Hiding in Plain Sight:

A Literature Review on the Impact of Gender and Location on Canadian Women’s Health

Karleigh Smith

Wmst. 498

Dec. 16th, 2016

University of Northern British Columbia

Author Note

This paper was written as part of an internship with the Women North Network

Hiding in Plain Sight: A Literature Review on the Impact of Gender and Location on Canadian Women’s Health

Although a gendered approach to health does not have an established presence, some countries are taking strides to effectively utilize this method. For instance, Canada is recognized internationally as a leader in gender-based analysis (GBA) (Hankivsky, 2006a), and for its outstanding health care system (Hankivsky, 2006b). However, the lack of progress around women’s health creates doubt about the accuracy of Canada’s standings. Despite international political statements about the importance and value in addressing this issue, and the establishment of Canada’s Women’s Health Strategy (WHS), there has been minimal progress on mainstreaming and institutionalizing a gendered lens on health issues and policies in Canada (Hankivsky, 2006b).

 The purpose of this literature review is to examine the effectiveness of the WHS for Canadian women, and how its main focus has shifted since the origination of the strategy in 1999. In particular, this paper will discuss how the literature demonstrates a need for the WHS to recognize that northern women’s health indicators and needs are distinct from those of women living in southern Canada. Current literature has accentuated that Canada’s high standard for health and living is not evenly extended across the population, with focus needed on the categories of gender and living location (Varcoe, Hankivsky, & Morrow, 2008).

For the course of this paper, the term health will be defined in concordance with the World Health Organization (WHO) definition to ensure clarity and consistency. WHO defines health as a “state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (as cited in Hankivsky, 2008a, p. 148). As such, health is a multifaceted concept and therefore must be examined in all aspects of life: biological, physical, and social (Brannon, Feist, & Updegraff, 2014). Although this notion of studying health through the biosocial model, as opposed to the biomedical model, is no longer a revolutionary idea, the concept of examining health through a gendered lens has yet to become a standard practice that is fully incorporated into everyday practices and policies (Hankivsky, 2008a).

**History of Women’s Health**

 Women’s health as a unique and distinct area of focus is still relatively new (i.e., approximately 60 years old). It can be argued that the creation of a separate women’s health category was derived from second wave feminists’ critiquing the way women’s health had been either ignored or narrowly defined (Varcoe et al., 2008). However, the women’s health movement developed both alongside, and parallel to, the women’s movement as a whole in Canada (Morrow, 2008). This means that each phase of the women’s movement contributed to the separation of women’s health from men’s health. The women’s health movement is attributed to the second wave of feminism specifically due to the various key issues identified and discussed during this period. For example, some main points brought to focus by second wave feminists were the medicalization of women’s bodies; reproductive health issues; violence against women; and women’s lack of opportunity to obtain a role, or state their opinion, in the health care sector (Morrow, 2008).

 The issue of women’s feeling unable to provide input in the health care sector has been a major part of the discourse and debate that has surrounded the gendered character of the health system (Varcoe et al., 2008). Browne, Smye and Varcoe (2008) further this discussion by examining the potential impact of giving voices to marginalized individuals and groups. Despite research supporting the inclusion of the marginalized, these suggestions continue to be largely dismissed when developing health policies and conducting research (Browne et al., 2008). It is argued that the issues of marginalized women are ignored because they are reinterpreted as issues of class, culture, lifestyle practices, or individual choices, rather than an issue of health (Browne et al., 2008). Due to these concerns being continuously discounted, variables that are perceived by marginal groups as significant have not been addressed. This is a clear example of why women and men’s health need to be distinct categories.

Despite the validity of viewing women’s health as separate from men’s, there has been inconsistent progress with the acceptance, funding and study of women’s health, health policies, and health status (Varcoe et al., 2008). Varcoe and colleagues (2008) attribute this resistance in contemporary Canadian society to six main challenges that are present across research, theory and policy. A brief summary of the six problems identified follows.

* The health care system continues to not incorporate gendered effects.
* The government has drastically reduced program spending.
* Initiatives in women’s health are not adequately funded, resourced, or implemented.
* The public is under the impression that the issue of women’s health has received sufficient attention.
* Feminist critique focuses on the differences between the sexes, rather than within one sex.
* Views of women and women’s health are strongly impacted by political and social ideologies.

(Varcoe et al., 2008) The aforementioned problems act as direct barriers to women’s health being accepted as a distinct category.

Women’s health is further disadvantaged by the common misunderstanding that the terms ‘sex’ and ‘gender’ are interchangeable. The difference between the two terms is discussed by Gleb, Pederson, and Greaves (2011), who state that gender is understood as a social and cultural construct that influences and impacts numerous levels of individual identities. In contrast, sex, often confused with gender, is deemed a biological construct that is determined by anatomy, hormones, and chromosomes. In other words, gender is something that a person performs, whereas sex is the biological components of the individual. While both sex and gender have the ability to impact a person’s health, a majority of the research only examines the impact of sex (Schiebinger & Stefanick, 2016). This may be the result of sex being more convenient for researchers to study, as it is easier to operationalize in comparison to gender. Furthermore, an operationalized construct such as sex can be incorporated into quantitative research methodology, which simplifies statistical analysis (Schiebinger & Stefanick, 2016). Gender is more complicated to study because it is not just one factor that has to be measured, but rather a cascade of variables that have be questioned and analyzed (Schiebinger & Stefanick, 2016).

The fact that both gender and sex have unique impacts on a person’s health further demonstrates the value and complexity of viewing a person’s health in the most distinct manner possible so that the individual will be able to receive the best help possible. For instance, Schiebinger and Stefanick (2016) review Pelletier and colleagues’ new methodology, used to analyze gender, which has lead to a deeper understanding of cardiovascular disease. The study examined the potential associations between sex, gender and cardiovascular risk for individuals with premature acute coronary syndrome (ACS). The results showed that sex had no effect, however gender did. The new methodology for determining gender determined a ‘femininity’ score between 1-100 for participants. Regardless of sex of the individual (i.e., male or female), those with a high femininity score were found to have an increased risk for experiencing a recurrence of ACS (Schiebinger & Stefanick, 2016). This study demonstrated the importance of researchers examining sex and gender as two separate variables, specifically in health research.

As the harms caused by a gender-blind approach to health became known, the value of gender-based health analysis became an international concern. Canada responded by developing the WHS. The WHS had the capability to improve the Canadian health services to be gender inclusive.

**Canada’s Women’s Health Strategy (WHS)**

**Initial Plan for the WHS**

International steps were taken for gender equality at the Fourth World Conference on Women (Beijing 1995), where 184 governments and 2500 nongovernmental organizations (NGO) made a commitment to the Platform for Action (PFA) (Hankivsky, 2006b). The PFA was a comprehensive global policy that outlined a set plan for action to achieve goals of equality and empowerment for women. Specifically, the PFA identified 12 critical areas of concern, and countries were urged to address the following: the girl child (i.e., addressing discrimination of female children); media; environment; economy; poverty; education and training; violence; health; armed conflict; power and decision-making; institutional mechanisms; and human rights (UN Women, 2014). Due to the intersection of these critical issues, many policies that were put in place addressed more than one issue (e.g., economy, poverty, health, and violence are all interrelated). This policy acted as a framework for guidance and inspiration for countries all over the world (UN Women, 2014).

