely or depressed. They frequently linked their poor mental health to social and geographic isolation. Socially, they talked about being limited by traditional role expectations with strong taboos relating to women in small communities. These women described limitations in their physical environment including lack of reliable, affordable, year-round transportation and poor access to supports such as recreation, education and childcare.

Actions 3 and 4: Invest in Communities and Women

3. Invest in women's health and community health through the Rural Health Access Fund and other sources to provide stable, longer term (at least three years) operational funding for community-based organizations to catalyse women's engagement in and coordination of economic, political and social services in rural, remote and northern communities.

4. Implement federal, provincial and territorial policies that will stabilize household

incomes and reduce the stress of women's "sandwiched" lives in rural, remote or northern communities, designed with gender/place/culture lenses to ensure recognition of the diversity among women, who bear the greater burden of poverty in Canada, often exacerbated by age, race, or disability.³⁷

Policy Priority #3: Improve Health by Improving Access to Diverse Services and Power

Issues of access dominate the rural health agenda, in the literature, the media and in popular consciousness. Researchers have noted that access means more than distance to a care provider and waiting time, but also continuity, appropriateness, quality, perceptions of quality and access to information. According to the women involved in this Study, true access also has to include decision-making. The women in this Study considered access in four primary facets: information, health care services, appropriate care and decision-making.

1. Improved Access to Information

Information is critical for informed choice in maintaining good health. At every stage of data gathering for this project, women spoke of the importance of having clear points of access to health-related information. Traditionally, physicians have acted as one of women's key local sources for health information. As family doctors become increasingly scarce, as women begin seeking a wider range of health information than doctors provide, and as the availability of rural health care services changes rapidly



over time, the existence of centralized, well-known information access points becomes ever more important. As one participant from Alberta reported, “It seems like our whole society is saying, ‘you have responsibility for your own health’ and that has changed. Twenty years ago it was the doctor that was responsible for my health, but now it is me. So the information I need needs to be extended to me.”

Information access points can assume a variety of forms. There is, for example, a website (www.rural-canada.ca) that acts as an information portal for rural Canadians. However, many rural, remote and northern living women do not have access to computers and the Internet. It was also pointed out that local communities often have the expertise to develop the most appropriate education materials for the women and people they serve, but they are starved for the funding needed to make this possible. Such access points are necessary not only for communicating health information to rural women, but also for gathering information from them.

Another important dimension is the effective sharing of information among service providers and agencies. Women reported difficulties accessing coordinated care, especially when they needed to travel long distances and to multiple jurisdictions to obtain that care. They found themselves responsible for maintaining records of their own health and recounting their story multiple times to various health care workers.

One final dimension of improving access to information has to do with research. Urban research and urban communication strategies don’t usually work with these populations. The gender/place/culture lenses need to be used to ensure that women’s health research is designed,

conducted, disseminated and applied to improve rural, remote and northern women’s health with their equitable involvement in all the research steps.

Actions 5 and 6: Develop Rural, Remote & Northern Women’s Health Policy

5. Create and support a Centre of Excellence for Women’s Health that conducts women’s health policy research in the Yukon, Northwest and Nunavut Territories; increase resources of the existing Centres of Excellence for Women’s Health so that women’s community organizations in rural, remote and northern Canada are engaged in the Centres’ research, development and dissemination of locally appropriate information, education and advocacy materials (in plain and local languages).
6. Reduce professional and jurisdictional boundaries that impede women’s access to health care and information by coordinating health information access points for rural, remote and northern users throughout Canada e.g. local libraries, telephone information lines, interactive websites, and community health centres³⁸.

2. Improved Access to Services

Participants in every phase of this Study spoke of the acute shortage of health care services, already well documented in the literature and in the media.

We have a right to services where we are... We pay the same taxes as people in the city. Why don't we have the same rights to services?"

– Consultation participant

This need for more services was reported in both general and specific ways. At a general level, there was broad recognition of the overall scarcity of health care services in rural, remote and northern locations. Certain kinds of services were reported to be especially scarce, including services for chil-

dren and adolescents, mental health services, support for caregivers or women who are sick at home, preventive services, specialist care—all needing more language options. In rural and northern areas, transportation is often constrained by weather, poverty and a lack of public transit. As a result, even services relatively close by can be “remote”.

To go to the doctor's even, although it's less than five minutes away, because I don't drive, unless my husband takes time off work, I have to count on someone else to take me.

Diversity of Health Services Needed

There was widespread acknowledgement that physician shortages exist in many parts of Canada and must be addressed. Some women did call for fewer barriers to the licensing of international medical graduates. More often, however, participants seemed to be suggesting that access to a physician is a necessary but not sufficient condition for care, since other non-medical dimensions of health are also important and health care for women encompasses more than doctors. Women recognized that physician shortages are less easily rectified in the short to medium term, which may be why the emphasis was on other strategies that could employ the gender, place and culture lenses to ease the strain on women and on the health care system itself more quickly, for example by:

- increasing the numbers of non-medical health practitioners such as midwives, nurse practitioners and respiratory therapists,
- covering the cost of alternative therapies such as chiropractics and naturopathy,
- training local paraprofessionals in health support and information sharing, and

- making rural transportation programs more accessible and affordable
- increasing the supply of mobile health services or local rotating clinics for speech therapy, mammography, physiotherapy, well-woman checks, healthy baby checks, bone density scans, family planning counseling, tests for sexually transmitted diseases, blood glucose checks, sight and hearing exams, ultrasound or other health services that benefit women and their families.

It's a lot easier to bring one or two people to a hundred than it is to send the hundred to two people.

Actions 7, 8 and 9: Expand Coverage, Increase Practitioners, and Educate Locally

7. Expand coverage for health services currently excluded from most provincial and territorial health insurance plans, including prescription drugs, midwifery, chiropractics, naturopathy and other forms of complementary care, including coverage for all costs related to travelling away from home for necessary care.
8. Coordinate the supply of physicians and other practitioners to ensure a fairly balanced distribution of services, to prevent destructive bidding wars between desperate communities and to recruit health care providers well-suited to meet the needs of diverse populations, for example, female practitioners and those who can communicate in local languages and culturally specific ways.
9. Establish education and training program incentives for students in all the health professions to specialize in locally and culturally appropriate health services (including complementary care) to underserved rural, remote and northern populations, particularly Aboriginal and other historically disadvantaged groups.

3. Improved Access to Appropriate Care

Those that need services fall through the cracks. They have to make their life emergencies wait. Really.

Health care access means more than increased supply of services. It also involves the provision of services that truly meet the needs of women in rural, remote and northern Canada. Many participants in our Study said they often take whatever services they can get without complaining, and quality issues seem like an abstract luxury when their basic health needs are not even being met. But from a policy perspective, paying attention to appropriateness can ensure that scarce health care resources are invested more effectively, in ways that will strengthen utilization and satisfaction.

As with access to services, appropriate care encompasses both the kinds of services being provided and the ways in which they are provided. As for the kinds of services offered, rural women spoke of wanting services that reflect their lives, in all of their diversity, including services that focus on disease prevention as well as health promotion. For example, although rural women support the use of early cancer detection services, they are less likely to use them if they are not available locally or culturally appropriate; the cost of accessing them outweighs their perceived benefit. Furthermore, women stressed the need for age-appropriate services to be provided. If adolescents or seniors, for example, are not explicitly taken

into consideration in the design of health services, they cannot be assumed to be using those services as readily as if the services were specifically targeting their needs.

