

The Determinants of Women's Health in Northern Rural and Remote Regions

**Examples and Recommendations from
Northern British Columbia**

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Table of Contents

1. The Northern Secretariat: Setting an Agenda for Women's Health Research in Rural and Remote Regions	3
2. Research Methods	6
2.1 Data Collection	6
2.2 Data Analysis	7
3 Women's Health in Context: Northern, Rural and Remote	9
3.1 Why women's health?	9
3.2 Why is context important?	10
3.3 Finding appropriate definitions	11
4. Research Findings	14
4.1 Introduction	14
4.2 Health Policy	15
4.3 Health Care Service: Access and Delivery	17
4.4 Health Education and Information	20
4.5 Community Development	21
4.6 Research	23
5. Discussion: Implications of Research and Recommendations	25
5.1 Policy oriented research and recommendations	25
5.2 Practice oriented research and recommendations	26
5.3 Building community capacity	26
5.4 Sustained discussion and dissemination	27
5.5 Inter-sectoral communication	28

1. The Northern Secretariat: Setting an Agenda for Women's Health Research in Rural and Remote Regions

Research into the determinants of women's health has been an emerging field that is gaining ground in the Canadian health research arena. Decision-makers are beginning to realize the need for clear and evidence-based information on how the determinants of health affect women in particular.

In her inventory of women's health research in Canada, Yvonne Lefebvre has underlined the important differences between men and women with respect to the determinants of health: "Women, groups of women, will differ from men and indeed other groups of women in their health care needs, and this difference is due not only to biological determinants but to economic, social and psychological factors as well" (Lefebvre 1996). Accordingly, it seems logical that to be rigorous health research should consider the impact of gender as a determinant of health as well as shed light on gender-specific diseases and disease outcomes (Greaves et al. 1999). However, while this 'logic' is gaining support, it is far from normalized; women's health research has been consistently under-funded, thus perpetuating policy and practice that is biased towards males and inadequately addresses women's health issues.

In fact, as recently as the mid 1990s the Medical Research Council Advisory Committee on Women's Health estimated that only about five percent of Canadian health research funding was spent on women's issues, while eighty-five percent of Canadian women experience a female-specific health problem during their lifetime. Moreover, of the women's health research conducted in Canada until the mid 1990s, seventy percent of studies involved pregnancy, reproduction, cancer and infectious diseases of women, while social and mental health research accounted for only sixteen percent (MRC Advisory Committee on

Women's Health 1994). These figures are significant given the estimate that one in four women suffer from severe depression at some point in their lives and that depression has been strongly linked to social and economic factors for women (Linton 1996).

The outlook for women's health research has been improving, however. Health Canada's 1996 inauguration of a national Centres of Excellence program for women's health has ensured that a range of women's health issues reach a national policy agenda. Additionally, the transition of the coordination of health research and funding to the Canadian Institutes for Health Research (CIHRs) has the potential to include women-centred research into its interdisciplinary research paradigm (Greaves et al 1999). These initiatives are designed to provide evidence on which to base health care planning and policy development that is responsive to women.

But while gender has been recognized as an important and discrete determinant of health worthy of a national research program, the impact of gender on health care and health status manifests differently depending on how it is combined with other determinants. For instance, the interplay between gender and education or socio-economic conditions is complex and powerful. These determinants, in turn, are often influenced by geographical location. Thus, not only is it important for research to guide health care planning and policy development that is responsive to women, it is perhaps more important for it to be responsive to *women in context*.

In this paper we take a social determinants approach to discuss the health of women who live in northern, remote and rural regions. Specifically, we use examples from the work of northern researchers at the University of Northern British Columbia and the Northern Secretariat of the BC Centre of Excellence for Women's Health to discuss the health status and health concerns of women from a variety of sub-populations who share the common experience of maintaining

health and seeking health care in the north. We look at how the determinants of health operate in centres far away from southern metropolitan areas, and how these factors interact to compound their influence on health and capacity for health seeking behaviour.

Through this qualitative research, we draw from the experience of a variety of women, to synthesize and articulate a clear statement about what it means for women to maintain their health in Northern British Columbia: what are the challenges and opportunities that women face as individuals and as members of particular social and geographic communities in these northern, rural and remote areas? What is unique about these challenges and opportunities? And what will this mean to decision-makers and health care planners? This research paper discusses the issues facing northern women's health and offers recommendations for action to improve the conditions that often undermine it.

