

Women's health in northern British Columbia: the role of geography and gender

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Introduction: Although research interest in women's health is growing, much of the literature does not sufficiently describe the importance of geography and gender for the health of women. This qualitative study explored factors in the northern Canadian context that influence women's health by interviewing 25 women in northern Canada.
Results: Findings reveal that the importance of the northern context for women's health can be attributed to the north's historical location, and its physical, sociocultural and political environments. The northern context contributes to the marginalization of northern women that is characterized by isolation, limited options, limited power and being silenced.
Conclusion: Health care practice and policy must attend to contextual as well as individual and sociocultural factors if women's health is to be advanced in northern settings.

Introduction : Même si la recherche sur la santé des femmes suscite de plus en plus d'intérêt, une grande partie des publications ne décrivent pas suffisamment l'importance de la géographie et de la sexospécificité pour la santé des femmes. Au cours de cette étude qualitative, les chercheurs ont analysé des facteurs du contexte du nord du Canada qui jouent sur la santé des femmes en interviewant 25 femmes du nord du Canada.
Résultats : Les constatations révèlent que l'importance du contexte du Nord pour la santé des femmes peut être attribuée à l'emplacement historique du Nord, ainsi qu'à ses environnements physique, socioculturel et politique. Le contexte septentrional contribue à la marginalisation des femmes du Nord caractérisée par l'isolement, les options limitées, le peu de pouvoir et le fait qu'elles sont bâillonnées.
Conclusion : Les politiques et les pratiques sur les soins de santé doivent tenir compte des facteurs contextuels autant qu'individuels et socioculturels si l'on veut promouvoir la santé des femmes dans le Nord.

INTRODUCTION

Various factors and conditions, labelled determinants of health, and the complex interactions among these determinants are now known to have a profound effect on health.[1] Determinants of health include 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, healthy child development, health services, gender, and culture.[1] In this paper we discuss how geographic location affects women's health in a northern Canadian setting, with emphasis on the determinants of physical and social environments and gender.

The physical environment includes factors in the natural environment such as air and water quality, geography and distance, as well as factors in the human-made environment such as community and road design, and housing and workplace safety.[1] Reports about the effects of the physical environment on health in northern Canada[2,3] tend to focus on the natural environment with minimal attention to the human-made environment. There

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is limited knowledge on how the natural and human-made environments influence the health of women.

Social environments include societal norms and values, social stability, diversity, safety, good working relationships and cohesive communities.[1] Social factors such as low availability of emotional support, low social participation, and social exclusion limit life prospects, supportive networks, life chances and self-esteem; these factors prove damaging at all societal levels, from the individual through to the community.[1,4] Little is known about the nature of social environments in northern settings and the effects of these environments on women's health.

Gender is a social construct based more in human culture than in biological difference.[1] Gender affects health through the "array of socially determined roles, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis" (p. 17).[1] Although minimal research has focused on the health of women in isolated settings, research that exists indicates that these settings create challenges for women's health. Health services provided by family physicians, public health nurses, and specialist services such as obstetricians either do not exist, are intermittent, or are limited in range and quality.[3,5,6] Issues of confidentiality and anonymity exist when women seek care in small communities, and lack of transportation to care elsewhere exacerbates access problems. The values and priorities of male physicians, the dominant care providers in small communities, often influence the practices of female physicians, nurses and other health care providers, thus compromising women's access to the type of care and provider they desire.[6] Because traditional roles of wife and mother are favoured in small communities, education and career opportunities for women are limited.[7–10] In addition, small communities have limited employment opportunities and access to high paying positions in the resource-based industries are largely denied women.[11] Although northern women may obtain employment, employment is often not permanent, respected, adequately remunerated, or is not work in which they can take pride.[12] These challenges not only limit women's health, they also compromise women's life chances.

Research indicates that understanding the contexts of women's lives is crucial to the advancement of women's health.[13–15] While studies employing quantitative research methods identify some aspects of northern women's health, in-depth qualitative understanding of the effects that a northern place has on women's health is needed. The study on which this paper is based used a qualitative research design to examine how women perceive and maintain their health within northern British Columbia (BC), Canada. This study seeks to enrich understanding of the northern social environment so that social support, which is key to northern women's health,[13] can be advanced. This paper describes one aspect of the study, namely factors in the northern context that influence women's health. Findings of the study that describe how women address factors to maintain their health in northern BC are reported elsewhere.[13]

Methods

This study was conducted in northern BC, where most communities depend upon a single resource-based industry such as forestry, mining or fishing. The largest city in northern BC, Prince George, has a population of 80 000; however, most communities are much smaller — some contain fewer then 15 residents — and are typically remote from each other and from larger centres. Many people in northern BC live on isolated farms and ranches.