Appropriateness has even more to do with how existing services are provided. Women had much to say about how services should be provided to meet their needs. Many of their comments, such as the need for integrated and holistic models of care, reflect the interests of women no matter where they live. Other comments in this category include the desire for female health care providers, for care that provides time for women to ask questions and build a relationship with their caregiver, and for care that is offered without any form of discrimination. Specific praise was offered, throughout the country, to Community Health Centres or Women's Health Centres, as models that succeed in providing this kind of multidisciplinary, women-centred care.

Other comments, such as the need for care to be offered at certain hours or in certain seasons, or provided in particular languages (especially Aboriginal languages, French, and the mother tongues of specific immigrant populations) with the corresponding cultural sensitivities, reflect the specific needs of

particular rural and remote populations. Appropriate care therefore involves paying attention, often at local levels, to the way that gender and place, alongside other health determinants such as age and culture, affect the kinds of care women are seeking.

Many participants in our Study said they often take whatever services they can get without complaining and quality issues seem like an abstract luxury when their basic health needs are not even being met.

Availability of health care services alone is not enough. Those services should be catered to the needs of the populations they serve. Issues of seasonality, access to money, confidentiality, and culture are key, and must be taken into consideration when designing how health care services are to be delivered. Rural, remote and northern populations are diverse, and much of the expertise on what is required for appropriate care is at local levels.

Action 10: Interdisciplinary, Integrated Holistic Models

10. Implement strategies to increase the recruitment and retention of primary care physicians, medical specialists and non-medical health practitioners in rural, remote and northern areas, (including midwives, public health nurses, therapists and nurse practitioners), such as a) acceleration of accreditation for foreign-trained practitioners and, b) facilitation of health professionals' involvement in new community health centres which utilize gender, place and culture lenses to provide diverse physical, mental, dental and social health services in one location and with mobile units through interdisciplinary, integrated models of holistic family health care.

4. Improved Access to Decision Making

While some policy makers at various levels across the country have been consulted throughout this project, those employed at the level of government holding most of the responsibility for health decision-making—the provinces and territories—have been less involved. Increasing the connections between women in rural, remote and northern Canada and policy makers at every level, but particularly the provincial / territorial level, remains an important goal for dissemination and uptake on the policy

priorities in this Study and successor projects undertaken by the Centres of Excellence for Women's Health—each having a mandate to produce research and information for use in developing women's health policies.

This fourth dimension of access circles back to the overarching priority that emerged from this Study, after many participants voiced frustration with the following contradiction: family well-being remains the responsibility of women, while political power over resource allocation still rests largely in male hands. The overarching priority of the participants in this Study is to be truly engaged in policy change based on "Gender Place Analysis" using data on the social determinants of women's health.

Action 11: GPA Policy Change Network

11. Ensure gender equity and parity in policy-making by creating a "GPA—Gender Place Analysis" policy change network of collaborative, mutually respectful partnerships between Canadian women in rural, remote and northern Canada and policy makers, at every level of government. Achieve this priority through increased funding to build upon the social capital of women community leaders in rural, remote and northern Canada, including funding leadership training, travel, networking, proposal writing, honoraria and childcare, as well as ongoing liaison with the Centres for Excellence in Women's Health, the Canadian Women's Health Network and other partners able to provide support and to collaborate on coordinated research, education, communication and advocacy strategies needed for an effective health policy change network of women in rural, remote and northern Canada.

Implementation of the Policy Priorities

... the place to start is with a vision where Canadians residing in rural and remote regions and communities are as healthy as people living in metropolitan and urban centres.³⁹

The revitalization of rural, remote and northern areas of Canada is a high priority among policy-makers and improving the economic status of women is seen as important in the promotion of the fair and equitable society envisioned in our Constitution. The participants in this Study identify poverty as a significant determinant of women's health.

Many rural, remote and northern women are at a cumulative disadvantage because of their location ("place") and their gender, with their concerns often being invisible to decision-makers. This Study represents one attempt to counter that trend, insofar as it has provided women community leaders from more than 30 rural, remote and northern places with an opportunity to communicate their health policy priorities.

The three policies and eleven related actions recommended in this report do not represent many new tasks, but suggest new ways of doing old tasks. They highlight the need to take gender, place and culture systematically into account in policy making, which needs to extend far beyond traditional

health care services. They demonstrate the multifaceted nature of health care access in these highly diverse communities, and call for a renewed commitment to delivering the resources women in rural, remote and northern Canada need to access health information, health services, appropriate care and health-related decision-making.

Conclusion

This Study has demonstrated that women representing diversity of language, culture, age, ability, sexual orientation, race, economic status and place convey a fundamentally simple and powerful message: to be healthy and to contribute to the health of families, communities and country, women in rural, remote and northern Canada have set three policy priorities:

1. Factor Gender, Place and Culture into All Health Policy,
2. Define Health Policy as More than Health Care Services, and
3. Improve Health by Improving Access to Diverse Services and Power.

These recommendations are interconnected and signal movement toward a transformative policy process that will strengthen the health and economic vitality of our country as a whole.



Endnotes

- 1 Including elected political representatives, Senators and other appointed officials with policy and law-making capacity.
- 2 In November 2002 the Study's National Research Steering Committee secured a policy research grant from Status of Women Canada to expand the original Study and gather new data through several means: a web-based questionnaire, a telephone-administered survey on a toll-free line, and 20-25 new focus groups using an improved set of questions. This next phase will extend the diversity and citizen engagement of this Study and focus on the effects of restructuring on women's health in rural, remote and northern Canada. It will also develop knowledge translation tools for communicating research results to policy makers, community agencies and to women in rural communities. Contact: Ivy Beaugeault, PhD at McMaster University
- 3 We recommend combining the qualitative results of this Study with the ongoing quantitative research on rural, remote and northern health being undertaken by a number of agencies, including Statistics Canada, the Canadian Institute for Health Information, Canadian Institutes for Health Research, the Rural Health Office of Health Canada, the Centre for Rural and Northern Health Research at Lakehead University and the Ontario Women's Health Council, among others.
- 4 For a full description of the methods, see Section C of this Summary Report. Lists of women who participated in each facet of the Study are found in Appendix A.
- 5 Milne, G. 2000. *Making Policy: A Guide to the Federal Government's Policy Process*. Ottawa, ON at p.1-3.
- 6 Milne, at p.2
- 7 Pross, A.P. 1992. *Group Politics and Public Policy*. 2nd Ed. Toronto: Oxford University Press; 119.
- 8 Coleman, W.D., and G. Skogstad. 1990. Conclusion. In: Coleman W. D., and G. Skogstad, editors. *Policy Communities and Public Policy in Canada: A Structural Approach*. Mississauga, ON: Copp Clark Pitman Ltd. pp. 314-320.
- 9 Canadian Centre for Justice Statistics. 2001/02 Transition Home Survey - Snapshot taken April 15, 2002. Contacts: 1 800 387-2231 ccjsccsj@statcan.ca
- 10 Statistics Canada Rural and Small Town Canada Analysis Bulletin, Vol. 3, No. 3. Table A1. Distribution of the "rural" population 1996. Catalogue no. 21-006-XIE at 14.
- 11 Horne T, Donner L, & Thurston WE. Winnipeg, Manitoba: PWHCE 1999.
- 12 "Gender-based analysis is a tool to help understand how the experiences of women and men are different and how they are the same. In the case of health, GBA illuminates the differences in health status, health care utilization and health needs of men and women." L. Donner 2003. *Including Gender in Health Planning: A guide for Regional Health Authorities*. PWHCE
- 13 A number of new projects on gender in health planning have developed in Manitoba and Saskatchewan since the release of *Invisible Women*. For more information contact Prairie Women's Health Centre of Excellence.