2. Research Methods

2.1 Data Collection

Data for this report was drawn from a variety of sources, the most important of which have been the research projects conducted through the Northern Secretariat of the BC Centre of Excellence for Women's Health at UNBC in Prince George. Through the findings of these projects, we have gained some understanding of the unique circumstances faced by a variety of women as they work to maintain their health and the health of their families and communities. Projects have explored topics in the health of Aboriginal women, lesbians, adolescent girls, women in mid-life and women who are chemically dependent, all of whom live in northern, remote or rural locations.

Along with the findings of these projects, we also conducted key informant interviews as part of our general outreach and communications campaign for the Northern Secretariat. We made initial contact by fax and telephone with women's centres and women-serving organizations in Prince George, Quesnel, Williams Lake, Vanderhoof, Mackenzie, Fort St James, Fort St John, Burns Lake, Smithers, Terrace and Prince Rupert. Women were asked to enumerate and elaborate on the main health issues for women in their communities, along with some of their recommendations to meaningfully address these issues.

In addition, two Northern Secretariat researchers followed up by undertaking community consultation meetings and focus groups in towns where we had been invited by women's organizations to introduce the Northern Secretariat and discuss the potential collaborative applications of its resources and expertise. These consultations followed the tenets of participatory and community-based

research in which the impetus for conducting research emerges from within the community itself. Researchers made site visits to a total of 5 northern communities including Quesnel, Williams Lake, Burns Lake, Smithers and Terrace. We intend to make more trips as closer ties develop with other communities' women's groups and women-serving organizations. We recognize that this research is a dynamic and on-going process and that different communities have different concerns and circumstances, which need to be addressed.

A third source of information for this paper was the data generated during a daylong meeting of the Northern Secretariat's Community Advisory Committee in Prince George. This committee comprises a group of around 40 women from within local, regional and provincial government, non-governmental organizations, post-secondary institutions, front line health services, women's groups and women-serving community agencies.

All data were collected through open-ended interviews, focus groups and discussions with key informants. While many research participants were identified because of their particular professional or volunteer work, we also conducted random convenience interviews with women at the various consultation sites. These data supplement, substantiate and indeed, enhance the statistical material available on women's health in the Northern Health Regions. Indicators from the Provincial Profile on Women's Health (1999) and reports from the Medical Health Officer in the Northern Interior Health Region are presented in chapter 3 to give context to the qualitative data.

2.2 Data Analysis

All primary data -- including interviews, field notes, faxed responses, focus group sessions, and comments -- were transcribed and treated as text. Each text was read as a whole to gain a sense of context and meaning; then coded for salient

themes that emerged. Analysis of these themes is informed by the hybrid critical-interpretive approach developed in medical anthropology and sociology (see Lock and Scheper-Hughes 1996, O'Neil 1994, Farmer 1998), as well as the contextual interpretive method developed by Corin and associates (1990 and 1995). At the heart of these analytical approaches is the importance of understanding the individual in social, political, economic and cultural context. These methods build from the personal accounts and the interpretations that women themselves assign to the health and health care concerns in their communities. At the same time, they take into account the fact that people's ways of thinking and acting are embedded in their social context and cannot be understood independently of this context (in this case, northern, remote and rural communities).

In this way, we can begin to uncover both the personal experience of health and health care issues, as well as understand the larger societal factors that influence it. As much as possible, analysis is supplemented with the women's actual words; text boxes of narrative material appear with our analysis of findings. These quotations form an integral part of the overall data presentation and are designed to be read as much for their singular power as for their significance to the analysis.

3 Women's Health in Context: Northern, Rural and Remote

3.1 Why women's health?

The work of population health research tells us that the health of populations is affected (or determined) by the relative access to the factors that enable health. These include: a clean physical environment, good social supports and low crime, good economic conditions, an enabling political environment etc. A gendered approach to these conditions is also revealing. It tells us that all members of the population do not equally experience these conditions since the factors that contribute to health and prosperity are not evenly distributed among the population.

