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

Policy Recommendations

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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 Àrecommendations 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 underway[2]), 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 audience[4].

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.)

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 healthcare–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 development[13].

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 policymakers take account of local realties 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

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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 something[25]

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 "GBA" [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 interrelated 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 centres[38].

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.

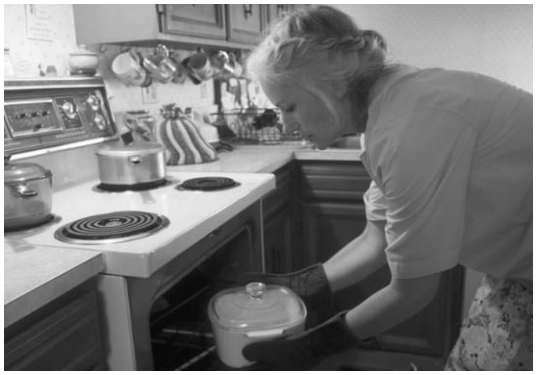
The three policies and eleven related actions recommended in this report do not represent many new tasks, but suggest new ways of doing old tasks. They highlight the need to take gender, place and culture systematically into account in policy making, which needs to extend far beyond traditional health 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 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.iwrp.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.