- 14 This was the case in the two recent federal documents on the state of health care in Canada: Romanow, R. 2002. *Building on Values: The Future of Health Care in Canada*, Ottawa: Government of Canada. Senator Michael Kirby, Chair. Standing Senate Committee on Social Affairs, Science and Technology. *The Health of Canadians: The Federal Role: Volume Six: Recommendations for Reform. Final Report*, October 2002.
- 15 Ibid.
- 16 Romanow 2002: 166
- 17 National Coordinating Group on Health Care Reform and Women. 2003. *Reading Romanow: The Implications of the Final Report of the Commission on the Future of Health Care in Canada for Women*. Centres of Excellence for Women's Health.
- 18 Wolfensohn J.D., 2001. Introduction in *Gender Development through Gender Equality, Rights, Resources and Voice*. Washington DC: The World Bank.
- 19 1249 U.N.T.S. 13. The full text of CEDAW, with its Optional Protocol is available online www.un.org/womenwatch/daw/cedaw and a CEDAW bibliography with the First CEDAW Impact Study by the International Women's Rights Project is available online at www.iwrrp.org A "treaty" or "convention" is like a contract among a group of states and is legally binding under international law. "States Parties" are the country members of the UN, like Canada, that have ratified CEDAW. By "ratifying" this convention, Canada promised to comply with its terms and agreed to be held internationally accountable for compliance. For the list of states that have ratified CEDAW along with Canada and its Optional Protocol, visit www.womenwatch/daw/cedaw/
- 20 For example, Article 14 (2) reads: "States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that they participate in and benefit from rural development and, in particular, shall ensure to such women the right: (a) To participate in the elaboration and implementation of development planning at all levels; (b) To have access to adequate health care facilities, including information, counselling and services in family planning; (c) To benefit directly from social security programmes; (d) To obtain all types of training and education, formal and non-formal, including that relating to functional literacy, as well as, inter alia, the benefit of all community and extension services, in order to increase their technical proficiency; (e) To organize self-help groups and co-operatives in order to obtain equal access to economic opportunities through employment or self employment; (f) To participate in all community activities; (g) To have access to agricultural credit and loans, marketing facilities, appropriate technology and equal treatment in land and agrarian reform as well as in land resettlement schemes; (h) To enjoy adequate living conditions, particularly in relation to housing, sanitation, electricity and water supply, transport and communications."
- 21 In electoral politics, in the two decades since the Charter, we have not succeeded in pushing women's electoral representation past the one-to-five ratio in the House of Commons. In fact, the numbers for women standing for election declined 4 per cent in the last federal election. Source: M. McPhedran with R. Speirs. *The Equal Voice Position Paper on Proportional Representation to the Law Commission of Canada*. Available online www.equalvoice.ca
- 22 Canadian Institute for Health Information. *The Women's Health Surveillance Report*. Released September, 2003.
- 23 Health Canada, Rural Secretariat www.rural.gc.ca/checklist_e.phtml ; Statistics Canada, 2001 Census—preliminary figure (July 2003) for the population is 31,629,677. For more information about the coverage studies of the 2001 Census, contact the Survey Methods Division Dave Dolson dave.dolson@statcan.ca

- 24 Statistics Canada. Ray D. Bollman, Ed., Rural and Small Town Canada Analysis Bulletin, Vol. 4, No 4. "The rural/urban divide is not closing: Income disparities persist" (21-006-XIE, free) www.statcan.ca
- 25 Howlett M, & Ramesh M. 1995. *Studying Public Policy: Policy cycles and Policy Subsystems*. Toronto, ON: Oxford University Press.
- 26 Ibid.
- 27 "Open Space" is described in Section I of this Report.
- 28 Grose F, Hiller J, Leclerc G, Sutherns R. National Consultation in Saskatoon, SK. March 19, 2003.
- 29 Statistics Canada. *The Rural and Small Town Canada Analysis Bulletin*, Vol. 4, no. 3, Friday, February 14, 2003, titled "The gender balance of employment in rural and small town Canada—1987 to 1999" (21-006-XIE, free) www.statcan.ca
- 30 See note 2.
- 31 Lalonde, M. 1974. *A New Perspective on the Health of Canadians*. Government of Canada, Ottawa.
- 32 Hamilton N. and T. Bhatti 1996. *Population health promotion: An Integrated Model of Population Health and Health Promotion*. Ottawa: Health Promotion Development Division, Health Canada.
- 33 The Rural Secretariat has developed a checklist of rural lens considerations, constructed from citizens' ideas expressed during national consultations. www.rural.gc.ca/checklist_e.phtml A checklist for conducting gender-based analysis (especially in the areas of health planning and programming) is available from the Prairie Women's Health Centre of Excellence (www.pwhce.ca).
- 34 Donner, L. 2003.
- 35 For rural Canadian examples of the links between poverty and health, see for example Donner, L. (2000) *Women, Income and Health in Manitoba: An Overview and Ideas for Action*. Winnipeg, Manitoba: Women's Health Clinic or Purdon, C. (2002) *Rural Women Speak about the Face of Poverty*. Rural Women and Poverty Action Committee, Grey Bruce and Huron counties, Ontario: Status of Women Canada.
- 36 "Social capital" has been defined by the OECD (2001) as a "collective good" of "networks with shared norms, values and understandings that facilitate cooperation within or among groups." Status of Women Canada in their research call, *Gender Dimensions of Canada's Social Capital*, identified women's "indigenous knowledge" as an important "contribution to the nation's social capital, noting that "Aboriginal women and women farmers have traditionally been plant breeders and experts in local biodiversity" but that "their expertise is not perceived as scientific knowledge and is often referred to as "intuitive." Contact research@swc-cfc.gc.ca
- 37 Participants recommended initiatives such as part-time benefits, flexible work hours, wage equity, tax equity for women at home with children and affordable high quality childcare.
- 38 Some provinces have tele-health lines already.
- 39 Romanow. 2002:165.

Rural, Remote and Northern Women's Health:
Policy and Research Directions

Appendices

List of Appendices

A.	Contributors to the StudyM3
B.	Committees' Terms of ReferenceM12
C.	Contact Information for the Women's Health Bureau, Centres of Excellence for Women's Health and National Coordinating GroupsM13
D.	Demographic SurveyM14
E.	Focus Group Interview GuideM15
F.	Instructions to FacilitatorsM16
G.	Project Consent FormM19

APPENDIX A

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Rebecca Sutherns

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Focus Group Participants

Names of Women who Agreed to be Identified

Labrador:***Forteau, Mary's Harbour and
Port Hope Simpson***

Tania Keats

Janet Dumaresque

Kathy Farell

Margaret Pye

Cheryl Rumbolt

Newfoundland:***Marystown***

Linda Murphy

Florence Walsh

Debbie Hillier

Amanda Power

Linda Oldford

Ontario:***Lion's Head***

Mavis Kyler

Ginny Wood

Colette Sauve

Vicki Travnicek

Woodstock

Mary Jane Bennett

Helen Dunlop

Francophone:

Solange Chevrier

Maria Lepage

Janice Murphy

Marie Dussault

Hélène McCarthy

Annette Richard

Ramona Le Bouthillier

Corinne Gagnon

Laurette Deveau

Ginette Deveau

Aline Bourgeois

Charline Roy

Doris Riopel

Gisèle Séguin

Doris Thibodeau

Madeleine Paquette

Lizanne Thorne

Colette Arsenault

Élise Arsenault

Karen Gilmore-Thomson

Diane Brault

Rita Martel

Nancy Caron

Muriel Bittar

Catherine MacDiarmid

Manitoba:***Oakbank***

Jeannette Johnson

Marlene Lussier

Mae Louise Campbell

Catherine Cook

Jeannette Goertzen

Judy Andrew

Angela Livingston

Marielee Nault

Irene Rockhill

Saskatchewan:***Watrous***

Lilliane Sabiston

Mary O'Hagan

Irene Karol

Natalia Schrader

Cathy McMann

Cathy Spencer

Mary Smillie

Sherron May Reid

Liz Gordon
Gayle McMartin
Margaret Cline

Yorkton

Bernadine Gibler
Carolyn McDonald
Arlene Pickard
Doreen Holden
Lillianne Sabiston
Wendy Paquin
Dorothy Minish
Janet Skutnitsky
Jocelyn Grant

Alberta:

Clive

Louise R. Bell
Faye Grose
Gloria Knight
Avis Sayers
Marion Grose
Roberta Proctor
Gwyneth Bailey
Carol Fifield
Darlene Brown

Fort Chipewyan

Maureen Clarke
Wendy Nelson
Dana Wylie
Freda Fraser

Vermillion

Johanna Wasylik

British Columbia:

Creston

Korlaina Huber
Carol Nagy
Amanda Chirico
Rachel Chirico
Wendy Palesch

Port Alice

Leanne Farrell
Leann Miller
Penny Bondue
Chandra Hovde

Tumbler Ridge

Cheryl Hayden
Sharon Bray
Rose Colledge

Northwest Territories:

Fort Smith

Gisela Becker
Julia Sewell
Joanne Gauthier
Lauraine Armstrong
Denise Coulthard
Sister Agnes Sutherland
Marcia DeWandel
Louise Beck
Colleen Macza
Linda Mabbit
Camilia Zoe-Chocolate
May Gauthier
Lesley Paulette
Marlene Wolki
Cheryl Cooper

Hay River

Liz Pope
Gloria Lennie
Anne McGuire-Smith
Brenda Hall

Inuvik

Ann Kasook
Jessie Colton
Nancy Chinna
Barb Lennie
Arlene Jorgensen
Miki O'Kane
Alice Kimiksana
Connie Alanak
Mary Teya

Yellowknife

Fiona Traynor
Diane Jamieson
Margaret Beauchamp
Susan Affleck
Marsha Argue
Kim Riles
Mary Anne Gauthier

National Roundtable

Saskatoon, October 20, 2001

List of Participants:

Carol Amaratunga
Madeline Boscoe
Ivy Bourgeault
Annette Brown
Mary Crawford

Marie DesMeules
Veronica Dewar
Judith Dowler
Nikki Gerrard
Marilyn Gray
Lorraine Greaves

Margaret Haworth-Brockman
Roxanna Kaminski
Wendy Kubik
Catherine Kulisek
Marlene Larocque
Renee Lyons
Marjorie MacDonald
Rosella McKay
Edith McPhedran

Marilou McPhedran
Barbara Neis
Barbara Parker
Jan Pitblado
Lilliane Sabiston
Rebecca Sutherns
Wilfreda (Billie) Thurston
Pamela Wakewich

Policy Roundtable

Toronto, November 18-19, 2002

List of Participants:

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Ivy Lynn Bourgeault
Assistant Professor,
McMaster University

Lynn Bowering
Chief Operating Officer,
Ontario Women's Health Council Secretariat

Barbara Clow
Senior Research Officer,
Atlantic Centre of Excellence for Women's
Health

Christine Dallaire
Assistant Professor,
University of Ottawa

Lorraine Greaves
Executive Director,
British Columbia Centre of Excellence for
Women's Health

Margaret Haworth-Brockman
Executive Director,
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Karima Hashmani
Research Assistant,
National Network on Environments and
Women's Health

Catherine Kulisek
Manager, Women's Health Contribution
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Women's Health Bureau, Health Canada

Esther Kwavnick
Senior Advisor,
Population and Public Health Branch,
Health Canada

Guylaine Leclerc
Executive Director,
L'Union culturelle des franco-ontariennes

Marilou McPhedran
Executive Coordinator,
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Women's Health

Liz Mulholland
Mulholland Consulting

Barbara Neis
Professor,
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Kathleen O'Grady
Director of Communications
Canadian Women's Health Network

Deanna St. Prix-Alexander
Executive Director,
Women's Health Bureau, Health Canada

Lillianne Sabiston
Community Partner
Prairie Women's Health Centre of
Excellence

Rebecca Sutherns
Post-Doctoral Fellow
McMaster University

Annette Willborn
Director, Women's Health
Manitoba Health

JoAnne Zamparo
Associate Professor,
Lakehead University

Biographic Sketches of Contributors

Deborah Barron-McNabb

Deborah is a Registered Nurse who resides in rural Manitoba and is of Métis descent. Her work as a Health Consultant is primarily concentrated in research, analysis, facilitation and negotiation on policy and program issues in a broad range of areas; and currently most specifically with an Aboriginal and Métis focus within provincial, national and international levels. She has served as co-chair of the Federal Government's Aboriginal Working Group on the National Children's Agenda and chair of the National Aboriginal Reference Group on HIV AIDS; advisor on the Federal Provincial Territorial Aboriginal (FPTA) Social Policy Agenda; participated in various processes and delegations (NGO and Official Government Foreign Affairs) to the United Nations including pre-Beijing (Women's Rights) and Cairo plus 5 (Sustainable Development) and Human Rights and the Freedom of Expression and Speech. In the past year she presented to the Romanow Commission. She currently continues to serve on numerous committees including the Ministerial (Manitoba Provincial Government) Advisory Committee on Diabetes, National Aboriginal Health Organization–Métis Centre Governing Committee, Winnipeg Regional Health Authority Continuum of Care Committee, as well as others. At present, Métis Rights specific to Health within the Canadian Health Care System and Health Information Privacy and Ethics are of particular concern and focus for her.

Madeline Boscoe

Madeline is the Executive Director of the Canadian Women's Health Network (CWHN). The CWHN is a partner in the Centres of Excellence in Women's Health Program where she serves as a member of the Steering Committee. She is a long-time staff person of the Women's Health Clinic, a community health centre for women where she currently coordinates their advocacy program and the Health Promotion and Counselling Team. Madeline is also a member of the Advisory Board of the Institute of Gender and Health of the CIHR where she chairs the Knowledge Transfer and Communication Committee and the co-chair of the federal Advisory Committee on Reproductive and Genetic Technologies. Prior to moving into community health and policy work she worked as a registered nurse in the Intensive Care Unit of the Hospital for Sick Children in Toronto and as a nurse-educator for Toronto's Public Health Department. With her husband and two children, she is a long-time resident of Winnipeg, though she remains home-sick for the rain and mountains of the west coast.