The study was conducted using a feminist grounded theory method. Feminist grounded theory seeks to generate a theory that explains how a central problem for women is resolved or processed.[16,17] The feminist grounded theory research process attends to tenets of feminist research such as respect for participants, avoidance of oppression and usefulness of findings. In addition, feminist inquiry considers not only women's individual voices and experiences, but also larger sociopolitical, economic, and cultural structures that influence women's lives.[18]

Ethical approval for the study was obtained from the University of Alberta and the University of Northern British Columbia. Women were recruited from 2 health regions in northern BC. Inclusion criteria were: able to read and write English, over 20 years of age, and have lived in northern settings for a minimum of 2 years. To reach women in remote areas, recruitment strategies included radio and television interviews about the research, publishing recruitment information in community newspapers and posting study information in feed and tack stores, grocery stores, and clothing shops in small communities. Recruitment information included the purpose of the study (identifying how living in the north influences women's health), the inclusion crite-

ria and the study procedures. Recruitment efforts were very successful; over 100 women from throughout the 2 northern health regions telephoned, emailed or applied in person for the research.

In compliance with the feminist grounded theory method,[16,17] the final sample of 25 women was selected using purposeful and theoretical sampling. Initially, women were selected to represent diverse geographical locations (cities, towns, villages, ranches, farms), ages and cultural backgrounds. In theoretical sampling, study participants are selected throughout the course of the research for their ability to enrich and enlarge upon themes and codes emerging from the ongoing analysis. Theoretical sampling also ensures that participants will provide contradictory as well as confirmatory evidence.[19] The recommended sample size for a grounded theory study is approximately 30 to 50 interview instances.[20] In this study, 75 interview instances were included (25 women, each interviewed 3 times).

First and second interviews were 1.5–2 hours in length and were tape recorded. Third interviews, which were about a half hour, were not tape recorded, but comments were noted and incorporated in the analysis. First interviews occurred in the women's homes and work places. Due to weather, distance and time constraints, three-quarters of the second interviews and all third interviews were conducted by telephone.

In first and second interviews, women were asked open-ended questions about how they maintained their health, how the northern context influenced their health, and how northern BC could be healthier for women. After each interview, each participant was provided with a summary of the analysis of her interview and invited to comment in a subsequent interview on the accuracy and completeness of the analysis and on emerging categories and relationships. These comments were incorporated into the data and analysis of the study. Third interviews provided each participant with an opportunity for final commentary on the emerging theory.

In addition to interviews, observations about geographical terrain, distance, road conditions and isolation were collected during travels to farms, ranches and small northern communities. Written documents such as maps, tourist guides, locally produced histories, newspapers and northern poetry enriched understanding of northern history, culture, and social and physical environments.

Data were analyzed using the constant comparative method of grounded theory.[16,19] Data analysis in grounded theory research occurs concurrently with data collection[16,19] Each interview tape was transcribed verbatim and then reviewed while listening to the tape to determine accuracy and to facilitate analytical thinking. With the assistance of the NVivo computer program, transcripts were then reviewed line by line and coded for categories. NVivo is designed for qualitative researchers who need to combine subtle coding with qualitative linking, shaping, searching and modelling. It is ideal for those working with complex data and for deep levels of analysis. Emerging categories were constantly compared to determine their nature and significance and their relationships to each other.[19] Second and third interview questions clarified, elaborated and verified emerging categories, subcategories and relationships. Consistent with the grounded theory method, data from the literature relevant to emerging categories and relationships also informed the analysis. Data collection and analysis ceased when no new information or insight was forthcoming about the categories and their relationships, and when the theory seemed to be elaborated in complexity and clear in its articulation of the central problem and the process used to address it.[19]

Results

The findings of this research revealed that northern women develop a process of resilience to address the central problem of vulnerability to health risks.[13] This vulnerability was influenced by the northern context and women's marginalization within that context. In this paper, we discuss findings regarding the northern context and effects of this context on women's health.

The sample

The final sample consisted of 25 women of diverse backgrounds (Table 1). The majority of the women were 20–60 years of age, had post high school education, were married or living common-law, employed full-time or part-time, in good health and of relatively adequate financial status. They represented various geographical locations including cities, towns, villages, a community with under 20 residents, ranches and farms. Culturally, one woman was Métis, one woman was First Nations, 2 were of Asian background, 3 were of European

background, and the remaining 18 participants claimed Canadian Caucasian heritage. Each woman selected a pseudonym and these pseudonyms are used throughout this article when referring to study participants.

The northern context

The importance of the northern context to women's health can be attributed to the north's historical location, and its physical, sociocultural and political environments.