In 1999, Canada decided on a course of action to partially address its commitment to the PFA. Canada developed the WHS, an integrated framework, which provides the context in which the country can consistently apply gender-based analysis throughout the health system (Austin, Tudiver, Chultem, & Kantiebo, 2007). Applying a gendered perspective to health is strongly encouraged by researchers because it is believed that this will correct the current ‘blind spot’ in health frameworks (Gleb et al., 2011). Gender-based analysis, also referred to as gender mainstreaming, is an analytical tool that has been utilized in Canada since the 1970s, despite its not being internationally accepted as a strategy until 1995 (Hankivsky, 2008, 145). Similar to the concept of health, gender-based analysis can be defined in several ways. For the course of this paper, the broad definition provided by the Economic and Social Council (1977) will be used when referring to gender-based analysis. This definition states that gender-based analysis is a strategy for making both men and women’s apprehensions and unique experience “an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and social spheres” with the intention that all genders will equally benefit (Economic and Social Council, 1977, p. 1). Gender-based analysis systematically integrates the concept of diversity amongst genders into the development of policies, programs, and future planning (Austin et al., 2007).

The implementation of WHS was important for other reasons, in addition to meeting the requirements of the Beijing PFA. For example, throughout all of Canada women have greater longevity than men, which indicates that a focus on women’s health will have longer implications (Health Canada, 2010). This is postulated for several reasons, such as men’s having a higher suicide rate, men’s being more likely to die from external causes (i.e., motor vehicle accidents), and personal and lifestyle determinants (Health Canada, 2010). However, when examining rates of death from cancer, women between the ages of 20-44 are more likely to die (Health Canada, 2010). By examining women and men’s health as interchangeable, damaging decisions are being made that have the potential to harm both gender groups. Differences between the two groups are not being examined; therefore, existing treatments and plans of action are not always the most beneficial options available. It is detrimental to the entire population when the following issues are not studied and implemented through a gendered lens:

* leading cause of death;
* the distinction in patterns of illness;
* the way women and men experience illness;
* the impact of women’s being primary care givers;
* differences in risk factors for men and women; and
* economic and personal determinants of health.

The WHS played a significant role in Canada’s promotion of women’s health and the use of gender-based analysis in all fields surrounding health (Hankivsky, 2006b). The implementation of the WHS demonstrates Canada’s support for the global recognition that women and men need to receive equitable experiences in the health system in regards to their diagnosis, treatment, role in research and voice in policies. While the WHS conforms to the principles determined by the PFA, the WHS emphasizes change in the health system particularly. This is visible when examining the overarching goal of the WHS. The predominant focus of the WHS is “to improve the health of women in Canada by making the health system more responsive to women and women’s health” (Health Canada, 2010).

The WHS outlined four main objectives to aid in achieving the aforementioned goal. Hankivsky (2006b) dissects each of these main objectives in detail. The WHS’s first key objective states that Health Canada needs to ensure that its policies and programs are gender and sex inclusive (Hankivsky, 2006b). One way that Health Canada attempted to fulfill this objective was by making the application of gender-based analysis in all health related fields a standard practice (Health Canada, 2010). Similarly, in 2000 Canada released a gender-based analysis policy that outlined methods for integrating this form of analysis into all branches of health (Hankivsky, 2006b). It was necessary for the government to focus on this particular objective as the other aims of the WHS were, in part, dependent upon its success.

The second objective of the WHS specified the necessity of increasing basic knowledge of women’s health to provide people with a deeper understanding of obstacles women face in the health sector (Hankivsky, 2006b). There have been several initiatives promoting awareness and emphasizing the inclusion of women in all stages of policy development (Hankivsky, 2006b). This is important because it allows women’s voices and opinions to be heard at an institutional level and time when change is occurring. Canada also tried to achieve this objective by establishing the Institute of Gender and Health (IGH) to support, aid, and actively advocate for research using a gender-based analysis. Furthermore, since the release of the WHS, Canada has paid substantial attention to health indicators (Austin et al., 2007). This focus has enhanced knowledge about health in general because it has provided a deeper level of understanding regarding how living situations, demographics, genetics, and personal choices potentially have negative or positive impacts on the health of an individual.

In addition to enhancing knowledge around women’s health, the WHS is focused on providing women with effective health services, as prioritized in the third objective (Hankivsky, 2006b). Improving health care has major implications for women as they are more likely than men to utilize health services, to be without extended health coverage, and to be living in poverty (Hankivsky, 2006b). There have been a number of improvements in this area since the release of the WHS. For instance, in 2004 Canada released Employment Insurance Compassionate Care benefits that allowed workers to take a leave of absence to provide care for a close family member who has an extremely high risk of death in the following six months (Hankivsky, 2006b).

The final main objective of the WHS was to develop approaches that endorse good health behaviours by discovering preventive measures and techniques to reduce risk factors that are most likely to endanger women’s health (Hankivsky, 2006b). This objective put responsibility on the government to find ways to assist the general population in avoiding damaging lifestyles, high-risk behaviors and dangerous situations, and from consuming products harmful to the individual’s health. This objective was applied to a wide range of issues, which made the implementation of preventive measures challenging. Canada funded several organizations geared towards achieving this objective, such as the Family Violence Initiative and the Tobacco Control Initiative (Hankivsky, 2006b). Moreover, Austen et al. (2007) took Hankivsky’s comments about this objective a step further by discussing how there has been progress on identifying problems in women’s health surveillance, and proposing plans to remedy these concerns. Women’s health surveillance is an ongoing process of monitoring the health of the populations through continuous collection and analysis of data. This knowledge is then integrated into practices, and quickly dispersed throughout the applicable population such as doctors, nurses, and health researchers (Austin et al., 2007). While Austin et al. did not talk about women’s health surveillance in direct relation to the WHS, this project received a large amount of support since the release of the strategy and would have significant implications for the fourth objective, as well as making a relative contribution to the other objectives.

In addition to being a focused framework with clear goals and objectives, the WHS also possesses other beneficial qualities. As discussed by Hankivsky (2006a), the WHS was proof of the government’s commitment to taking action to improve health, and specifically to advance women’s health. The document made clear and cohesive arguments for why women’s health needed to be distinct from men’s, and the advantages to all genders of creating this distinction. Moreover, the WHS is in concordance with international priorities and goals, thus keeping Canada an active member in addressing global concerns. Finally, the WHS also provided a path to integrate gender-based analysis into the health field. Hankivsky (2008) goes on to mention that another distinct benefit of the WHS is that the strategy advocates for a lifespan approach when studying health. The WHS does not follow a traditional lifespan approach because it prioritizes three distinct age ranges to examine. However, it *is* promoting a lifespan approach because it forces researchers and health workers to acknowledge and examine gender and health at multiple ages. The three stages that the WHS encourages the health field to examine through a gendered lens are childhood and adolescence, early to mid-adulthood, and elderhood (Hankivsky (2008).

**Limitations of the WHS**

The WHS possessed potential to implement significant changes in women’s health in Canada. Unfortunately, impediments arose at each level of its objectives and in the actual design of the strategy. This section of the literature review will discuss the problems that have been identified for each of the WHS objectives previously discussed. This section will end with a discourse on how the actual framework of the WHS was missing a key component that would have drastically increased the effectiveness of the strategy.

 One of the main problems that has been identified with the WHS is that each of the four objectives involved improvements that could not be quickly fixed, and with time the strategy lost momentum to continue making meaningful change. The first objective (Canada’s implementing gender-based analysis as a standardized practice in the health field) did result in some improvements, such as the release of a gender-based analysis policy in 2000. Unfortunately, the few successes that arose do not outweigh the problems that remain; thus this objective was, overall, not attained. For instance, Gleb, Peterson and Greaves’s (2011) article discusses the need for gender analysis, and how an evaluation of gender-based analysis in health related fields has not been undertaken. As detailed above, understanding the role of gender in individual health is critical to improving the health sector. Gleb and colleagues (2011) conducted a search through several academic databases, searching for theoretical and conceptual literature on health promotion, specifically women’s health promotion, in the last 40 years. This study concluded that gender was rarely identified as a determinant of health in previous studies. However, it was also mentioned that gender was not viewed as having a critical role in successful health promotion, as it was not identified or discussed in this context in the literature (Gleb et al., 2011). Thus, because it was not examined, gender was made to appear unimportant to health. This illustrates that, despite efforts made by the Canadian government to introduce gender-based analysis, gender remains overlooked or disregarded in the health field. Gleb and his associates note that when gender is mentioned specifically, its complexity and influence over other factors that impact health are overlooked.

