

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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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.