Ivy Lynn Bourgeault

Ivy is an Assistant Professor in the Health Studies Program and Department of Sociology at McMaster University. She also holds a New Investigator Award with the Canadian Institutes for Health Research and is heading a five-year study of the impact of gender and place on the rationalization of the health-care division of labour in Canada and the United States. Ivy is a feminist medical sociologist who has published extensively in national and international journals not only on midwifery and maternity care in Canada and the United States, but also on alternative medicine, patient consumerism, and the relations between health professions and the state. Ivy has been involved extensively within the women's health research community in Canada through the National Network on Environments and Women's Health at York University, and the Centre for Research on Women's Health at the University of Toronto. She is a member of the CIHR Gender, Sex and Health Review Panel.

Aimee Clark

Aimee has lived in the Northwest Territories for 14 years. Currently, she lives with her 5 children in Fort Smith. Having 24 years of progressive experience in accounting, she opened her own small accounting business. In 2002, she completed a report "Falling Through the Cracks" distributed across Canada. As an indirect result of this report, she was nominated and elected to the National Anti-Poverty Organization (NAPO) as the board member for the Northwest Territories. She is currently working on the anti-poverty coalition in the Northwest Territories and is developing a Pan-Northern group in conjunction with other Northern NAPO board members.

Barbara Clow

Barbara is the Senior Research Officer at the Atlantic Centre of Excellence for Women's Health. As a social historian of medicine, her research deals with various

aspects of the history of medicine and women's health. She is currently involved in a study of Black women's health in rural and remote communities of Nova Scotia, as well as the history of drug regulation in North America. In May 2003, Barbara became Acting Executive Director of the Atlantic Centre of Excellence for Women's Health.

Christine Dallaire

Christine is an Assistant Professor at the School of Human Kinetics in the Faculty of Health Sciences of the University of Ottawa. Much of her research interests focus on Francophone minorities, particularly issues of youth identities, women and health. She is presently collaborating on a research project examining the Franco-Ontarian community's interest and intervention in health. She is also part of a research team that received Health Canada funding to investigate public perception and acceptable levels of health risk among Canadians.

Lorraine Greaves

Lorraine is a well-established researcher in women's health and gender, focusing on a range of topics of concern to women, women's health researchers, policy makers and community advocacy groups. She is the Executive Director of the British Columbia Centre of Excellence on Women's Health and a member of the research team of the Cross-Centre Initiative on Rural and Remote Women's Health, a project of the Centres of Excellence for Women's Health Program (CEWHP). She is the lead investigator on the Gender and Women in Rural Research project, funded by CIHR. She was the principal investigator of the CHSRF/SSHRC Institute Design Grant on Women's Health and the lead author of CIHR 2000: Sex, Gender and Women's Health (1999). She has written extensively on integrated multi-sectoral health research in Canada. Her expertise lies in applying a gender-based analysis to health issues and policies such as tobacco use, addictions, violence, physical activity, FAS, and economic-costing models. It is this expertise that offers a base for extending the principles of gender analysis and gender mainstreaming to research, policy, and community development issues in rural and remote health.

Karima Hashmani

Karima is the Research Assistant who has provided invaluable and indefatigable coordination for this Project. Although she is based in the office of the National Network on Environments and Women's Health (NNEWH) and reports to the NNEWH Executive Coordinator, she liaises with all the Centres of Excellence in this cross-centre initiative. Karima has international experience in qualitative research on rural women's health. Having graduated from the Faculty of Environmental Studies (FES) at York University, she extended her academic knowledge to the field when she travelled to the state of Gujarat to work on a sustainable water project for women living in rural and remote areas of India. Her work included interviews with women to conduct an assessment of their needs in relation to their health, the health of their families and clean water access. She also evaluated the outcomes of water projects already in operation and wrote up "lessons learned" to be shared with other communities.

Margaret Haworth-Brockman

Margaret is the co-director of this Study and the Executive Director of the Prairie Women's Health Centre of Excellence. Trained as a biologist, Margaret worked for over 12 years in wetland biology, conducting and publishing work from a variety of quantitative research projects on the Prairies. In 1994 she was appointed Chair of the Equity and Access Committee of the Midwifery Implementation Council, by the Manitoba government. She consulted with women throughout Manitoba and co-authored many of the documents, policies, procedures and strategic planning as part of the operations of the College of Midwives of Manitoba. She served as the first Registrar and Executive Director of the College of Midwives of Manitoba. Margaret has written over 30 published papers, articles and presented papers including a chapter in the 2000 National Guidelines for Family-Centre Maternity and Newborn Care. She is a member of numerous steering committees for women's health in Winnipeg, concerning women and poverty, services for addicted women, Aboriginal women's health issues, and care giving.

Noreen Johns

Noreen is a farmer from Zelma, in central Saskatchewan. She has long been an activist in the agricultural and women's communities. She is a founding member of the Saskatchewan Women's Agricultural Network (SWAN) and the Canadian Farm

Women's Network (CFWN), and has encouraged and supported the participation and recognition of women in all aspects of the agricultural industry. Noreen has been an active member of several community and provincial boards and associations. She has served as Vice Chairperson for the Provincial Health Council, chairperson of its subcommittee on Health Physical Environment, member of the Farm Stress Line Advisory Committee, chairperson of the Carlton Train Regional College Board of Trustees, and the rural consumer representative on the Saskatchewan Health Information Network (SHIN). She is currently a volunteer Board Member of the Saskatchewan Heart and Stroke Foundation, serves on the Advisory Board for the Centre for Rural Studies and Enrichment at St. Peter's College, Meunster, and is a member of the Farm Support Review Committee.

Catherine Kulisek

As a 1984 masters graduate of Carleton University, Ottawa, Catherine has expertise in the justice and health portfolios of the Government of Canada. Catherine's early career was spent as a case-management officer and researcher in federal penitentiaries. In 1988, she joined Justice Canada and was involved in policy and program development related to legal aid, crime prevention through social development, women in conflict with the law and child custody and support. She joined the Women's Health Bureau in July 2001, as the Manager of the Women's Health Contribution Program. Together with the Centres of Excellence for Women's Health, Canadian Women's Health Network, and other women's organizations, Catherine participates in the development of evidence-based initiatives intended to improve the health of women and girls in Canada.

Marlene Larocque

Marlene has worked with the Prairie Women's Health Centre of Excellence and numerous other community-based organizations dedicated to justice for First Nations women. She has facilitated community-based research and projects at the regional, national and international level and has worked with Indigenous Women's organizations throughout the Americas while she was based in Quito, Ecuador.

Guylaine Leclerc

Guylaine conducted the Francophone focus groups, with Christine Dallaire, for this Study. She is the Executive Director of l'Union culturelle des franco-ontariennes, the largest non-profit group for Francophone women in Ontario, and has been for the past 12 years. She has been a member of the Coordinating Committee of La Table féministe Francophone de concertation provinciale de l'Ontario for a number of years and is responsible for the health committee of the organization. It is in this capacity that Guylaine represents La Table as a Community Partner in the National Network on Environments and Women's Health (NNEWH).

Gail Lush

Gail is the coordinator of the Women's Health Network, Newfoundland and Labrador and a facilitator for focus groups in this Study. She is also a part-time graduate student at Memorial University in the Department of History. She is studying the history of nutrition and health education at the Grenfell Mission in Newfoundland and Labrador, and has a research background in women, health, and science in the 20th century.