Continuing with the critiques of Gleb and associates, Hankivsky further comments on areas where improvement can occur. Primarily, Hankivsky (2006a) examines the implementation of gender-based analysis; she discusses how the analysis is rarely done in a systematic fashion that encompasses multiple areas that affect health. Hankivsky goes on to discuss how gender-based analysis continues to be excluded from policies. An example used to illustrate this argument is the Romanow Commission on the Future of Heath Care in Canada that was released in November of 2002 (Hankivsky, 2006a). This policy was released three years after the WHS was issued, and has been disparaged for its failure to incorporate a gendered approach when conducting its analysis and proposals for future actions (Hankivsky, 2006a). This indicates how major policies were permitted to ignore gender, despite the commitment to a gendered lens in the WHS. Additionally, this article touches on how many activists, health care professionals, and researchers remain skeptical of utilizing a gendered approach, whereas many community-based groups are unaware that gender-based approaches exist (Hankivsky, 2006a). The articles by Gleb et al. and Hankivsky demonstrate that while the WHS provides an outline for introducing gender-based analysis, the strategy did not ensure its use in the health sector.

Similar to the first, the second objective of the WHS, increasing the basic understanding of women’s health (Hankivsky, 2006b), is also critiqued for not being implemented in a manner that would have ensured substantial change. Hankivsky (2006b) comments that, although Canada made numerous attempts to achieve this objective, needs related to women’s health continue to be marginalized. Hankivsky (2006b) argues that this marginalization occurs for several reasons. First, women’s opinions and perspectives are often not heard, or at least not fully understood. As men in a position of power do not experience the same barriers that women do, the concerns of women about how their health needs are not being met are often overlooked. Additionally, Hankivsky (2006b) argues that the current list of health indicators is inadequate because women’s unique concerns are ignored if they are not directly related to reproductive health. When the health indicators do take gender into account, it is simply a list of the differences between females and males in regards to health, and does not delve into the connections among gender and other social and cultural determinants of health. Hankivsky (2006b) continues to discuss the difficulty Canada has faced in increasing knowledge about women’s health, arguing that this difficulty arises because researchers continue to conduct research only in their own locations, thus minimizing the chances of these studies being representative of alternative perspectives. Hankivsky (2006b) ends her critique on the second objective by commenting that people with direct experiences with women’s health are still being excluded from positions, meetings, and locations where they could potentially make a significant impact in changing how women’s health is studied, discussed, taught, and monitored.

The third and fourth objectives of the WHS were to have the Canadian government take on the task of improving women’s health services and to actively promote positive health behaviours by taking preventive methods to reduce risk factors. Similar to the first two objectives, for both these final objectives to be effective, the government would have to commit to them and ensure that these priorities are met. Furthermore, in order to improve women’s health services, current deficits must first be identified. Therefore, some form of a gendered approach would have to be taken to indicate where services are unsatisfactory for women, and what the risk factors are for each gender independently. In addition to a gender-based method, health research needs to direct attention to vulnerable minorities of women, who are often overlooked in regards to their distinct health needs and risk factors (Hankivsky, 2006b). When these women are examined, they are often grouped together with women who make up the majority of the population, leaving the individual struggles of the minority group unnoticed by researchers. This is seen in particular when examining Aboriginal women living in smaller, rural, and often northern communities of Canada (Hankivsky 2006b). The importance of examining this specific demographic will be discussed in further detail later on.

 As it is a systematic framework, implementation of the WHS can only be effective if the design for the WHS is complete. However, it is argued that the WHS needs to have a mandate that states how often the strategy should undergo formal evaluations for effectiveness. Hankivsky (2006b) affirms that while there have been progress reports on the implementation of gender-based approaches, the WHS has never undergone a formal evaluation. Furthermore, it is mentioned that Gender-Based Analysis Policies, an organization that focuses on a main component of the WHS, has also never been the topic of a formal evaluation. This is a systematic flaw with the WHS, as it prevents evaluations from occurring. Therefore, the effectiveness of the WHS is assumed rather than known.

Based on the above information, Canada’s WHS should be reviewed and ultimately revised. The strategy originally possessed vast potential to implement changes in how women’s health was treated in Canada. Unfortunately, these idealistic improvements never became a reality. Currently women’s health organizations are still struggling to inspire change in practices, procedures, and policies with a few of the same key concerns that promoted the women’s health movement in the first place. An example of three issues that continue to be areas of great concern for the women’s health movement are: “the medicalization of women’s bodies, the failure of medical science to consistently include sex and gender as a part of their analysis, and the implementation of health policies by governments that fail to adequately recognize women’s roles as caregivers” (Morrow, 2008, p. 55-56). The prevalence of these issues despite the women’s movement and the attempted implementation of the WHS demonstrates a clear need for the WHS to be revised.

In addition to the revision of the WHS to address the aforementioned problems with the strategy, a regular evaluation process should also be determined and applied. While steps were made in implementing the WHS, incorporating a mandatory evaluation process for different health sections, and the strategy itself, would make the WHS more effective. Moreover, a majority of the critiques of the WHS are directly related to the neglect of women’s concerns and needs because a gender-based approach is not being conducted at any level of the health industry. An intersectional approach would ensure that not only are gender differences examined, but that gender differences are regarded in concordance with other social and cultural determinants. Intersectionality is a theoretical framework in which interlocking identities, oppressions, and social realities are examined in relation to each other (Morrow & Hankivsky, 2008). By making the intersectional approach mandatory for health researchers, Canada could ensure that gender is examined in relation to all areas of health. This would be particularly useful when studying geographical differences in health indicators between Southern and Northern Canadian women, as it would guarantee that women are not melded together into one group. This, therefore, would facilitate an effective examination of the differences among women living in Canada.

**Definitions for Geographical Health Indicators**

It is important to note that while there are clear distinctions among northern, rural and remote communities, for the remainder of this paper, literature that focused on any of these communities was utilized, because these three types of communities have been documented to have similar barriers to, and experiences with, the health care system. What constitutes northern Canada greatly varies throughout the literature. For this paper, northern Canada will be defined in concordance to Statistics Canada’s definition (2009) for ‘rural northern,’ with the exclusion of all rural restrictions. Therefore, northern Canada refers specifically to all of the territories and any regions that are found to be above the following latitudinal lines for each province: 54th for British Columbia, Alberta, Saskatchewan, Quebec, and Ontario; 53rd for Manitoba; and 50th for Newfoundland and Labrador. If a community resides directly on this latitudinal line, it will be classified as either northern or southern depending on where the majority of the population of that community resides on that line. This definition was chosen because it recognized that at a set point the northern towns in each province have more in common with the territories than with the southern areas of the same province.

Furthermore, there are some important differences between Aboriginal health needs and northern Canada’s health needs; this paper will focus on the factors that influence the health of women living in northern Canada. The reports and rates that come from this section will include, but not be solely focused on, Aboriginal women. To clarify the paper will draw attention to where Aboriginal women’s health and health needs are unique from the general population of women residing in northern Canada.