According to the BC Provincial Profile of Women's Health (A Statistical Overview of Health indicators 1999), there are factors that are more likely to affect women than men and therefore result in lower health status among women. Moreover, just as these factors are not evenly distributed between men and women, nor are they equally distributed between groups of women themselves. Certain groups of women (such as Aboriginal women, lesbians, young women, elderly women, women with disabilities and women who are chemically-dependent or street-involved) may experience considerable marginalization that compounds or deepens the effects of these factors.

The factors include:

- Lower educational levels
- Multiple responsibilities of work and family

- Lower income and poverty
- Underemployment
- Social and geographic isolation
- Physical, sexual and emotional violence
- Community dynamics

These factors determine health status by influencing behaviour and constraining women's choices and access to health care, healthy foods and healthy lifestyles, for instance. They affect a woman's available time, resources, knowledge, self-esteem and physical capabilities to actively engage in healthy and health seeking activities for herself and her family. By so doing, these factors have a direct and generally negative impact on women's health status in relation to that of men (and sometimes other women).

3.2 Why is context important?

The factors that affect access to health resources (and ultimately the health status) of all Canadian women are compounded and intensified in more rural, remote and northern areas. In addition, there are further influential factors particular to these areas. Research and outreach conducted by (and in association with) the Northern Secretariat in northern BC has contributed to an understanding of these additional factors through our participatory data collection process.

They include:

- Isolation - physical and emotional
- Transient population
- Seasonal employment / fluctuating resource-based economies
- Harsh climate
- Low population (when used as basis for determining public investment in services)

- Substandard, limited or non-existent services
- Limited access (No accounting for transportation required or distance covered to deliver or access health services)

To understand the interplay of these factors as they affect the health of women in northern, rural and remote locations, we must first understand what constitutes 'northern,' 'rural' and 'remote'.

3.3 Finding appropriate definitions

In their call for a rural health research agenda, Watanabe and Casebeer (1999) acknowledge the theoretical difficulties in providing hard and fast definitions to characterize place.

Indeed, "rural is what people recognize as rural" (Troughton, cited in Watanabe and Casebeer 1999). Clearly, there is an urgent need for an understanding of 'northern' 'rural' and 'remote' that is at

"Northern" is defined by where you stand. There are people who don't think P.G. (Prince George) is north. They resent Prince George for getting all the resources for health while the rest of the region goes without. They look on Prince George the way Prince George looks on Vancouver.

*Key informant,
small community northwest of PG*

once flexible as well as universally meaningful. Only with such an understanding can we begin to work toward mitigating the health challenges and developing the healthy opportunities that this context presents (Watanabe and Casebeer 1999). This point is echoed in *Toward a Healthy Future: Second Report of the Health of Canadians* (1999), in which it is suggested that finding regionally relevant health indicators is a priority.

Acknowledging the semantic and ideological difficulties with concrete definitions, it is at least useful to consider some of the elements that characterize northern, rural and remote communities. Contrasting from Statistics Canada's definition of metropolitan areas, these communities are notably resource or agriculture based.

Their economies and social environment are generally not as diversified as those of urban areas. In addition, these regions will generally not attract the diversity of health and community services that are found in urban areas. These characteristics combine to create genuine regional disparity with respect to health indicators for women. This regional inequality is the context in which our research findings are located. Statistics from the Provincial Women’s Health Profile (British Columbia 1999) highlight the impact of this context on women’s health and will help to bring our research findings sharply into focus (tables 1,2).

Table 1: Highest rates for social determinants, by top three regions (in order from highest)