Historical location

Because of the severe climate, social isolation and relative absence of material resources, indigenous peoples and early settlers needed to be self-reliant, hard working, and able to live off the land.[21] These attributes survive in the north today. Casey, a ranch woman in the study, noted that women are still expected to carry on the tradition of living off the land by having large gardens and canning and preserving food. Other historical elements include a heritage of control of the north by outsiders, impoverishment of indigenous populations, emphasis on rapid, profit-oriented resource development and exploitation, and limited ability of local northern residents to control their destinies.[21] Fluctuations in the economy, globalization of markets and the political view of northern settings as primarily locations for resource extraction have created and perpetuate northern communities of insecurity and transience.

Because of resource-based employment opportunities, northern regions have been comprised largely of relatively younger populations who come north in search of work. When resource-based economies fluctuate and jobs are lost, young people move elsewhere in search of employment. Consequences of this demographic shift include inconsistency and decline in the quantity, quality and nature of goods and services in northern communities, and instability, insecurity and the under-resourcing of northern communities.

Table 1. Sociodemographic information on the 25 study participants

Variable	No. of participants
Age	
20–30	2
31–40	5
41–50	6
51–60	7
61–70	2
71–80	2
81–90	1
Education	
<Grade 9	2
Grade 9–13	8
Trade/Technical diploma	8
University undergraduate degree	6
University graduate degree	1
Marital status	
Married or common-law	14
Divorced / Separated	5
Widowed	2
Never married	4
Employment	
Currently employed	
Full-time	10
Part-time	7
Not employed outside the home	3
Retired	5
Rating of health	
Good	16
Fair	8
Poor	1
Annual household income, $	
<10 000	2
11 000–20 000	6
21 000–30 000	1
31 000–40 000	5
41 000–50 000	2
51 000–60 000	4
61 000–70 000	1
71 000–80 000	2
>80 000	2

The physical environment

Climate, distance and geography, pollution, and dependence upon resource-based employment were noted by women in the study as problematic. Long periods of cold weather exacerbate physical problems such as arthritis and make getting around difficult, especially for elderly women and women with physical disabilities. Christine, a woman who had lived 23 years in the north, noted that winter weather results in being "housebound . . . more depression and anxiety." Several women noted that the long, cold, dark winter season also contributes to the depressive condition termed seasonal affective disorder. Leah, a young northern woman, stated, "Winter is so damn depressing here. Seasonal affective disorder syndrome — half the town has it." Gill[8] noted that, especially in February, the incidence of mental disorders (known as 'cabin fever' or 'housewife psychosis') among northern women reaches its peak. Travelling in the north is time consuming, expensive and hazardous. Long distances, poor road conditions and large logging trucks make travel dangerous, especially in winter. Barbara

summed up many northern women's perspectives when she stated: "I'm really stranded here for 6 months of the year. It's my own fear of driving on winter roads."

For some women, though, the physical environment provided accessible and affordable opportunities for outdoor recreation, such as skating, hiking and swimming. These activities were valued if women had good physical and mental health, and the time and finances to participate. Women who enjoyed solitary activities could better cope with the isolation engendered by northern distance and winter weather.

Women in this study were concerned about pollution in northern environments caused by resource-based industries such as pulp mills. Jocelyn lived near a pulp mill town and perceived that "a mill town is not the healthiest place to live," and Mary observed that "living here in Prince George is the only time I've had asthma. . . . I really feel that it has to do with the pollution due to the pulp mills." Still, women may be reluctant to complain too loudly about the pollution because it is the resource-based industries that provide jobs and income for their families.

Although the north provides resource-based employment, the precarious nature of the employment due to decline in resources and international influences can result in unstable communities, decline in the diversity and quality of goods and services, and threats to community security and sustainability. Casey, a ranch woman, noted that, as a result of a mine closure, "the population has gone down. . . . The elementary school may close. The fall fair's no longer held." Diminishing employment within the north and consequent seeking of jobs outside of the north weaken the community because fewer people are available to sustain it. This affects women's quality of life, as women often assume — or are designated — the responsibility to deal with contexts of diminishing goods and services.

The sociocultural environment

Overfamiliarity, outsider status and lack of resources were the primary negative sociocultural factors noted by women in the study.

In spite of — or perhaps because of — the vast distances between people and communities, overfamiliarity can lead to lack of anonymity and compromised confidentiality. Over-familiarity occurs when people in small isolated communities become visible and identifiable, with the result that unduly intimate and personal liberties may be taken and presumptions made.[22] Park explained how being known can interfere with women's abilities to access services:

> If somebody's car was parked at the women's centre . . . people kind of assume that she's gone there to get help. . . . When you're going to see a counsellor, you may be seeing her in other social functions as well . . . so women probably feel their confidentiality is at stake. . . . In bigger cities, nobody knows where you're going for help.

Being an outsider in a community can also be a problem for women in small northern communities. An outsider is someone who is different from the dominant community culture and characteristics, and is unconnected to family or other personal ties in the community.[23] Outsiders tend to experience less inclusion and more exclusion. Conversely, an insider is someone who has been a long time resident of a community and who is intimate with the community's norms and assumptions.[24] Insiders are included and valued.