 **Geographical Health Indicators**

The Canada Health Act is an important legislation that perceives the concept of health as a platform for social justice, which is why this document aspires to ensure that all forms of health care are accessible to the entire nation (William & Kulig, 2012). Regardless of these noble intentions, current literature demonstrates that the Canadian health sector as a whole overlooks the unique needs of northern communities, forcing northern communities to take additional steps to receive the same level of health care (e.g., travelling a great distance or waiting longer for the arrival of supplies) (Cole & Healey, 2013; Young, Ng, & Chatwood, 2015). With the majority of Canada’s large cities found in the south, concerns about the health sector that are brought forth by those living in northern towns are often disregarded. Canadians living in rural and remote areas of northern Canada merit additional attention in regards to their health needs due to their unique geography, history, and population (e.g., the large proportion of Aboriginal peoples) (Sutherns et al., 2004). The health system is an area of major concern for those residing in the north, and particularly for those living in the Northern Territories, with health outcomes clearly lower than in the rest of Canada (Young, Ng, & Chatwood, 2015).

Canada is known for its diversity, and rural Canada is no different. Rural Canada is a highly diverse area in regards to economy and ethnicity (Sutherns, 2004). The majority of rural Canadian communities are built around natural resources as the extraction of these resources provides people with employment. It is a priority for Canada to have these resources extracted, as Canada uses these resources to participate in foreign exchanges (Sutherns, 2004). With people in rural communities doing such important jobs, it’s interesting that rural health systems, specifically in the north, are of lower quality than the health services provided in other areas of Canada. The stated reason for these obvious differences in the health system is that due to the low population density and the isolation of these communities it is extremely challenging to provide quality health care (Sutherns, 2004). Alternate influences and reasons for this gap in the health system between the rural and urban communities will continue to be mentioned, with the difference between northern communities and southern communities differences in health care, specifically in regards to women’s health, being explicitly discussed in greater detail.

 The importance of geographical location in health is made apparent in Giesbrecht, Cinnamon, Fritz and Johnston’s (2014) summary of the themes in geographies of health and health care that emerged at the 2012 Canadian Association of Geographers annual conference. While this paper discusses numerous themes that emerged, one theme of particular relevance was the impact that environmental determinants can have on an individual’s health. The environment plays a significant part in determining an individual’s health because it influences a number of the determinants of health such as air quality, risk of injury, disease epidemiology, vitamin D deficiency, and others. Although not all of these topics will be further discussed due to lack of literature examining a gendered difference as well as a geographical one, this article articulates the value of analyzing health in concordance with geography (Giesbrecht et al., 2014).

As previously established, current literature has demonstrated that while women access the health sector more than men, this frequency of access forces women to constantly confront and be disadvantaged by the barriers in the health sector. Northern women are confronted with additional roadblocks that mean that they will not experience the same level of health care that women from southern Canada encounter. Though efforts have been made to focus on Canadian women’s health as a category distinct from that of men, there have nevertheless been persistent issues in how the topic is discussed, particularly in regards to geographical location. There are several areas in the health system that demand further analysis in regards to both a gendered (Hankivsky, 2008a) and a geographical (Young, Ng, & Chatwood, 2015) perspective. In particular, health status, the health care system, and health policy all need to be examined in further detail (Hankivsky, 2008a) in order to gain a deeper understanding of the way gender and geography impact Canadian women’s health. Fortunately, there is research on these three categories of the health system. While some of the literature is ambivalent and even contradictory, some findings indicate a clear distinction between the health of women living in northern Canada and that of women residing in other parts of Canada. Despite the amount of research, this literature review utilized a limited number of examples for each section, with each example chosen because it is predominant in the literature, or significant in terms of information.

**Health Status**

 According to Hankivsky (2008a), the term health status refers specifically to illnesses, diseases, and health conditions. In regards to health status, there has been a large amount of research focusing on outlining the differences in how females contract, physically and emotionally react to, and respond to these ailments. There is a limited amount of literature exists which examines how geography impacts health status. However there is literature demonstrating both a gender and geographical difference in health status specifically with regards to cervical cancer, breast cancer, and instances of violence against women.

**Cervical Cancer.** Cervical cancer results when a malignant tumorgrows from the cells in the cervix. Rates of mortality due to cervical cancer have substantially decreased since the introduction of the Papanicolaou smear (Pap smear) in the 1950s (Popadiuk et al., 2006). Regardless of this decrease, the Canadian Task Force on Preventive Health Care (CTFPH) determined that there were approximately 350 deaths caused by cervical cancer in 2011 (CTFPH, 2013). Proper screening practices and Human Papillomavirus (HPV) are two main obstacles concerning northern women’s health in regards to cervical cancer. This demonstrates the significance of gaining a better understanding of how gender and geography affect, and are affected by cervical cancer.

Cervical cancer has a high long-term survival rate after treatment when compared to other cancers (CTFPH, 2013). Unfortunately, these rates only matter if the cancer is diagnosed early, as more advanced instances of cervical cancer have a stronger association with mortality. The Canadian Task Force on Preventive Health Care (2013) reported that women who have never received, or have not obtained for a large period of time, a pap smear to screen for cancerous cells are most likely to possess an advanced form of cervical cancer. While it has been documented that yearly screening once over the age of 21 is unnecessary, it is vital that women be screened regularly. A study conducted by Worthington, McLeish, and Fuller-Thomson (2012) demonstrated that the number of women in Canada who have never had a pap smear is quite low (approximately 5 percent). However, this study also estimated that 17 percent of participants had variable adherence, indicating that encouraging women to undergo regular pap smears is still of great importance.

 A report constructed by the Cervical Cancer Prevention and Control Network (CCPCN) (2010) attempted to determine a set of key performance indictors to be used in pap smears across Canada to allow for a regular monitoring system where direct comparisons could be made within the country. It was discussed how recommendations were made to improve the screening process by outlining required components of organized screening. As of a follow up in 2006, no province or territory had implemented a system to ensure that all recommendations were met, with the following provinces and territories missing a majority of the recommendations: Quebec, New Brunswick, Yukon, Northwest Territories, and Nunavut Territory (CCPCN, 2010). This is particularly concerning given the already-lacking health services for northern women, as three of the five jurisdictions listed are located entirely within the northern regions of Canada. The lack of proper screening protocols in the territories may be dependent upon the fact that there is not a consistent presence of health professionals for women to build a relationship with, a factor that was recognized by Worthington and associates (2012) to be a common reason for women to report various levels of adherence to receiving regular pap smears. Screening for cervical cancer remains a factor in the overall health of northern women, as these women have a decreased likelihood to attend regular examinations.

Another area of significance for northern women in regards to decreasing rates of cervical cancer is placing a greater level of importance on the risks of human papillomavirus (HPV). Although HPV affects individuals of both sexes, women are more vulnerable to experiencing serious health risks if the virus is not treated. HPV is a common sexually transmitted infection that has been found to be strongly associated with the development of cervical health issues such as cervical cancer (Jiang et al., 2013). While the majority of HPV infections are asymptomatic and do not pose a health risk (Mah et al., 2011), persistent infections by a particular strain of the virus are of great concern. For instance, it has been discovered that types 16 and 18 of HPV are present in, and therefore partially accountable for, approximately 70 percent of all diagnosed cervical cancer cases (Jiang et al., 2013). Furthermore, Jiang and his colleagues (2013) claim that some form of “HPV is detected in almost 100% of women with invasive cervical cancer” (p. 1-2). To clarify, HPV does not necessarily result in cervical cancer. However, the majority of people diagnosed with cervical cancer are found to have a comorbid HPV infection. With the importance of viewing HPV with a gender lens identified, it is important to discuss the value of examining this infection in regards to geography. A cross-sectional study conducted by Jiang and his associates (2013) found that HPV prevalence varied by region, but overall was higher in Northern Canada than in other areas of Canada. With HPV potentially having such harmful impacts on women’s health, it is extremely important that northern women receive, and have access to, regular pap tests, as these exams can detect HPV and allow for the type of HPV to be determined.