Social determinant	Regions with highest rates
Number of women on Unemployment Insurance.	<ul style="list-style-type: none"> • Okanagan • Peace Liard • Northern Interior
Rates of children in care (per 1000) <i>Note: this corresponds with regions of lowest socio-economic status measured by rates of poverty, unemployment, level of education.</i>	<ul style="list-style-type: none"> • Northern Interior has highest rate (14.5) • Cariboo • Northwest
Criminal code offenses (per 1000)	<ul style="list-style-type: none"> • Northwest (23.3) • Northern Interior • Peace Liard
Spousal assault (per 10 000)	<ul style="list-style-type: none"> • Peace (10) • Cariboo • Northwest / Northern Interior •
Sexual assault (per 10 000) <i>Note: estimates are that 39% of Canadian women have experience sexual assault, while only 6% of assaults are ever reported to police.</i>	<ul style="list-style-type: none"> • Northern Interior (28-34) • Peace Liard • Northwest
Hysterectomy (per 1000) <i>Note: Lowest rate in Vancouver (2.8). Northern women 3 times more likely to have a hysterectomy than women from southern urban areas</i>	<ul style="list-style-type: none"> • Peace (7.5) • Northern Interior
Mental health (per 1000) <i>Note: 20-30 % of BC population has sought mental health resource. 60 % of clients are women. Rural and northern regions of the province have higher rates of mental illness than urban areas</i>	<ul style="list-style-type: none"> • Cariboo (10) • Coast Garibaldi • North West

Table 2: Additional Indicators of Women’s Health in Northern, Rural and Remote Areas	
Single Parent Families <i>Note: 83% of single parent families are headed by women.</i>	<ul style="list-style-type: none"> • Highest rate in Northern Interior
Respiratory Conditions	<ul style="list-style-type: none"> • Northern Interior, Peace Liard, Northwest and Cariboo regions have highest rate of respiratory disease • Northern Interior, Cariboo and East Kootenay regions have most particulate matter in air (25-35 pm10)
Reproductive Health	<ul style="list-style-type: none"> • 31% of children with disabilities were because of alcohol or drug abuse in Northern BC • Northwest and Peace Liard regions have highest teen pregnancy rate (68/1000) • Northwest region has highest % of adolescent girls engaging in unprotected sex (32%)

To be sure, there are also definite health advantages presented by northern, rural and remote areas -- notably the opportunities for sport and recreation, easier access to nature, food security and proximity to fresh food producers, to name a few. However, it is clear that northern, rural and remote regions rate comparatively poorly on nearly all measures of health indicators in British Columbia. Health care is compromised by distance, environment, travel costs and by limited or poor services to begin with.

The primary research undertaken for this report, along with data drawn from other NS projects, provides personal depth to these statistics. This research points to an inferior health care system in which northern, rural and remote women's health is under-served and often poorly understood.

4. Research Findings

...What's more appalling is the deterioration in places like Prince George, Terrace, places like that -- their inability to get core services, like general surgery, orthopedics and obstetrics. That's a problem of the regionalization process. It's really left these people without the resources they need. I was in Terrace - that hospital is about a 75 bed hospital by design. The government admits by their population they should run a 45 bed hospital and yet they're only running 20 beds in Terrace. That's an appalling way to look after people in these parts of the province.

...There's no doubt that for the higher technology, if you're in northern BC, you have a more difficult time getting to the technology.

*Dr. Ian Cortis, President, BCMA
Almanac Radio Show, CBC, Dec. 8th, 1999.*

4.1 Introduction

Having statistically sketched the social and economic context that shapes and characterizes northern, rural and remote health care and conditions, we now turn to qualitative research findings that help to expand and interpret this picture.

This section presents an overall analysis of research carried out in small towns, First Nations communities and larger centres across the north from August 1999 to March 2000. The themes presented here are both extrapolated women's concerns and drawn from their own recommendations for change. In some instances, women addressed 'policy', 'services' or 'education' or 'community development' directly. In other cases, interpretive analysis of women's concerns revealed the categories to which they correspond best.

4.2 Health Policy

In the narratives we collected women were very clear that health care policy formulated in the south does not resonate with northern, rural or remote realities. It does little to recognize or address the barriers they face. In particular, determining the allocation of scarce health resources by population (population-based funding) has been identified as a major barrier to health care by women who work in the health care sectors as well as by women who are health care consumers. When funding depends on numbers rather than need, the populations in northern, rural and remote communities are at greatest risk. What gets cut are the programs not identified as priorities: health promotion, women-friendly health access centres or resources.

To resist this, the policy of health authorities, legislation, and health promotion activities need to take into account the groups and the health risks prevalent locally. Members of Community Health Committees (instituted to support the health care regionalization process) tell us that their work needs to be respected

Stop MSP from funding doctors for services that are or can be provided by a nurse. We're paying doctor's rates and using valuable time letting doctors perform services that nurses are doing in remote places where there are no doctors. That's a waste of resources. Anything done by a nurse anywhere in the province should be done by a nurse everywhere. If nurses are good enough to do 'medical acts' in remote places, we should be good enough to do it in anywhere. There is a much better way to make use of doctors' time and skills, especially here where there aren't enough of them!