Outsider status is created in several ways in northern communities. Outsider women who are new to the community or who have identities, associations and experiences that are seen to be somehow different may be deemed outsiders. Christine, a woman who moved to the north from elsewhere, explained how being new and unfamiliar may act to create outsider status:

> . . . when you first move up here . . . you don't have the network of people that you may have had. . . . You have to develop that and it takes time. Small communities may be very friendly once you get into them, but they can be very cold as well. . . . Possibly they want you to prove yourself.

Women who return to a community after leaving may also find that they have become outsiders because they now subscribe to different norms and values. Outsider women experience more limited employment opportunities, social isolation and marginalization than women who are perceived as insiders.

Insider status can be achieved in several ways. Casey, originally an 'outsider' woman, suggested that marrying an 'insider' man can facilitate inclusion:

> My father-in-law was very highly regarded in the community. I took my husband's surname when we married . . . that was definitely an in. And I think it expedited my acceptance into the community.

Rosie, a woman who moved to the north and has lived there for many years, pointed out that becom-

ing an insider requires an initial acceptance of community norms and political awareness:

> You have to prove yourself as being acceptable. You have to meet the principles of the community. You have to not be intrusive, you have to take people as they are, and know where the hierarchy is in a bigger community, the political base of the community. You have to be willing to respect their attitude, even if you don't agree with it. There's got to be that acceptance period. Once you're accepted, you're family.

For some women, achieving insider status is problematic. Mary, an Aboriginal human services worker, described several instances where her children or clients "had to try to defend themselves against people who are not of the same race as them." Ruhi, a young South Asian woman who had recently immigrated to Canada, noted that new immigrants may be pressured by their cultural community to minimize their culture and conform to the Canadian way of life. Women who do not subscribe to insider behaviours such as becoming married and having children are likely to have more problems achieving insider status in the north. Elizabeth, Casey, Leah and Marie, women who were single or child free, noted how the "couples and child oriented" nature of their communities affected their mental health. Elizabeth stated: "As a single person, you never quite fit in." Casey noted that since she and her husband now have their niece living with them and so 'have a child,' she feels more included in community events than when she did not have a child.

The northern sociocultural environment was less problematic for women who had adequate finances, time, good health and interests that coincided with those in the north. Women with adequate finances could purchase resources within and outside the north, women with adequate time could travel to resources, women with good health did not need resources that could not be accessed in the north, and women who enjoyed the north or who did not realize the potential of resources such as enhanced cultural amenities did not expect or miss these in the north.

The political environment

The political environment in the north can be characterized by 2 elements: undervaluing of the north and undervaluing of women. Undervaluing had profound effects on northern women's health.

Undervaluing of the north is reflected in misunderstanding, exploitation, lack of commitment and lack of political power and support. Misunderstanding results from minimal contact between southern and northern residents. Southerners rarely travel north, thus "they think we're still mukluks and sleighs, sled dogs. They figure Prince George is a little one-horse town where the horse died" (Signe).

Undervaluing of the north is also evident in the exploitation of northern natural resources and the inequities that exist between northern and southern locations. As Christine noted: "We northerners don't get our share of resources. We provide all sorts of stuff for the province but we don't get back in return." Several women identified a lack of commitment to the north by human services professionals as an important manifestation of undervaluing. Health care professionals come to the north for various reasons: because jobs are available, to obtain professional experience, and for more generously remunerated employment.[25,26] However, they may have little intention of staying in the north. Unhappy and uncommitted care providers compromise women's health. As women in the study explained: "Some of the people hate it here. And when you don't like where you are, you don't do a good job"(Christine). Jocelyn noted: "I have never gone to the same doctor twice. . . . it seems that every time I see a doctor, I have to start over." Thus, northern women and northern communities often benefit very little or not at all from the rich experience gained by workers in their communities. This type of situation, where the north is undervalued by workers, compromises consistency of care and the building and sustaining of northern communities.

Lack of political power was also recognized as evidence of the undervaluing of the north. Sparse populations result in fewer elected positions and thus, less representation in government, as reflected in Elizabeth's comment:

> The political attitude — it's that we don't exist. There's not enough of us in the north to vote to make a difference, so we're totally ignored.

Lack of political power was seen as leading to under-resourcing of northern communities, and this under-resourcing could lead to dissatisfaction and depopulation of the north. For example, Marie had decided to leave the north for more resources elsewhere so that she could obtain "the quality of life I want to lead."