Research has found that Aboriginal women have different experiences with cervical cancer than other women in Canada. To start, it has been noted by Young et al. (1997) that Aboriginal women are at greater risk for cervical cancer. While there is much speculation in the research as to why Aboriginal women are at a heightened risk, there is little definitive proof. Colleagues Browne and Smye (2002) discuss two possible explanations for higher prevalence among Aboriginal women for risk factors for cervical cancer. First, Aboriginal women are less likely to receive regular pap smears when compared to non-Aboriginal women, which as previously discussed can play a large role in Aboriginal women’s increased risks. Second, Aboriginal women show higher rates for some risk factors. For instance, the following four risk factors are believed to be linked to cervical cancer: being sexually active before the age of eighteen, having multiple sexual partners, having HPV, and tobacco use. All four of aforementioned factors are found in higher rates in Aboriginal women than in non-Aboriginal women (Browne & Smye, 2002). Another potential reason discussed by Hislop et al. (1996) (*as cited in* Browne & Smye, 2002) for the difference between Aboriginal women and non-Aboriginal women is cultural attitudes. For instance, the notion of prevention has not held a lot of significance in the Aboriginal community when compared to the promotion of being healthy. This indicates that healthcare’s promotion of women needing to receive pap smears in order to prevent cervical cancer would not be as effective in the Aboriginal population who respond better to promotional ads that discuss maintaining health, or getting healthier bodies. It is important to note that Aboriginal women’s different relationship with cervical cancer is not necessarily the same across all Aboriginal groups. Regardless, the strong prevalence of cervical cancer in Aboriginal women needs to be further examined for the benefit of all women.

Cervical cancer is a health status issue that the literature identifies as a serious area for concern for all women, but for women residing in the north in particular. While it is extremely important to be aware of the signs of cervical cancer and to receive regular pap tests, women need to be cautious of other cancers that primarily impact females.

**Breast Cancer.** Breast Cancer is a prevalent issue, and as of 2016 it remains the most common cancer diagnosis in women (Canadian Breast Cancer Foundation, 2016). While breast cancer can affect men, this is uncommon; therefore, this type of cancer is of more concern to women than to men. There is minimal research looking at breast cancer rates in northern Canada compared with other parts of Canada. The Canadian Breast Cancer Foundation does not report the territories on their chart that demonstrates the prevalence of breast cancer in each province, because the numbers from the territories are too small. When provinces are examined in a study about breast cancer, data typically include all areas of the province, making further comparisons of the north and south difficult. Breast cancer is a gendered disease that targets women; whether it targets northern women to the same or a differing degree as southern women remains to be studied.

A study implemented by Lubin et al. (1982) demonstrated that the causes of breast cancer might differ among postmenopausal women and premenopausal women. The study utilized the cases of 577 women who had breast cancer and resided in northern Alberta after all unaccounted for cases were excluded, and 826 control women. Northern Alberta was studied to due it being an area that at the time has high incidence rates of breast cancer across women from all age groups ranging from 30 to 80. The study was conducted between 1976-1977, and is thus an older study, but its findings are worth discussion. This study indicated that risk of breast cancer for women with both low parity and late age (older than age 24) for first birth instead of high parity and younger age for birth was found to exceed chances by sevenfold at older ages (older than 45), however it was found to be a slight deficit for younger women (under 45). Furthermore, it was found that there was a huge reduction in chances of breast cancer (more than 50 percent) for women aged 55-80 who had an early natural menopause. Interestingly, there was not an increased risk seen at ages 45-54 which the authors suggest indicates a ‘lag’ in the protective effective effects of undergoing early menopause (Lubin et al., 1982). These findings are important to note as they demonstrate some of the reasons why breast cancer rates differ so much among women. Additionally, the study mentioned that the control sample selected did not completely match the data gathered from census Canada particularly in the lowest age bracket examined. It was speculated that the information gathered and the census not matching may be due to urban-rural differences; however, there was no proof that this was the cause of the differences. This article highlights that at certain ages there are some different biological, cultural (i.e., age of first childbirth), and perhaps geographical (i.e., urban vs. rural communities) differences in some of the risk factors for breast cancer.

Although there is little research comparing breast cancer rates in northern Canada to other areas of Canada, exposure to the risk factors can be compared geographically. Although there is no current evidence that the following risk factors are directly linked to breast cancer, they provide potential topics of investigation for future research. With genetic factors accounting for approximately 5-10 percent of those who develop breast cancer, environmental and personal choices also play a significant role (Health Notes, 2012). According to the article “Breast Cancer: How to reduce your risk” (Health Notes, 2012), inactivity, obesity, and alcohol consumption are three of five lifestyle and environmental factors listed that have relationships to geography in the literature.

A study conducted by Shields and Tremblay (2002) revealed results that support the notion that alcohol consumption and obesity rates (contributed to by a non-active lifestyle) are geographically different throughout Canada, with northern communities scoring significantly worse[[1]](#footnote-1) than other peer groups on numerous factors deemed a health risk. Peer groups were determined by categorizing the 139 health regions into one of ten groups based on socio-demographic profiles, meaning that similar locations, size of the community, socioeconomic status, and exposure to health services were all taken into account. An algorithm developed by Statistics Canada formulated these peer groups (Shields & Tremblay, 2002). Peer groups C and F comprised northern communities where education levels were on average lower and that had a higher percentage of Aboriginals in the populations than other communities. The results indicated that both groups C and F scored either the same as, or significantly worse than, their peer groups on rates of obesity and heavy drinking. The only exception found in these groups was the Northwestern Regional Health Authority health section, which scored significantly better on the heavy drinking section. While this study did not specifically look at breast cancer rates and geographic variations across Canada, it does illustrate that some of the main risk factors for breast cancer are more prominent in the north. Furthermore, the aforementioned risk factors that are influenced geographically are also very common risk factors for a variety of other diseases. Therefore, the recognition of these factors may potentially lead to disease prevention activities for women in the north.

In addition to there being evidence of higher prevalence of risk factors for breast cancer, there is a significant lack of services that are capable to diagnosis and treat cancer in the North. With incidence of cancer on the rise, the Canadian government has publically announced a commitment to making treatment centers and options closer to homes (Brigden et al., 2015). While there have been some improvements made in establishing cancer centers out of the metropolitan areas in Canada, there remains to be a significant issue of having these centers in the north (Brigden et al., 2015). The lack of northern services is said to occur partly due to marketplace realities (Brigden et al., 2015). Regardless of what financial benefits come with services being offered in or near metropolitan areas, there is need of cancer services in the north, and people residing in the north should not be dismissed due to their location.

Cancer is a dangerous and deadly disease. Understanding what demographics make people more susceptible to having cancer at some point in their life is valuable. Gaining a better comprehension of these factors allows for prevention programs, such as treatment for excessive alcohol consumption, and services like pap smears will lead to a healthier society over all. The role that gender and geography play in regards to cancer is far from certain, and future literature needs to further exam these relationships. However, there are other health status issues that jeopardize women’s lives because of external situations.

**Violence Against Women.** Violence against women is categorized as a health status issue as violence is a condition that strongly influences women’s health. In Canada, approximately 51 percent of adult women report having experienced some form of violence personally at some point in their adult lives (Sen, 2016), thus indicating that half of the entire female population will potentially be exposed to some form of direct violence. Although measures have been taken to address the issue of violence against women in Canada, it remains a serious and consistent issue that is affecting communities countrywide (Sinha, 2013). Gendered violence is a challenging issue to address because it occurs in several different forms such as the following: rape, intimate relationship violence, domestic abuse, sexual abuse, incest, female trafficking, female infanticide, family abuse, genital mutilation, emotional abuse, and stalking (Sen, 2016). Although this list is not inclusive of all forms of violence against women, it does provide a sufficient overview of how pervasive this problem is in numerous interactions, with differing rates of severity at each level.