Nurse, Prince George

and incorporated into a meaningful planning process that address all sectors including a diversity of women's interests.

For instance in a study conducted by NS and community researchers, First Nations women express their concern that perceptions of racism and poor understanding of Aboriginal women are causing many members of their communities to avoid health

care services, especially for female preventive screening activities. As a solution, these women call for female nurses to perform Pap tests for instance (Browne, Thomas and Fiske 2000).

Many northern nurses to whom we spoke echoed this need to reorient tasks, but emphasized another reason for doing so: more efficient and logical use of time and resources. In most regions, such a transfer of duties would require enabling legislation that allows nurses to take on some activities normally performed by doctors.

In addition to reconsidering duties and funding methods, all of the material informing this analysis emphasized the need for more sensitivity and awareness of the issues faced by diverse groups of women in northern, remote and rural regions. For instance, among many lesbians and adolescent women and women living with HIV, issues of confidentiality were raised repeatedly. Small town environments may be more personable, but when anonymity is personally crucial, such a social environment is emotionally devastating and in some cases, unsafe (Anderson et al., in press, Terrace Women's Centre, forthcoming).

Similarly, the personal issues faced by women who are street-involved or substance abusers need to be understood within the context in which they live. In a northern, remote or rural environment, these women are highly visible, and thus open to stigmatization, stereotyping and both physical and systemic abuse. Moreover, the vulnerable economy, driven by male-oriented resource jobs offers these women little opportunity to transcend their situation (Smithers AIDS research team, forthcoming). Health policies aimed at northern, rural and remote areas therefore need to develop meaningful methodologies for including women from all sectors in planning and decision making. The boards of front-line health agencies often provide for client input. However, this does not always translate into broader government initiatives and policies that are flexible

(according to local realities rather than bureaucratic schedules) and responsive to local women and the agencies that serve them.

4.3 Health Care Service: Access and Delivery

Data collected for this synthesis also makes it clear that women who live in northern, rural and remote areas are generally not happy with the health services available to them. The concerns raised by women fall into at least three rough, but related categories. These are: 1) *Getting* and keeping health care providers in northern, rural and remote locations (recruitment and retention), 2) *Getting to* those providers (physical and geographic barriers) and 3) *Getting along with* those providers (emotional and social barriers).

Recruitment and retention:

Rural, remote and northern regions have difficulty attracting and retaining qualified and experienced health care providers. Quite simply, there are few incentives to work here. The client base can be very small in some communities, which makes it uneconomical for physicians' practices. On the other hand, regionalization has also meant that in larger centres like Prince George, physicians and resources are seriously overburdened. Thus depending on location in the north, health care providers are either faced with too few clients to support a practice, or too many to ensure quality service delivery. Designing attractive and competitive salary models (rather than fee-for-service) that allow for time-sharing schedules should be considered to help recruit and retain quality health professionals.

I went to my doctor and he knew less than me about my condition - I'd had a really good relationship with my doctor in Victoria. Now I wonder whether to trust his competency.

Newcomer to the north

These realities are poignantly illustrated by the personal stories of their repercussions. In our research, we learned of one community that was

You just get to know someone, trust them and think you have a great health care provider and then, boom - they leave.

Student, in class presentation

galvanized around the lack of access to obstetrical care. The only doctor delivering babies offered this service only two weeks a month since he could no longer maintain his 24 hour a day, seven days a week on-call schedule. As a consequence, pregnant women nearing delivery were forced to travel to other communities to deliver their babies, away from the support of family and friends. The financial and emotional burden of this medical evacuation was compounded for mothers receiving social assistance. To social services, delivering in another community is not considered an unforeseen medical circumstance and therefore is therefore ineligible for compensation of personal costs incurred.

Physical and geographic barriers:

The above story also serves to illustrate the health impact of isolation and distance, which is especially potent when combined with low income and thus lack of reliable transportation and child care. Thematic analysis of collected data reveals that isolation, geography and climate, all influence women's access to adequate health care services in the north.

