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

Introduction

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Project #1 of the National Rural and Remote
Women's Health Study

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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 Care[1], 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 Canada[2]. 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 researchers[3].

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.

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

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 Scotia[5]. 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.

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 health[6] 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 delivery[7].

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). Cargivers' 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.