 Acts of violence impact women’s physical health not only through the direct abuse that occurs, but also through mental conditions like anxiety and depression manifesting in physical symptoms (Sinha, 2013). To reiterate, the literature demonstrates that women have increased emotional and mental problems, such as extreme levels of stress during and after being a victim of violence, which can have a negative effect on their physical health as well. Furthermore, a study conducted by Mericle and Havassy (2008) discovered that the majority of individuals entering treatment for mental health or substance abuse reported having experiences with violence as either the perpetrator or, more commonly, as the victim. The connection between substance abuse and violence is a highly debated topic in the literature as outlined by Parker and Auerhahn (1998). What is agreed upon is that, while gendered violence impacts all members of the community in various ways and with differing levels of severity, it does impact women’s mental and emotional health.

 Violence against women is a gendered issue, where all women are potentially at risk despite personal factors such as age, race, religion, class, etc. (Sen, 2016). With the gendered aspect of violence well documented in the literature, geographical components to gendered violence in Canada should be considered. In a report edited by Sinha (2013) for the Canadian Centre for Justice Statistics, it was stated that the territories, which comprise a vast majority of the north, have continually reported having the highest rates of violence against women. Additionally, all three territories had drastically higher rates of violent crimes in general than the rate for Canada, with Yukon’s rate being four times higher, Northwest Territories nine times higher, and Nunavut almost thirteen times higher than rates in Canada as a whole. When these numbers are analyzed by way of gender, female victims outnumber the male victims in all provinces and territories except British Columbia, with Manitoba, Saskatchewan and the Territories having some of the greatest gender gaps (Sinha, 2013).

 This geographical difference between northern Canada and other areas of Canada has been connected to northern women’s tendency to posses risk factors associated with gendered violence (Sinha, 2013). Statistical research in Canada has demonstrated that women in the north face higher probability of experiencing violence, compared to other women in Canada (Sinha, 2013). The reasons explaining why northern women are at a heightened risk are not completely understood, but many researchers have made the argument that some of the risk factors associated to being a victim of violence are more apparent in the northern female population. Four identified risk factors for gendered violence are young age (Johnson, 2005), being Aboriginal (Adelson, 2016), being single (Johnson, 2005), and having lower than a high school level education (Sinha, 2013). Each of these four factors has been identified as increasing risk of victimization, particularly being of a younger age and being Aboriginal (Sinha, 2013; Adelson, 2016). According to Sinha (2013), as of the 2011 and 2006 censuses, all four of these factors were found in higher rates in the north than the rest of Canada. The extent to which each of these risk factors, age, being Aboriginal, being single, and lacking a high school education; affects the likelihood of experiencing violence in the north is unknown. However, the identification of each of these factors allows for prevention and support groups to be targeted for these populations.

Violence against women is a dynamic issue that negatively impacts not only the victims, but also the entire community. The notion of violence as a gendered issue is well accepted by the general population and supported by academic research. Therefore, future directions should focus on examining compounding variables that place particular groups or individuals at greater risk. Note that violence against women in the north is further complicated by ‘health care’ issues at a community level such as delayed response times, lack of shelters, and limited health resources (Dyke, Stickle, & Hardy, 2012). As these issues in particular also affect other aspects of northern individuals’ health, they will be discussed in more detail in discussions of the Health Care System.

**Summary.** From illness, to disease, to conditions caused by the environment or social interaction, the studying of health status continuously proves to be an asset in understanding an individual’s health. To examine the relationship between health status and other factors, such as gender, allows for a more intrinsic understanding. Therefore, it is valuable to recognize the compounding influences that gender and geography can have on an individual’s wellbeing, as this allows for a greater understanding of northern women’s experiences and their struggles with all areas of health status issues.

While health status is an important area to study, it is important to be cautious that health status issues do not overshadow the significance of examining the health care system and health policies. Together, these three areas make up the Canadian health system, and allow for a deeper understanding of how women, specifically northern women, are at a vast disadvantage throughout their lives in all three of these areas simultaneously.

**Health Care System**

 The term ‘health care system’ has been used as interchangeably with the ‘health system’ as a whole, including policies, diagnoses, and diseases. For the remainder of this paper, the term health care system will refer only to the accessibility, quality, and quantity of the services provided by the health system. In the literature, considerable criticisms are presented regarding how the health care system in the north is operated, with recurring areas of concern being the minimal resources and the inaccessibility of the health care system. These two areas encompass a large portion of problems in the north in relation to the health care system.

 **Minimal Resources.** Northern communities are often remote and rural areas that are significantly under-resourced with health services, information and professionals (Leipert, Landry, & Leach, 2012). Northern Canada is noticeably lagging in regards to providing health care services. This discrepancy between the north and other areas of Canada occurs partially because of finances. As of 2009, the three territories were all paying more money per capita towards the health care system than the country of Canada as a whole, with Nunavut exceeding the country’s payment by approximately 11,000 dollars (Marchildon & Chatwood, 2012). Despite the government of Canada’s financial investments to improve the health care system, the territory as a whole is financially burdened. Marchildon & Chatwood (2012) argue that because of the large financial burden that would occur if Canada tried to establish comprehensive health care services in the north (i.e., with the communities being so scattered) it is easier and more affordable for the government to transport those in need the long distances to a more reputable health service. Funding is a significant barrier that is partially to blame for the minimal health resources in the north, but it is not the only obstacle.

 The lack of health resources in northern Canada is a complex issue that is compounded by several different variables such as the remoteness of the north; long distance between suppliers and receivers; low population densities; weather conditions; and funding. Young and Chatwood (2011) propose that the solution to the resource problem in northern Canada could be solved by Canada’s changing its suppliers. The authors present the argument that Canada could greatly benefit from forming circumpolar connections to receive supplies as opposed to the current north-south partnership (Young & Chatwood, 2011). This proposal demonstrates that there are potential solutions for the lack of resources, if professionals and the government are willing to consider new options to provide women in the north with the resources they need to develop and maintain good health.

There is an increasing need for health care professionals to come to the north (Leipert, Landry, & Leach, 2012). While placing emphasis on recruiting and retaining new doctors appears to be a logical option, on its own this measure has been unsuccessful in the past. Spencer and Spencer (2006) make the argument that to address this problem, the focus should be on early exposure to rural medical practices. It has been argued in the literature that physicians with rural medical training in school are more likely to take a job in a rural community. In response to the lack of health care professionals, primary care services in the north are dependent on nurses and midwives (Marchildon & Chatwood, 2012). It is common for these nurses to have advanced practical standing and be well trained in their job (Marchildon & Chatwood, 2012). However, they are missing three to four years of further education that a doctor receives. Having a regular doctor to form a bond with is extremely important for patient adherence, but in the north the majority of women are unable to find a family doctor (Turcotte, 2015); only 15 percent of women in Nunavut and 40 percent of women in Northwest Territories were able to report that they have a regular doctor (Turcotte, 2015). Another reason for addressing the lack of health resources in the north as a gendered issue is because rural communities are more likely to support larger families of a younger age than in other areas of Canada (Leipert et al., 2012). Throughout the full term of their pregnancy, northern women need a health care professional to ensure that both the mother and child are experiencing a healthy pregnancy. With northern women being more susceptible to numerous health problems, having a steady flow of resources becomes a gendered priority.