Not only do you have to worry about how you're going to get to town, and the cost of the travel, and is the road safe and where you're going to stay, there's also who's looking after the kids while you're gone. Then you get there and the doctor is off at an emergency and they've changed your appointment. You end up having to stay and making long-distance arrangements for the care of your family.

Focus group of out of town respondents , including aboriginal women

For instance, travel costs to specialist services have made it problematic for families to seek appropriate care, and these costs increase in more remote areas. There are no travel allowances and the population base is considered inadequate to support specialists or high technology diagnostics even in the larger northern centres.

Consequently, individuals subsidize the cost of health care services with their own time and money. As several research participants expressed it: in the north, there is already a two-tier medical system, simply because northerners have no other choice (for necessary and time-sensitive treatment) but to pay for it south of the border. For those who cannot afford it, going south of the border is not a choice. Even for those who can afford it, throughout most of the year there is the threat of missing a coveted appointment with a specialist because the plane was grounded for snow!

Emotional and social barriers:

There are other barriers that are experienced more often by First Nations women or immigrants who may not share the same language, cultural norms and sometimes socio-economic status as the health care providers. First Nations women described

Racism is a huge problem in hospitals in the north. the stereotypes hit you as soon as you walk in.

*Aboriginal respondent,
Prince George*

interactions with the mainstream health care system that are so negative and invalidating that they are discouraged from seeing health care professionals altogether. This practice can thus reinforce, rather than alleviate, poor health status (Browne 1997, Browne, Thomas and Fiske 2000).

There is only one medical building here. It has all the doctors. So there is no privacy.

Terrace report research

Lesbians participants reported similar experiences of discrimination and invalidation based on their sexual orientation (Anderson et al. 2000). Not only were lesbians once labeled sick and degenerate within the medical model (see also Terry 1999), numerous lesbians still find it is exceedingly difficult to find fair and equitable physicians who do not view them as

'other.' Moreover, just as with the lack of cultural awareness, without public education of lesbian health issues, many are discouraged from consulting

physicians and have a limited ability to contact multiple health care services and support groups.

To be sure, negative and invalidating interactions with the health care system are common to urban areas as well. The difference is that for women in northern, rural and remote areas, accessing another health care provider or alternate medical resources is nearly impossible. Consequently, a common outcome

for too many women is to avoid health care services entirely, to access them only in acute or life threatening circumstances or to live with chronic conditions without treatment or support. This leaves women with less choice and more responsibility to maintain their health and the health of their families (see also Crook 1995). This lack of choice is particularly constraining when women with very sensitive medical issues such as HIV or substance abuse cannot find a supportive provider, or when their confidentiality is compromised simply by being seen to visiting a particular clinic or service provider.

Women aren't going to walk through doors marked "substance abuse counselor" or "sexual assault centre". Not in a small town. Everyone would know in no time.

Community Health nurse

4.4 Health Education and Information

We had a lot of education to do in the community about women's health issues but we made a difference and we have a really strong women's community now.

Key informant interview, Williams Lake

Because of the scarcity of health resources in the north, there is less access to medical knowledge and a lack of variety in available information. Perhaps because of this lack in public

resources, we encountered many self-motivated women determined to inform themselves and each other on health education. There was a strong call from a variety of these women and their various sectors to develop collective women's

health resource centers where information on health issues, alternatives and sources of support could be obtained.

Indeed, due to isolation and lack of resources, most women in northern rural and remote communities have added responsibility for self-care and health-maintenance. For this reason, public health education and health promotion is an important investment in the region. Women are thirsty for any opportunities that provide such education and promotional information, as evidenced by the success of the recent Women's Health in Mid-Life project undertaken throughout the Northern Interior Health Region.

There is staff burnout in agencies. There is little opportunity, time, money, resources to train staff, especially in with sensitive or difficult issues.

*Administrator,
Front line health agency.*

From their perspective, respondents from within the health care sector also emphasized the need for professional education and information on women's health and an awareness of the issues that influence it. They suggested opportunities for professional development that would sensitize providers to the interrelated

and contextualized social, emotional, economic and political complexities of women's health care. Better understanding could lead to less frustration, more efficient and appropriate methods, better patient relations and compliance and less provider burn-out.