Undervaluing of women in the north is most clearly seen in the undervaluing of women's roles and perspectives. Women described this undervaluing as reflecting a "redneck" attitude, one that

favours men's values, interests and behaviours, and traditional oppressive roles for women. Leah, a young single woman, stated: "It's a really redneck mentality here. The man's the breadwinner. I don't see a lot of choices for women here." Rhoda stated:

> The woman's place is in the house chewing the leather [laughs]. . . . It's about that sign I saw (when I was travelling): "Lexington, Kentucky: Where Men Are Men and Women Are Glad of It." That's the kind of attitude around here. . . . that's partly why there's violence and drinking and it's like an old time western movie.

However, even traditional roles such as mothering were sometimes not respected. Eileen, a single mother who had grown up in the north, moved away for several years, and then returned, observed:

> I noticed a lack of respect for me as a mother and as a thinking person, particularly by men in the community. There's this idea that men and women are on different sides. . . . There isn't easy mixing between the sexes here. Everything is more gender labelled.

Undervaluing of women may also result from the nature of employment in northern communities. Resource-based industries tend to be male-oriented and prefer male employees; few of the pulp mills, for example, employ female foresters. Eileen noted:

> The resource-based work place isn't integrated in terms of gender. . . . The pulp mills are male work places, and the offices are run by women.

In addition, small northern communities do not have many opportunities for well paying, satisfying work for women. Jobs for women tend to be in low status, traditional and low paying sectors. Gender segregation at work can accentuate and sustain gender segregation and the undervaluing of women at home and in society at large.

Undervaluing of women was clearly exemplified in the attitudes of some physicians. Women felt undervalued when physicians did not respect them, or denigrated them, and when they excluded women as equal partners in their care. The following comments provide a beginning appreciation of physician attitudes and behaviours that women in the study experienced:

> When I asked for a second opinion, my doctor was quite rude. He wanted to know who I thought I was that I should ask for a second opinion. . . . quite arrogant, and he told my husband and me to prepare ourselves for the fact that it was cancer. (Vicki)

> My doctor said that it was absolutely none of his concern about doing follow-ups for patients, and didn't I know that he was a very busy person, and didn't I know that it was my responsibility if I wanted a follow up with a specialist, and he had no more time to spend on my file. (Vicki)

Asking for a second opinion and for specialist consultation indicates women's commitment to self-care and empowerment. Such requests require courage and initiative in the north because these requests often involve substantial travel and expense, and the assertiveness to endure responses of unsupportive physicians. Although female physicians were often perceived as more caring and respectful of women, female physicians are rare in the north and their practices fill up quickly. To deal with physician shortages and attitudes, geographical challenges and women's desires for respectful holistic care, women often turned to public health nurses and other care providers. Alice noted: "You can go to the health unit. The public health nurses really open their doors."

"Listening," "respect," "preventive medicine" and "helping me — and I underline *helping* me — do what I could to be responsible and knowledgeable regarding my body, health, mind and emotions" were rarely experienced but highly valued approaches in physician care that women in this study talked about.

The political undervaluing of the north and of women was less problematic for women who were less dependent on the north, less committed to the north, or who were able to leave the north for respites and resources. These women were able to avoid or negate some of the undervaluing and provide themselves with hope and sustaining experiences. However, women needed time, finances, knowledge and awareness in order to avoid or address the undervaluing they perceived in the north.

Marginalization of northern women

Marginalization as experienced by women in the study relates to experiencing inequitable access to resources necessary to achieve and maintain health when compared with non-northern women and men within the northern context. Marginalization that northern women experience can be characterized by 4 aspects: isolation, limited options, limited power and being silenced.

Isolation

Women in the north are isolated first and fore-

most by the physical environment, especially in winter. However, isolation is also created by social and political environments. Women in the study believed that northern social and political environments isolated women from each other. Although northern beliefs in traditional gender roles may favour women-only groups for traditional activities such as child care, women-only associations for other reasons, such as for self help or to advocate for women, may be seen as problematic, perhaps because these associations are perceived as 'subversive' or threatening to the status quo. Park, a director of a women's centre, explained:

> People have the perception that they [staff in women's resource centres in small northern communities] are a bunch of men-hating, lesbian women and that the Centre is there to rip the family apart.

Park noted that lesbian relationships can expose women to safety issues and "affect their mental, emotional, and physical health" because these women may feel they must keep their relationships "in the closet" due to lack of acceptance of diversity in small northern communities.

Social and political environments can also isolate women in the north by creating unstable and chronic underfunding of women's centres in small communities. Underfunding limits the social and other resources that these centres can provide for women. In the few communities where women's centres exist, they provide vital — and often the only — services that facilitate women's health, particularly from a holistic health promotion perspective. Park noted that men sometimes access centre services as well. Limits to and losses of these centres contribute significantly to the isolation of northern women and restrict the ability to make change at personal and community levels.