The lack of resources and health personnel in the north is particularly concerning because of the high Aboriginal population living in northern regions who are known to experience a disparate burden of disease (Marchildon & Chatwood, 2012). The Aboriginal population alone should be reason for more health resources in the north, let alone the aforementioned geographical interaction with gender putting northern women’s health at higher levels of risk. Although gender may not play an explicit role in resource issues like geography does, women are most likely to utilize health services, and are at more risk for contracting diseases or falling ill. Therefore, the gender impact of improving the amount of resources in the north is not disputable. However, the lack of resources is not the only problem identified with the health care system in the north.

**Accessibility.** A reemerging theme found in the literature is concern over the inaccessibility of the limited health services provided in northern Canada. Giesbrecht and colleagues (2014) recognize that while the topic of accessibility of the health care in the north has been presented and discussed by many researchers, the concept and operational elements (i.e., affordability, spatial access) are not often clarified. Young and associates make the comment that the health care system cannot be fully assessed by studies asking questions only of the perspective users; managers, policymakers, and health providers also need to be questioned for a proper valuation. Lack of accessibility is claimed to be a harmful factor in the north but is not discussed in further detail.

Accessibility to the health care system is a gendered issue in the same way that lack of resources is. Women frequently act as the primary caregivers for their children, are in need of a doctor more regularly than men for mandatory pap smears and check-ups during pregnancy, and are more likely to seek medical assistance when feeling unwell; under these circumstances, accessibility to health services should be considered a gendered issue. Issues of accessibility are mostly found in the north, as remote areas in other parts of Canada are closer to established and specialized health services. Although the implications for access to health services are unclear, it needs to be recognized for the large amount of impact it can have in particular circumstances.

**Summary.** Prior to the 1950s, in northern Canada the notion of a governmental health care system was almost completely absent (Marchildon & Chatwood, 2012). While much research still remains to be done on the effects of the current health care system on northern women, Canada has made vast improvements in its own system. The impact that the health care system has on women in the north is not always directly apparent in the research, but by looking at who utilizes the services, and who is at the most risk for illness, the gendered component becomes discernible. Although substantial information can be gathered from studying the health care system and health status, health policies have to also be studied for a comprehensive perspective on northern women’s health.

**Health Policies**

Health policies are created to provide set regulations for numerous issues, particularly development, implementation, and evaluation (Hankivsky, 2008a). The roles of health care policies are integral to the entire country, they lead the direction of the health care system by determining what areas need more attention, what is currently beneficial in the health system, and what changes can be made. The WHS, for example, is one such policy. In the case of the WHS, however, the argument has been made that this policy was ineffective partially due to the missing components in the strategy itself, such as having a set process for evaluation.

Unfortunately, some health policies are unsuccessful due to issues beyond the policy itself. For instance, Gore and Kothari (2012) conducted a policy analysis on health related initiatives from January 1st, 2006 to September 1st, 2011. During this research a contradiction was found between the policy documents at a provincial level (in this particular case British Columbia and Ontario) that stated the importance of further examination on social determinants of health, and the health sector, which had failed to incorporate any of the recommendations. Gore and Kothari (2012) make the argument that contradictions like this occur because of the neoliberal approach to economics that pushes for resources to go into a market, which therefore has resulted in the government’s inability to support potentially life-altering interventions to improve Canadian’s health and well-being. While the health sector is not the only important service that has received cuts in funding, the lack of implementation of health policies is disconcerting.

A study conducted by Sarker, Lix, Bruce and Young (2010), illustrated a need for health policies discussing the implementation of community-based prevention interventions in the north, to be properly enforced. This was a cross-sectional study that examined the three territories during two different time periods by examining data previously gathered by the Canadian Community Health Survey. The first round of data collection occurred from September 1st 2000 to November 2nd 2001. After this point, data collection occurred regularly every two years, with the second group of data being examined in this study being from January 4th, 2005 to January 8th 2006. This study found that for Aboriginal populations there was an increasing prevalence of chronic diseases not visible in non-Aboriginal populations (Sarker et al., 2010). Furthermore, a negative shift in the distribution of risk factors in the Aboriginal population was also observed. These results suggest that there is a lack of community-based preventive interventions, and a lack of primary care being given in northern communities (Sarker et al., 2010). These results demonstrate a clear need for health policies to take action, and demand that a higher level of health care and health services be provided in the north.

As previously established, Canadian health policies have room for improvement, specifically those policies pertaining to social demographics such as sex and gender (Hankivsky, 2006b), sexual orientation (Charest et al., 2016), geographical location (Sibley & Weiner, 2011), and ethnicity (Browne & Fiske, 2001). With increasing focus in health research being on social determinants (Sibley & Weiner, 2011), the intersections of multiple components are becoming increasingly important. Therefore, it is necessary for health policies to include a section on proper implementation of intersectionality, and to create a pre-determined system for evaluating the effectiveness of these practices. According to Varcoe, Hankivsky and Morrow (2008), intersectionality is the notion that gender is experienced simultaneously with experiences of other factors such as socio-economic status, nationality, race, age, sexual orientation, weight, disabilities, and other factors of social difference. In other words, intersectionality is a tool to examine the way an individual’s experiences with multiple forms of oppression (e.g., classism, racism) are influenced, impacted, or hindered by each other (Varcoe et al., 2008). Intersectionality does not assume that these experiences will add on top of each other but rather interact with each other in a way that alters, and influences the experiences an individual has. It would be extremely beneficial to use an intersectional approach when examining women’s health or men’s health, as it would draw attention to the differences among individuals of one sex rather than between the two different sexes (Varcoe et al., 2008). A focus on the differences among women would emphasize the way other factors such as but not limited to poverty, racism, sexuality, and geography intersects with the notion of gender to affect individual health experiences (Varcoe et al., 2008).

**Conclusions**

 Canada has been attempting to advance the health care system by acknowledging the value of women’s particular needs and experiences with health as a unique category. However, the current measures and policies in place to address the issue of women’s health are no longer effective, indicating that the current approaches in place need to be evaluated and altered. For instance, the WHS was an effective course of action in theory, but implementation of this health policy was underwhelming, specifically in regards to the absence of an evaluation process. Despite this, providing a good health care system for the country is not an easy task and overall Canada maintains a relatively high degree of health (Varcoe et al., 2008). Unfortunately, it appears that this high degree of health is not sustained across all regions and populations of Canada, with women having a lower health rate than men, and, specifically, women residing in northern communities. Women of northern Canada are confronted with unique barriers than women from other parts of Canada do not have to overcome. These additional obstacles ensure, regardless of amount of effort and determination, that women from the north are unable to experience well-being to the same degree. This remains true across all three levels of the health system as broken down by Hankivsky (2008a): health status, the health care system, and health policies. Northern women’s experience with the health system is an example that supports the need for future research to examine all encounters with health through different social determinant perspectives. Canada has considerable potential moving forward for developing policies to enforce research that utilizes different social determinant perspectives such as gender and geographical living locations.

References

Adelson, N. (2005). The embodiment of inequality: health disparities in Aboriginal Canada. *The Canadian Journal of Public Health, 96*, 45-61.

Austin, S., Tudiver, S., Chultem, M., Kantiebo, M. (2007). Gender-based analysis, women’s health surveillance and women’s health indicators – Working together to promote equity in health in Canada. *International Journal of Public Health, 52*, S41-S48. doi: 10.1007/s00038-006-6052-z.

Brannon, L., Feist, J., & Updegraff, J. (2014). *Health psychology: An introduction to behavior and health.* (8th ed.). Belmont, CA: Wadsworth Cengage Learning.

Brigden, M., La, W., Spadafora, S., El-Marghi, R., Whitlock, P., & Champion, P. (2015). Update on community oncology practice in Canada: A view from the trenches. *Oncology Exchange 14*, 12-16.

Browne, A. & Fiske, J. (2001). First Nations women’s encounters with mainstream health care services. *Western Journal of Nursing Research 23*(2), 126-147.