Edith McPhedran

Edith has chosen to live rural area for the past 26 years, where she has had the pleasure of raising her two teenage daughters. She is passionate about maintaining the quality of life in rural areas. Edith works as a community facilitator in rural central Alberta for Child and Family Services. Her social work experience includes front-line crisis intervention, community development, social action and advocacy. She has been involved in special projects including the Central Alberta Women's Single Parent Review and Rural Women's Leadership in western Canada.

Marilou McPhedran

Marilou is the co-director of this Study and the Executive Coordinator of National Network on Environments and Women's Health (NNEWH), the Centre of Excellence based at York University in Toronto. Trained as a lawyer, she has provided strategic counsel in health and human rights to public and private institutions for the past 25 years. Marilou chaired Canada's first task force on the sexual abuse of patients in 1991 and a second task force in 2001 reviewing Ontario legislation based on their widely-adopted policy of zero tolerance of sexual abuse. As founding director of York's International Women's Rights Project, she directed the ten-country impact study on

the United Nations Convention on the Elimination of All Forms of Discrimination Against Women from 1998-2000 and is currently writing a book on prevention of sexual abuse.

Barbara Neis

Barbara is the chair of the National Research Steering Committee for this Study and is the co-director of Safety-Net, A Research Alliance in Workplace Health and Safety in Marine and Coastal Work at Memorial University, St. John's, Newfoundland. She is also a Professor in the Department of Sociology. Dr. Neis has researched many different aspects of the Newfoundland and Labrador fisheries and has recently begun linking that research with international fisheries-related developments. Her current areas of research focus include occupational asthma to snow crab and fishing vessel safety (funded by CIHR.), the human health impacts of restructuring in the Newfoundland and Labrador fisheries (funded by SSHRC and NSERC, Health Canada, the National Network on Environments and Women's Health), and local ecological knowledge and science (funded by SSHRC and NSERC).

Lilliane Sabiston

Lilliane is a self-employed farm partner and co-owner of Sabiston's Wood Grain Products near Kelliher, Saskatchewan. Her interests in promoting family farms with their issues and women's issues, especially concerning health have led her to become involved in a variety of committees. She has been involved in Saskatchewan Women's Agricultural Network (SWAN) as the chair and a board member. She sits on numerous affiliated committees and boards with some common interests. Lilliane is currently chair of the Farm Stress Advisory Group, board member of the Prairie Women's Health Centre of Excellence, Alcohol and Drug Abuse Advisory Council and co-chair of the Farm Family Opportunities Initiatives. She has recently been appointed Returning Officer for Lost Mountain-Touchwood Constituency. She was vice-chair of the Touchwood-Qu'Appelle Health District for seven years and also was appointed to the Board of Trustees of the Carlton Trail Regional College from 1992-1999. She has established valuable networks while attending various workshops and conferences over the years.

Lynn Skillen

Lynn is a Professor in the Faculty of Nursing, University of Alberta. She holds a PhD (Sociology), MHS (Health Care Practice), and BScN (Nursing). Her research focuses on the promotion of women's health and safety in paid and unpaid work environments in urban and rural communities. She teaches courses on health assessment, international health, and occupational health. Currently, her projects include: research on the promotion of personal safety among nursing students in high risk community areas with colleagues in Mexico, Colombia, Peru, Chile, and Alberta; research with Western Canada colleagues on a model for effectiveness in occupational health practice; and delivery of capacity-building courses in Spanish in Latin America.

Lana M. Sullivan

Lana is a Research Associate with the British Columbia Centre of Excellence for Women's Health. Her current research includes understanding the impacts of economic restructuring and health care reform on rural populations. Previous research included projects on social capital, social cohesion, and community capacity in rural and small towns; the role of the voluntary (third) sector; housing transition in single-industry towns; and commuting patterns between rural and urban towns.

Rebecca Sutherns

Rebecca holds a post-doctoral research and teaching position at McMaster University, funded by the Canadian Health Services Research Foundation. Her research interests include women's health and sustainable rural communities, having recently completed a qualitative study of women's experiences of rural maternity care for her PhD in Rural Studies. Prior to returning to academia, Rebecca worked in the nongovernmental sector in the areas of international development and advocacy. She is an experienced facilitator, speaker and adult educator.

JoAnne Zamparo

JoAnne is an Associate Professor at the School of Social Work of Lakehead University. Her interest is in community mobilization and social action that leads to social and health policy development and changes. She uses participatory-action research methods in the area of Inuit traditional knowledge, family and kinship as well as youth engagement in northern, rural communities.

APPENDIX B

Committees' Terms of Reference

National Management Committee

The National Management Committee: Funding and Modifying the Study

As a cross-centre initiative, this Study benefited from the management expertise of the Executive Directors of the four Centres of Excellence, the Canadian Women's Health Network and the CEWHP Manager in the Women's Health Bureau, (or designates).

The Terms of Reference accepted by the Management Committee were to:

- Be available to the co-directors for consultation on key decisions
- Assist the co-directors in guiding the conduct of the project, including finances and reports to funders, principally the WHB
- Direct facilitation and reporting of the regional focus groups
- Help identify key informants for focus groups and national Think Tank
- Consult with the Research Steering Committee in the development of remaining phases of the project
- Determine the emphasis on findings, conclusions and recommendations
- Liaise on the progress of the project with the Research Steering Committee
- Oversee coordination of national consultation
- Consult with the research steering committee in the development of communication and implementation strategies for the project results.

National Research Steering Committee

The National Research Steering Committee was established with the following Terms of Reference:

Tasks:

- Refine the scope of the project;
- Define the population to be studied; formulate key research questions;
- Determine methods appropriate to the population under study (e.g. thematic literature review with gaps analysis, focus groups for recommendations, discussion papers, roundtables, consultations, policy framework, research and action plans)
- Identify key contributors, informants and participants;
- Receive reports from NNEWH on the progress of the focus groups and other research;
- Review draft and final reports from NNEWH in order to provide feedback on findings, policy and research recommendations;
- Advise the PWHCE on the structure, content and participation of the National Consultation; and
- Make recommendations for the development of communication strategies for the dissemination of project results to achieve policy impact.

Diversity in the membership of the National Research Steering Committee should bring a wide range of perspectives to the development and consideration of the research evidence. The members are equally valued for their expertise and experience reflecting diverse interests, skills and locations.

APPENDIX C

Contact information for Women's Health Bureau, the Centres of Excellence for Women's Health, and National Coordinating Groups

Women's Health Bureau

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Atlantic Centre of Excellence for Women's Health (ACEWH)

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British Columbia Centre of Excellence for Women's Health (BCCEWH)

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Vancouver, BC V6H 3N1
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National Coordinating Group on Women and Health Protection

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Appendix D

Demographic Survey

Rural and Remote Women's Health Focus Group Demographic Survey

Thank you for agreeing to participate in this joint research project involving Centres of Excellence for Research in Women's Health in four regions of Canada. This research has been funded by the Women's Health Bureau of Health Canada. The research in this project is being administered by the National Network on Environments and Women's Health (NNEWH), based at York University in Toronto. Dr. Suzanne MacDonald and Marilou McPhedran are responsible for this study at York University. You can reach Marilou at marilou@yorku.ca or by phoning 1 416 736 5941 if you have any questions or concerns. Collect calls will be accepted if you mention that you are a focus group participant.

Before we begin today's focus group discussion, we are asking you to take a few moments to write your answers to the short survey in the space provided below. You will not be identified in the report on the results of this focus group. Information from this survey will be used to produce a summary profile of focus group participants in different parts of Canada, without any individual being identified.