In addition to isolating women from women, the social and political environments also isolate women from men. Marie observed: "We have loggers, miners, ranchers and there's this macho sense, there's this real male camaraderie, and it excludes women." Women attributed the social division of the sexes to the dominance of the male culture in the north. Exclusion of women and segregation of the sexes can sustain and foster isolation and oppression of women.[27]

The north can also create isolation through the fostering of a social status as 'outsider,' as someone who lives in the community but is not truly part of the community. Outsider women experience greater social isolation and marginalization than insider women. For example, in small communities, outsider women may be isolated from the few employment opportunities that exist. Leah, a woman who grew up in the north, noted that for women new to her community

> It is so hard for them because they didn't grow up here and people know that. You have to be friends with someone to 'get in,' you can't just be a new person [to be included or hired].

Limited options

The limited quantity, quality and diversity of goods, services and education available in the north also reflect and impact upon the status of northern women. Goods that are limited include diverse and affordable food, especially fresh fruit and vegetables, and clothing and goods for women and children. Because women in the north often do most of the shopping for their families, limitations in these goods is especially problematic for women. One participant stated: "You're either buying the really low, low quality stuff or you're paying top dollar." It is perhaps reflective of the undervaluing of women that small communities have a greater selection of goods related to the northern male lifestyle, for example, hunting weapons, outdoor recreational vehicles, and farming, ranching and forestry related supplies.

Daycare services, supports for parenting and relationships, and artistic and cultural opportunities were some of the services and experiences that women found restricted. For example, Park noted that the women's centre had only "one full-time counsellor — it's not for the full year and it's a contract position." This was inadequate because over 100 women come yearly for one-on-one counselling to the centre. Eileen noted that "there were no services that were oriented to treating the whole family" when her marriage broke down. Limitations in services constrained women's abilities to obtain resources that could support them in employment, personal situations and family relationships. Limited cultural experiences in music and the arts made living in the north harder because the relief from the harshness of the north and the enhanced quality of life that these experiences could provide were not available.

Women found particularly problematic the limitations in traditional and alternative health care services and in health promotion and disease prevention services. Limited numbers of nurses,

physicians, hospitals, mental health and other services exist in the north. The north has difficulty recruiting and retaining health professionals, and recent health care reforms and personnel shortages have resulted in the elimination or downsizing of health care sites. Women's options were thus compromised and they often had to put up with inadequate care:

> There's more depression up here in women than in men. And yet, from what I can see, physicians' solution is drugs . . . not counselling. Without counselling, I would never have come out of my depression. I would never have learned to turn it around. (Christine)

> It's the amount of time that doctors spend with you — 10 minutes at the most and . . . I always feel that I'm being pushed out the door. (Rhoda)

> The first thing my doctor says to me is "The government pays me to see eight patients a day and you're the twelfth." I didn't feel like I was going to get any kind of quality check-up or interview and he was very quick and brusque with me. (Barbara)

Although women in urban areas may experience similar limitations, in rural and remote areas women are more compromised because they have fewer or no other options; they may not be able to access a second opinion or change care providers because they don't exist in their communities or close by. Medical specialists, such as psychiatrists, from southern urban areas occasionally fly to northern communities to provide care for a few days. Sometimes clinics are held in remote northern communities. Women felt that this was inconsistent and second-rate care and, for the most part, ineffective.

Quality of care was also compromised by the knowledge and attitudes of physicians. Women felt that their health issues were often dismissed or downplayed by physicians, as displayed in attitudes that

> . . . women bring on a lot of their own illnesses, that whatever a woman has that she's responsible for it directly. If a man has it — he's the bread winner so he deserves to have [care]. (Barbara)

Disrespect of the contexts of women's lives and of their needs was evident, as Elizabeth, a single woman, vividly articulates:

> That man was brutal, but he was the only gynecologist. . . . I just thought "this man shouldn't even be a doctor." He was rough, and he says to me, "Well, if you're going to have kids, you better have them now." And I said, "Well, I'm not into being a single parent." [He says] "Well, what's the matter? Good looking girl like you, you should be able to find a man." I would have asked to go somewhere else but there was nowhere else to go.

When the nature of women's lives and their perspectives are not taken into account, or when care is difficult to access, women may choose to forego care, or they may receive care that does not fit with their values or lifestyle and that is not timely or appropriate. As a result, women may live with disease and illness longer, experience increased complications of treatment due to advanced illness and endure compromised recovery.

To avoid or minimize the impact of inadequate and inappropriate health care, women wanted to prevent health problems and promote their health. Services that women favoured included massage, midwifery, naturopathic services, health education, and social and counselling services. However, these services either do not exist in most northern communities, are provided in inadequate ways, or are not included in the national health insurance plan. Women thought that physicians were often ill-informed about, or did not appreciate, the value of health promotion and illness prevention services, and that physicians needed "a more open mind" regarding alternative health care. Christine summarized the values of several women in the study when she stated that she appreciated that her physician "told me about people to see about different holistic medicines." Physician discomfort with women's requests for alternative health care services and limited availability of other health care professionals, such as public health nurses who could advise women, resulted in under use or ineffective use of health promotion and illness prevention services. Consequently, northern women often live with pain, discomfort and illness that could be prevented, and that is not treated in a timely, valued and effective manner.