4.5 Community Development

The characteristic transience of northern populations and the seasonal and fluctuating nature of resource or agriculture based economies of northern, remote and rural areas all have a profound impact on the health of women, their families and communities. Women whose families depend on the restricted economy of the north experience cyclical incomes and stresses that affect health conditions.

Women report increased incidence of domestic violence, depression and stress that coincides with this seasonal cycle of unemployment.

You see that a lot [denial of illness]. My mother in law is a prime example, she would be almost dying but would keep going because there was no-one else if she stopped. "

*Focus group participant,
north of PG.*

For many women, these personal circumstances are further complicated by the politics of place. In particular, the "mythology" of the north prevails. A sense of independence and the frontier spirit figures prominently in many families. Often this contributes to the denial of the seriousness of health concerns and a glorification of the social circumstances which undermine women's health, rather than recognizing the problem and working to address it systemically and socially.

Acknowledging the predominance of this attitude, many research participants pointed to the important opportunities for health promotion activities in northern rural and remote locations. Some suggested that the health issues particular to these areas are best addressed through a health promotion model that emphasizes community development and the sharing of local knowledge.

We need to network with the community in order to build meaningful inter-agency relationships and support realistic health goals

Health care provider

In particular women whose work or personal circumstances regularly bring them into contact with "the system", expressed the need for increased communication between agencies and sectors (health and social service for instance). As one activist in Burns Lake asked: where is the border between helping a women and constraining her autonomy when it comes to health and social programs? More meaningful communication between sectors could lead to greater efficiency so that a woman who needs help will not have her life dominated by this "system."

Instead, those sectors can also focus on changing the environment that has caused her to need help.

4.6 Research

With the growing recognition of the social, economic, political and cultural determinants of health in Canadian health practice and research, women are increasingly calling for their health needs to be addressed beyond the domain of reproductive health. Thus an integrated

We're tired of being researched. We are being researched to death. Women are dying while you do your research.

*Rural and Remote Health
Conference participant*

model for health research should acknowledge the interaction of physical, social and mental and environmental health needs as well. As the World Health Organization has long emphasized, health is more than just the absence of problems or disease. It is a resource for everyday living - a measure of the individual capacity to cope with life circumstances and the environment (WHO, 1986).

While it is anticipated that an agenda for women's health research will now form and integral part of the Canadian health research landscape, the potential for flexibility and diversity in such an agenda is only beginning to be addressed. Just

We want more than research. We want to really be involved. They came to do a community consultation here two years ago... We never even saw a copy of the report.

Focus group, Quesnel.

as white men have historically dominated health research, white, middle-class, urban, non-disabled women have been the norm in feminist research. There remains a gap in research data for aboriginal women, women of color, lesbians, women across the lifespan, women with disabilities, women who are or have been street-involved. (NAC 1995, Dion-Stout 1997).

The research projects, interviews and consultations undertaken by the Northern Secretariat has uncovered issues *particular* to each of these groups. *Common* among them, however, was the call for meaningful, useful, respectful and above all, participatory research. The everyday concerns of living, working, caring for families and staying healthy in northern, remote and rural environments are too demanding for women to sustain health research that does not promise results and opportunities for participants.

Consequently, we learned that the research agenda for northern, remote and rural communities must be specific and principled. It must be defined and guided by the principles of sustainability, community development, capacity building, public participation and action. This point has been emphasized in strategic planning process for northern, rural and remote health research in general (Watanabe and Casebeer 1999). Given the findings presented here, the point seems even more salient for research with women living in these communities.

5. Discussion: Implications of Research and Recommendations

The synthesis of data presented in this paper has served to illustrate some of the realities that shape and constrain the health of women in northern, rural and remote areas. While this is by no means an exhaustive account, it does allow us to point to possible strategies and make some recommendations.

5.1 Policy oriented research and recommendations

From the point of view of policy makers, all evidence collected through women's health research must be specific and focused in order to be applicable to policy change. As the president of the BC Medical Association articulated it in a radio interview, “the aging population keeps getting used rhetorically as a reason why we just need more of everything. That’s not true. You need more specifically of the things that are used by the aging population, because if you don’t provide those, they’re going to start placing strains all over the system” (CBC Radio, Dec. 8, 1999). Similarly, women researchers are clarifying the issues that affect women specifically or in specific ways. They know that solutions must be clear and focused even while their impact will be felt holistically.