Completion of this survey is voluntary. You may refuse to answer any specific questions on the survey. Please place your completed survey back in the unmarked envelope and put it into the box near the focus group facilitator. If you do not wish to complete this survey, please place the blank survey form back in its envelope and place it in the box. Thank you very much!

Questions

1. How old are you?

<input type="checkbox"/> 16-25	<input type="checkbox"/> 26-35	<input type="checkbox"/> 36-45	<input type="checkbox"/> 46-55	<input type="checkbox"/> 56-65	<input type="checkbox"/> 65+
--------------------------------	--------------------------------	--------------------------------	--------------------------------	--------------------------------	------------------------------

2. What level of schooling did you complete? _____

3. Is your personal annual income, after taxes:

<input type="checkbox"/> \$15,000 – 24,999	<input type="checkbox"/> \$25,000 – 34,999	<input type="checkbox"/> \$35,000 – 44,999	<input type="checkbox"/> Above \$45 000
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4. What is your occupation? _____

5. What is the approximate population of your community in the rural or remote area where you live? _____

6. What is your present marital status?

<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Unmarried and living with partner
<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed

7. If you have children, what are their ages? _____

8. a) Do you live in the same geographic area as where you work? _____
 b) How many miles one way do you have to travel to work? _____

9. If different from where you live, what is the approximate population of where you work? _____

10. Approximately how far/how long do you (or your clients/ the women you represent) have to travel to reach the closest:

nurse?	distance _____	travel time _____	don't know _____
nurse-practitioner?	distance _____	travel time _____	don't know _____
physician?	distance _____	travel time _____	don't know _____
specialist?	distance _____	travel time _____	don't know _____
alternative health care provider?	distance _____	travel time _____	don't know _____

Appendix E

Focus Group Interview Guide

- *Health*
 - What are the things, such as assets/resources/services that promote your health/the health of your clients? (Facilitator may need to prompt people here to think broadly beyond physical health and health care, e.g. spirituality, economics, workplace issues, division of labour; mental health, threats of violence, environmental concerns etc.)
 - What are things, such as barriers/attitudes/rules/lack of services that threaten your health/the health of your clients?
- *Rurality*
 - When you think of rural and/or of living remotely, what comes to mind?
 - Do you think of yourself as a rural woman? As someone who lives rurally or remotely? Both?
 - What makes your life rural and/or remote?
 - In what specific ways does living rurally or remotely affect your health or the health of those in your care? (e.g. geographic dispersion of services, income, employment conditions, access to education, social expectations and attitudes, weather/seasonality, degree of social support, quality of social relationships, housing, recreation etc.)
- *Policy Framework:*
 - “If you could have the undivided attention of key health-decision makers to talk about the state of women’s health in your community, what issues would you raise?”
 - “If you could change two things to promote better health of women in your community, what would they be?”
 - “How satisfied are you with the quality of health and health care for women and girls in your area?”
 - “Do you think the quality of health care for women in your area has changed in the past two years? In the past five years? For better or worse? Please give examples.
- *Research Agenda:*
 - “How would you define “your community”? Are there women’s health issues about which you think more information is needed in order to prompt appropriate action in your community or region?”
 - “To put it another way, have you ever felt concerned or curious about some aspect of women’s health care in your area and wished that someone would look into it further?”
 - “Based on a review of research that has already been done, the following gaps in research were identified: [**insert gaps listed in Wakewich paper here**] How important is it to the women and girls of your community for more research on each of these topics to be done?”
 - The Centres of Excellence do research that involves community members from the start. Do you have any suggestions on how to improve this model?
 - Are there any other issues relevant to policy, research and the health of rural women and girls that you think we should address?
- *Wrapping Up:*
 - “Although all of this information will be given to the Centres of Excellence for Women’s Health to be included in the research project, there may be a few themes or issues which have particularly stood out for you as you listened to everyone’s perspectives today. What are they? Is there anything else you would like to say?”
 - “I want to thank you for your time and your very helpful contributions. Your willingness to meet with me today makes this focus group possible. The focus groups of women in rural and remote areas across Canada will produce the core of the knowledge that this research project will generate. It could not be done without you. I’ve been asked by the women who are working on this project who are not here with us today to give you their sincere appreciation for helping in this way. We all hope that by giving our time and expertise to this project that we can make some real changes for women and girls living in rural and remote areas of our country. Thank you very much.”

Appendix F

Instructions to Facilitators

This is a community/academic partnered research initiative of the four Centres of Excellence for research in women's health (the Centres) and the Canadian Women's Health Network, funded by the Women's Health Bureau of Health Canada. The co-investigators of this project are Dr. Suzanne MacDonald and Marilou McPhedran of York University in Ontario. The following guidelines were developed by the Research Steering Committee of this project, chaired by Dr. Barbara Neis of Memorial University in Newfoundland and coordinated through the National Network on Environments and Women's Health—NNEWH, the Centre of Excellence based at York University. These Guidelines are to be followed by all of the Centres and their contractors in developing, conducting and reporting on focus groups with women in different regions of Canada, as an integral part of this research initiative. All documents and materials, in original form, as specified in these Guidelines and in the agreements made between NNEWH and other Centres as well as between Centres and those retained by the Centres to facilitate, record and report on the focus groups are to be delivered to Marilou McPhedran at NNEWH, 214 York Lanes, York University, 4700 Keele Street, Toronto, ON M3J 1P3, for further analysis and secure storage. Questions and suggestions should be directed to the Research Steering Committee, through Marilou at marilou@yorku.ca.

Focus Group Outcomes

- Each focus group facilitator should deliver to her respective contracting Centre, which in turn will be delivered by each Centre to NNEWH:
 - The originals of the signed consent forms, as well as the written demographic surveys completed by each focus group participant;
 - A summary of the demographic survey results, without identifying participants, including commentary on who was or was not in attendance and why, with suggestions for improvement, if any;
 - A synthesis report on findings, organized according to the subheadings of the questions beginning on page 3, below;
 - The original audio tapes of the complete discussion of each focus group (identification of the speakers is not expected), as well as the written summary prepared by the focus group recorder, including all questions asked and any answers. Note: copies of the audio tapes may be made and kept by the Centres but not by the facilitators or recorders, unless specific written permission has been granted by agreement with the respective contracting Centre and NNEWH;
 - A list of names and contact coordinates of possible invitees to the National Think Tank in January 2003, drawn from those participating in the focus groups, who have indicated an interest in attending and, in the opinion of the facilitator, would contribute their perspectives actively and add to the diversity of representation at the Think Tank (see consent forms);
 - A list of names and contact coordinates of those who indicated that they would like to receive the final report of this project (see consent forms).