In addition to limitations in goods and services, women also noted limitations in education. Women valued education because, especially in the under-resourced north, "women have to have the information to be responsible for themselves" (Elizabeth), and because education would enhance women's self-esteem and sense of agency, especially for women in low socioeconomic situations. Mary, an Aboriginal woman who works with low-income Aboriginal women, explained:

> A lot of [my clients] want to just be able to take a course, just to feel good that they can do something. . . . you know, 'cause if they can do one course, maybe they can do this [other activity to improve their lives] and, you know, [it] branches off from there.

Women felt that improving women's education would also strengthen families. Lilac stated: "A

woman needs an education. You educate a boy, you educate a man. You educate a girl, you educate a family."

In spite of the benefits of education, educational resources are limited in the north. Libraries, health education personnel and community colleges are not readily accessible due to distance and weather. Computers and the creation of the University of Northern British Columbia in the north in 1994 have increased the ability of northern women to acquire information and education. However, women must still have the money, time and self-confidence to access these resources. Often they must also relocate to Prince George to access on-campus university classes and other educational resources. Study participants believed that women in the north live in a patriarchal culture that does not privilege the advancement of women. Thus, girls and women may not be encouraged or supported to access educational resources or achieve academic success.

The politics of funding for education seems to be an ongoing problem in the north. Although more affordable technology such as satellite dishes, computers and the Internet are facilitating distance learning, this technology is only available to women who have the funds and technology such as electricity and telephone services to access these education resources.

Limited power

Aspects of limited power were evident in women's descriptions of their agency and activities and in observational data. Several women suggested that women's voices and perspectives are not valued because northern communities are segregated by gender, with women occupying the less powerful role:

> There's this idea that men and women are on different sides. I think it's partly pure sexism. That women don't have anything interesting to say. (Eileen)

> I hate to say this in this day and age, but women don't feel that they have a lot of power in a lot of rural communities. . . it's like stepping back in time 40 years. (Rosie)

Within the north, women's lives are often linked to economic dependence on men who are employed in the resource industries. This limits women's power. Marie noted that women's dependence on resource-based economies may compel them to tolerate gender inequities to sustain employment for their husbands. "If you're blatant about it [feminism] and open about it, it's not really good, because you might be ostracized or not accepted." In a small community with few jobs, non-acceptance could cost one one's livelihood.

Women's economic dependence is further perpetuated by the assumption that housewives and mothers do not need to be responsible for their own economic well-being and that women's primary responsibility is to home and family, as Eileen's comments reveal:

> If you're going to be a 'real' woman — quotes around that, right — and be married and have a family or be a mother, you don't do that kind of thing [have a well paying job].

In addition, few well paying and satisfying jobs exist for women in the north, and the limited access to education compromises women's acquisition of well paying and satisfying employment that might be available.

Religious beliefs that foster traditional attitudes can further compromise northern women's power. Leah observed:

> A large religious population here probably contributes to the lack of opportunity for women with beliefs such as "men are the bread winners, women belong at home raising the children."

Marie believed that while the church fosters a sense of community, it may also result in rigidity of values, whereby people become "so dogmatic . . . they don't want to actively listen and even consider the possibility that there could be other answers."

Limited power that results from religious and male values was most often noted by older and single women and by women who had university education and life experience outside the north. It may well be that women who are aware of other ways of being and who have independent life experiences may be better able to locate northern women's power — or lack thereof — in the structures of northern communities.

Being silenced

Women in the study noted the importance of having a voice. The overwhelming response to recruitment initiatives indicates that northern women have a great desire for a voice in health-related matters, and suggests that northern women often do not have the opportunity for such participation.

The silencing of northern women's experience and their desire for voice were revealed in several of the women's comments about the research:

How wonderful it is that someone's finally sitting down and reaching out to women and finding out what people are thinking. This is so needful. I talked last time about women not having a voice — well, this is giving women a voice. (Jocelyn)

I admire you so much for having done this [research]. Our . . . voices wouldn't be heard if it wasn't for you drawing them out and possibly putting them where they will be heard. (Amelia)

I think what you're doing is really valuable. This [research] needs to be done because men have been in control for so long and women have just had to go along with it. They've had no say. They've had no say at all. (Signe)

Other indicators of northern women being silenced include the limited number of women in public positions of authority and decision-making. For example, during this study the Prince George city council of 10 elected members included only 2 women. Prince George has had only one female mayor in its almost century-long existence. Representation of northern women in elected provincial and federal government positions is also very much in the minority. Women's lack of representation in public venues reflects social, political and gender roles and power structures inherent in northern resource-based communities.[28]

The importance of women having a voice was also evident in women's stated preference for face-to-face interviews, rather than written surveys or telephone interviews. Although women would be listened to in telephone interviews, it seemed that the women felt that they would not 'really be heard.' Face-to-face interviews in women's communities and across their kitchen tables were important in conveying respect, facilitating communication and understanding, and decreasing the silence that many northern women experience. Casey, a ranch woman, explained:

. . . a lot of times up here we get a lot of phone research . . . and the people at the end of the line don't care. It's all written out for them. . . . It's just cold. . . . Whereas a face- to-face encounter — there's a body there, there's warmth, there's humanity. There's a connection.