To assist and support the uptake and application of women-centred and regionally-focused evidence, the Northern Secretariat has already succeeded in securing the support of the provincial Minister’s Advisory Committee on Women’s Health. MAC has recently announced that the area of rural and remote women’s health in BC will become its major focus for research and lobbying. An appropriate follow-up to this announcement would be to establish an informational link between MAC and the Northern Secretariat through mutual representation on committees.

Recommendation:

That the Northern Secretariat prepare a formal report for the BC Ministry of Health identifying direct policy changes that would improve health status for women in the northern, remote and rural BC, based on evidence gathered through research projects.

5.2 Practice oriented research and recommendations

Beyond the immediate contributions of both community and university, there are steps that governments can take to make health research more relevant to in the lives of women. One recommendation is for further research into mechanisms that can better combine the strengths of both mainstream and complementary therapies in a mutually supportive rather than adversarial way. Many women with whom we spoke indicated that they have turned to complementary medicine out of necessity (whether because it is geographically or emotionally more accessible).

Recommendation:

That the Northern Secretariat undertake research initiatives on the efficacy of current programs and services and the existence and efficacy of alternatives.

5.3 Building community capacity

If policy or practice oriented research is going to have any meaningful impact or application in the lives of northern and rural women, these women must be involved in its development. For women to meaningfully participate in the research process, they must understand its demands as well as its potential. In our work, we have encountered the resilience, strength and wisdom that already exist among women of the north. Based on what is already in place, the Northern Secretariat can help to harness the local knowledge and concern, and to turn it into models of participatory health research and program evaluation, community

action plans and needs assessments for instance. In this way, we can continue to help foster local capacity while providing a research product of broader interest to planners and policy-makers.

Recommendation:

That the Northern secretariat mandate include community development activities that will enhance local capacity to participate in, initiate and analyse research projects.

5.4 Sustained discussion and dissemination

While MAC's newest focus has meant good news for women from northern, remote and rural communities, this study has demonstrated the need for a regular forum for the continued and shared discussion of the health issues that emerged in our overview. Therefore, we suggest investing in the sustainability of the NS Community Advisory Committee. In its current capacity, the CAC informs the mandate of the NS, however as a vehicle for discussing and disseminating information on women's health, the CAC itself is an important legacy to the social infrastructure of northern, rural and remote areas.

To be useful, research findings must be both widely and strategically disseminated. The CAC could ensure this by organizing annual panels or workshops, a conference or a summer institute that would combine dissemination of existing research, networking to develop new research, and training in research methods for community researchers.

Recommendation:

That the Northern Secretariat pursue mechanisms and funding to expand the Community Advisory Council to a regional wide representative body.

5.5 Inter-sectoral communication

Finally, and perhaps most significantly from the point of view of government, we suggest interministerial and intergovernmental collaboration on women's health. Women themselves, along with researchers and analysts, have contributed to a considerable broadening of the definition of health. While it is now widely recognized that several diverse factors contribute to health, structures of governance and policy continue to circumscribe it within a singular portfolio: a federal or provincial Ministry of Health. Consequently, discussion and policy around health develop in the absence of input from those who deal with its true determinants: economic security, environmental sustainability, family and social services, etc.

Recommendation:

What is needed is an intergovernmental and interministerial mechanism for meaningful sharing of knowledge, skills and insights. This might take the form of a conference that brings together the federal government's Rural Secretariat, Status of Women Canada, federal and provincial Ministries of Health, the Women's Health Bureaus (federal and provincial), the Ministry of Women's Equality, ministries with social service, employment and economic development portfolios, and the Northern Commission. These stakeholders respectively produce individual initiatives designed to improve the lives of women, yet there is little awareness or understanding of either their combined effects or their combined potential to influence women's health. A concerted effort to create policy from the integrated perspective of these determinants of health is a more progressive, realistic, and in the long run, efficient way to approach issues in women's health. Where health resources are as inaccessible and scarce as they are in Northern BC, the positive impact of such integration and efficiency would be far-reaching.