Focus Group Facilitator's Responsibilities

1. The facilitator is responsible for thorough preparation including: a) ordering appropriate refreshments, b) ensuring that the audio-taping equipments and tapes are ready and in working order, c) ensuring that a recorder is in place to ensure full recording of the entire discussion, and, d) arranging for compensation for reasonable expenses. In the focus groups, the facilitator is responsible for explaining the context, expectations and objectives of the meeting, as well as the intended audiences and follow-up plans for any information generated. Wherever possible, we would like facilitators to provide the

consent form in advance to participants of the focus group(s) to give time for review. The following examples, in quotations, of what should be said to the focus group participants are given to assist facilitators and to ensure that focus group participants in different regions receive similar information:

- a. *Context:* “This meeting is one of several focus groups around the country. This is the second part of a national project hosted by the Centres of Excellence for Women’s Health. The project has an advisory committee, which includes women such as you. We hope to develop a policy framework and research agenda on rural and remote women’s health, which can be used by the federal, provincial and regional governments. The first phase was a literature review and roundtable discussion, late in 2001. Later phases will include a national conference in January 2003, followed by a final report to health policy makers and researchers. You are welcome to receive a copy of the final report. Please just leave your name and address on our mailing list.”
 - b. *Objectives of this session:* “Today we’d like to hear your thoughts about health, health care and its availability for you and your community, and other factors which affect your health. We won’t be making any decisions in this focus group and we don’t expect that we will all agree with each other about many of the points we discuss. But your comments will help us all to reach a better understanding of what health issues are important for women who live in rural Canada. We are interested in what you have to say about the availability and quality of health care services of women you know. We know that women are usually responsible for the health of all their family, but our questions today are not about your personal health or how you help care for family and friends. This afternoon’s focus group is a chance to hear your expertise and experience, which will be included in the findings of this research project. We are interested in your opinions of women’s health issues in your community.”
 - c. *Follow-up:* “The audio tapes from today’s meeting, a written transcript of the audio-tapes, a summary of today’s discussion and a summary of the written survey that you filled out will be delivered to the Research Steering Committee, and then combined with results from across the country. We will include your thoughts in the research report, which will be part of the national conference on rural and remote women’s health in 2003. Finally, a discussion paper with recommendations for a new research agenda and policy framework for rural and remote women’s health will be prepared after the Think Tank and submitted to Health Canada. As the focus group facilitator, I am responsible for preparing the summary report on this focus group without identifying any of the individual speakers and I will send you a copy to review before the summary is submitted to the Research Steering Committee. Please let me know if you would also like a copy of the final report and if you want your name listed in the report in our thanks to focus group participants. I need to have this in writing from you, as part of the consent form that you have already signed.”
2. The facilitator is responsible for obtaining signed informed consent to participate from each person in attendance, as per the attached consent form IN ADVANCE OF THE FOCUS GROUP. Facilitators should be aware of the parameters of the study (e.g. women will not be asked or encouraged to discuss personal health matters).
 3. The facilitator is responsible for ensuring that each participant completes and returns the attached demographic survey at the start of the session.
 4. The facilitator should pay attention to who is and who is not in attendance. (For example, how did people come to be there? How might the process of recruitment have excluded some women or points of view? What is likely to be present/absent in the discussion because of who is there?) This will then be reviewed with the Director of the Centre and

included in the focus group summary. Focus group participants should be invited to comment on this concern.

5. The facilitator should then guide the group through a discussion of the topics described below. Facilitators should remember that the discussion should not be limited to health care and service delivery, but should reflect a broad understanding of the social determinants of health, for example, education, economics, laws and policies, social services. It should also adopt both an appreciative and critical orientation, soliciting reflection on both what is and what is not working well for women and eliciting suggestions for achievable, positive changes. Facilitators must ensure that the questions listed are addressed, but other issues that emerge as relevant to participants should also be pursued and noted during the discussion.
6. The facilitator is responsible for ensuring that the session is both tape-recorded and accurately recorded on paper. Doing and/or checking the recording during the session should be the responsibility of a recorder rather than the facilitator.
7. The facilitator is responsible for ensuring a smooth flow to the session, including setting a positive tone, staying on topic, keeping time, taking appropriate breaks, encouraging full participation, and taking the time at the end of the group to thank the participants sincerely for their invaluable contribution of time and expertise, on behalf of all the women who are cooperating on this research project.
8. In some cases, face-to-face small group sessions may not be possible. In order to include women living remotely, the process of data collection may need to be modified through the use of telephone and/or video conferencing.
9. The facilitator is responsible for generating a focus group summary in two parts: one of the demographic data and the other of the discussion themes outlined above.
10. The facilitator should create and hold a master list of focus group participants drawn from the completed consent forms and should assume responsibility for sending copies of the summaries to those participants in a timely manner.
11. In consultation with the Centre, the facilitator should review answers on the consent form and, using her own good judgment, generate a list of potential invitees to the National Think Tank.
12. The facilitator should be prepared to provide the participants with follow-up support or appropriate referrals to community supports (if necessary). It is important to have at least one other person with the facilitator who is present and available to record the group discussion as well as to provide support to participants who could experience some difficulties/challenges that may arise during or as a result of the discussions.

Appendix G

Project Consent Form

SCHEDULE B – Consent Form

[NOTE to the Facilitator: Please try to distribute this form to participants in advance of the focus group and to follow up with a phone call in case there are questions or concerns.]

Dear Ms. _____.

Your name was given to me by _____ who suggested you might be willing to participate in a focus group we are conducting. The focus group concerns health issues for women living in rural and remote areas of Canada. These focus groups have been organized to allow us to hear your voice on the nature of the health services that you have accessed and your assessment of the quality of health care actually delivered over the past decade or so. This is a joint research project with Centres of Excellence for research in women's health in different regions of Canada that has been funded by the Women's Health Bureau of Health Canada. The research in this project is being administered by the National Network on Environments and Women's Health (NNEWH), based at York University in Toronto. Dr. Suzanne MacDonald and Marilou McPhedran are responsible for this study at York University.

The focus groups will be held on _____ from _____ to _____. We are asking for approximately a half-day of your time. You will be provided \$ __ to help pay for any costs associated with taking part in this study (e.g. travel and child care costs). This money will be given to you at the start of the focus group session, and will be yours whether or not you refuse to answer any questions or whether or not you complete the session.

The format of the focus group will be a short written survey with questions for you to answer and some additional questions for the group discussion that will help us understand your perspective on services in rural and remote areas, including social programs and social services related to women's health. We will be asking you to suggest changes to policies and practices that would improve your access to services and improve the services available to you, other women and girls. We will not ask you to discuss your personal health matters. You may refuse to answer any specific questions on the survey or in the group. You should also feel free to offer opinions and information on issues or subjects not raised by the facilitator that you think are relevant to this research. You are free to withdraw comments at any time.

After the focus groups are completed and the tapes are transcribed, a draft report containing summaries and unidentified quotes from the focus groups will be prepared. You will be given the opportunity to review the draft report from your group. Results from these focus groups will be compiled and summarized for the project's research committee, which includes community leaders, researchers and policy makers. Findings will also be summarized in a final report to Health Canada from this project and possibly in publications generated from the research. The contents of the final report will be communicated to local communities, health care professionals, and policy makers through a national "Think Tank" to be held in early 2003.

Please feel free to contact York University Human Participants Review Sub-committee with any questions or concerns - research@yorku.ca or telephone: 1 416 736 5055. Requests for copies of the focus group summary should be directed to Marilou McPhedran, Executive Coordinator, National Network on Environments and Women's Health, York University, 214 York Lanes, 4700 Keele Street, Toronto, Ontario, M3J 1P3. Email: marilou@yorku.ca or telephone: 1 416 736 5941; fax: 1 416 736 5986.

I hereby agree to be interviewed in a focus group on women's health in rural and remote areas of Canada, subject to the conditions listed above. I agree/do not agree to be identified by my name in the acknowledgments in the final report.

I am/am not interested in a possible invitation to the national Think Tank in early 2003.

Your Name [please print]: _____

Signature: _____ Date: _____ /02

Address: _____