Fred, a woman who has lived in the north all her life, valued face-to-face research because it afforded her the opportunity to evaluate the respect for her, and to voice concerns and be heard:

. . . seeing the person and seeing their face . . . a lot of communication is body language, that they aren't a threatening person . . . not laughing at you. . . . A voice on the phone — it's really impersonal. What you're doing is listening, and you did a good job of it.

Discussion

This study revealed how the historical, physical, sociocultural and political contexts of the north influence northern women's health by contributing to their marginalization. More specifically, the marginalization experienced by women in northern BC was characterized by isolation, limited options of goods, services and education, limited power and being silenced.

While there is considerable research focusing on marginalization related to race, ethnicity and socioeconomic exclusion, less attention has been directed to marginalization resulting from geographical location and gender. Geographers and social and political scientists have discussed marginalization in the north in terms of the terrain, distance and sociopolitical and economic factors, such as the lack of political power and economic dependence on a single resource.[8,12,21,29,30] This study reveals important new information about the relationship of geography and gender and implications for women's health. For example, this study found that the depth and scope of factors in the northern context such as extensive distances and isolation, prolonged severe climates, power and sociocultural aspects of relationships, and fewer health and human service resources make northern women's needs more acute, their solution options more limited, and their plight more problematic. Moreover, a 'pile-up' or accumulation of contextual factors such as isolation and severe climate and limited personal and social resources increase northern women's marginalization and health challenges.

Hall, Stevens and Meleis[27] note that one's identity, associations, experiences and environments can all form the basis of an individual's or a group's marginalization. Various attitudes and behaviours such as discrimination, scapegoating, stigmatizing and segregation may also serve to marginalize and exclude women.[4,27] This study confirms, clarifies and extends information about factors of marginalization and exclusion that affect women's health in northern settings. For example, this study revealed that women without male partners may be stigmatized and excluded in northern settings and that this may be seen as legitimate because of patriarchal male-dominated values and behaviours that are promoted within socioeconomic contexts in northern communities.

A strength of this study is that it provides beginning information about diverse women's lives in northern settings. The study included northern

women who were elderly, young and middle-aged; disabled and able-bodied; poor, middle-class and wealthy; Caucasian and from minority cultures; and women from remote, rural and urban locations. Thus, this research extends understanding about how geography intersects with other determinants of health in remote northern settings. Nevertheless, the small study sample limits the depth and scope of understanding about the health and lives of northern women. Research is especially needed regarding the health and marginalization of northern women who are physically disabled, elderly, low income, lesbian, single/widowed/divorced, and about those who live in particularly remote settings. Given the size and nature of the sample, the findings regarding health provider attitudes and behaviours may not be reflective of health providers as a whole; therefore, additional research that explores human service provider attitudes and behaviours from the perspective of consumers and providers would be beneficial. Participatory action research and research that uses interviews, focus groups and other methods that privilege women's voices and experiences would enrich understanding and would foster respect, inclusion and empowerment as northern women 'come to voice' in research.

Conclusions

This study has relevance for rural and northern health care practice and northern women's health. To strengthen northern women's access to quality health care, equitable inclusion and empowerment, increased efforts must be made to recruit and retain human service professionals in the north, especially female public health nurses, nurse practitioners and physicans who will provide respectful and appropriate care and who are comfortable with the professional and personal aspects of living and working in small northern communities.[25,31,32] Northern health practitioners must be able to work in environments that are culturally diverse, where lack of anonymity, scarcity of resources and isolation characterize life, and where they may be regarded as outsiders.[6,32–34] In addition, health care practitioners must include women as equal partners in health care and realize that women are experts of their own lives.

Human service providers in northern settings must include in their practices advocacy for healthy public policy, community development and coalition building approaches. These activities, if conducted for and with women,[6,14,35] help to give power and recognition to northern women, make the most of limited resources and draw enriched resources to northern communities.

In 2002, a national report on health care in Canada[3] highlighted the need to improve health and access to health care for people in rural and remote communities. When national reports include initiatives and suggestions proposed by women in geographically isolated settings, such as the women in this study, health care practice and women's health in rural and remote settings will significantly improve.

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