Browne, A. & Smye, V. (2002). A post-colonial analysis of healthcare discourses addressing aboriginal women. *Nurse Researcher, 9*(3), 28-43.

Browne, A., Smye, V., & Varcoe, C. (2008). Postcolonial feminist theoretical perspectives and women’s health. In Morrow, M., Hankivisky, O., & Varcoe, C. (Eds.), *Women’s Health in Canada: Critical Perspectives on Theory and Policy* (pp. 124-142)*.* Toronto, ON: University of Toronto.

Canadian Breast Cancer Foundation. (2016). Breast cancer in Canada, 2016. Retrieved 16 November 2016, from https://www.cbcf.org/ontario/AboutBreastCancerMain/FactsStats/Pages/Breast-Cancer-Canada.aspx

Canadian Task Force on Preventive Health Care. (2013). Recommendations on screening for cervical cancer. *Canadian Medical Association 185,* 35- 45.

Cervical Cancer Prevention and Control Network. (2010). *Performance monitoring for cervical cancer screening programs in Canada*. Report prepared by the Public Health Agency of Canada.

Charest, M., Kleinplatz, P., & Lund, J. (2016). Sexual health information disparities between heterosexual and LGBTQ+ young adults: Implications for sexual health. *The Canadian Journal of Human Sexuality 25*(2), 74-85. Doi: 10.3138/cjhs.252-A9.

Cole, M. & Healey, G. (2013). Doing the right thing! A model for building a successful hospital-based ethics committee in Nunavut. *International Journal of Circumpolar Health, 72*, 883-887.

Dyck, K., Stickle, K., & Hardy, C. (2012). Intimate partner violence: understanding and responding to the unique needs of women in rural and northern communities. In Leipert, B., Leach, B., & Thurston, W. (Eds.), *Rural Women’s Health* (197-214). Toronto, ON: University of Toronto.

Economic and Social Council (ECOSOC). (1997). Adopted by ECOSOC 18 July 1997. Retrieved 8 November 2016, from http://www.un.org/womenwatch/osagi/intergovernmentalmandates.htm

Gleb, K., Pederson, A., & Greaves, L. (2011). How have health promotion frameworks considered gender?. *Health Promotion International, 27*(4), 445-452. doi: 10.1093/heapro/dar087

Giesbrecht, M., Cinnamon, J., Fritz, C., & Johnston, R. (2014). Themes in geographies of health and health care research: Reflections from the 2012 Canadian Association of Geographers annual meeting. *The Canadian Geographer 58*(2), 160-167.

Gore, D. & Kothari, A. (2012). Social determinants of health in Canada: are healthy living initiatives there yet? A policy analysis. *International Journal for Equity in Health 11*(41), 1-14.

Hankivsky, O. (2006a). Reflections on women’s health and gender equality in Canada. *Canadian Woman Studies 25* (3,4), 51-56.

Hankivsky, O. (2006b). Beijing and beyond: Women’s health and gender-based analysis in Canada. *International Journal of Health Services, 36*(2), 377-400.

Hankivsky, O. (2008). Gender-based analysis and health policy: The need to rethink outdated strategies. In Morrow, M., Hankivisky, O., & Varcoe, C. (Eds.), *Women’s Health in Canada: Critical Perspectives on Theory and Policy* (pp. 143-168)*.* Toronto, ON: University of Toronto.

Health Canada (2010). *Women’s health strategy*. Retrieved from Health Canada Website: http://www.hc-sc.gc.ca/ahc-asc/pubs/\_women-femmes/1999-strateg/index-eng.php#why*:*

Jiang, Y., Brassard, P., Severini, A., Mao, Y., Li, A., Laroche, J., … Morrison, H. (2013). The prevalence of human papillomavirus and its impact on cervical dysplasia in Northern Canada. *Infectious Agents and Cancer 8*(25), 1-11.

Johnson, H. (2005). Assessing the prevalence of violence against women in Canada. *Statistical Journal of the United Nations ECE 22*, 225-238.

Leipert, B., Leach, B., & Thurston, W. (2012). Introduction: Connecting rural women’s health across time, locales, and disciplines. In Leipert, B., Leach, B., & Thurston, W. (Eds.), *Rural Women’s Health* (3-25). Toronto, ON: University of Toronto.

Lubin, J., Burns, P., Blot, W., Lees, A., May, C., Morris, L., & Fraumeni, J. (1982). Risk factors for breast cancer in women in northern Alberta, Canada, as related to age at diagnosis. *Journal of the International Cancer Institute 68*(2) 211-217.

Mah, C., Deber, R., Guttmann, A., McGeer, A., & Krahn, M. (2011). Another look at the human papillomavirus vaccine experience in Canada. *American Journal of Public Health 101*(10), 1850-1857.

Marchildon, G. & Chatwood, S. (2012). Northern Canada. *Circumpolar Health Supplements 9,* 41-52.

Mericle, A., Havassy, B. (2008). Characteristics of recent violence among entrants to acute mental health and substance abuse services. *Social Psychiatry & Psychiatric Epidemiology 43*, 392-402. doi: 10.1007/s00127-008-0322-4.

Morrow, M. (2008). ‘Our bodies our selves’ in context: reflections on the women’s health movement in Canada. In Morrow, M., Hankivisky, O., & Varcoe, C. (Eds.), *Women’s Health in Canada: Critical Perspectives on Theory and Policy* (pp. 33-63)*.* Toronto, ON: University of Toronto.

Morrow, M. & Hankivsky, O., (2008). Feminist methodology and health research: Bridging trends and debates. In Morrow, M., Hankivisky, O., & Varcoe, C. (Eds.), *Women’s Health in Canada: Critical Perspectives on Theory and Policy* (pp. 33-63)*.* Toronto, ON: University of Toronto.

Parker, R. & Auerhahn, K. (1998). Alcohol, drugs, and violence. *Annual Review of Sociology, 24*, 291-311.

Popadiuk, C., Gauvreau, C., Bhavsar, M., Nadeau, C., Asakawa, K, Flanagan, W., … Miller, A. (2016). Using the cancer risk management model to evaluate the health and economic impacts of cytology compared with human papillomavirus DNA testing for primary cervical cancer screening in Canada. *Current Onocology, 23*(1), 56-63.

Sarkar, J., Lix, L., Bruce, S., & Young, K. (2010) Ethic and regional differences in prevalence and correlates of chronic diseases and risk factors in northern Canada. *Preventing Chronic Diseases Public Health Research, Practice, and Policy 7(1)*, 1-11.

Schiebinger, L. & Stefanick, M. (2016). Gender matters in biological research and medical practice. *Journal of the American College of Cardiology 67*(2), 136-138.

Sen, P. (2016). Development and Violence against Women. *Gender and Development, 6*(3), 7-16.

Shields, M. & Tremblay, S. (2002). The health of Canada’s communities. *Supplement to Health Reports 13*, 1-24.

Sibley, L. & Weiner, J. (2011). An evaluation of access to health care services along the rural-urban continuum in Canada. *BMC Health Services Research 11*(20), 1-11.

Sinha, M. (2013). Measuring violence against women: statistical trends. *Statistics Canada, Catalogue no. 85-002-X.*

Spencer, A. & Spencer, S. (2006). It takes more than rural roots to make a rural doc. *Canadian Journal Rural Medicine, 11*(2), 129-130.

Statistics Canada. (2009). Box 1 Definitions of rural. *Original catalogue no. 21-006-X.* Retrieved from: <http://www.statcan.gc.ca/pub/21-006-x/2007007/6000446-eng.htm>.

Sutherns, R. (2004). Understanding rural and remote women’s health in Canada. In Sutherns, McPhedran, & Haworth-Brockman (Eds.), *Summary report remote and northern women’s health: Policy and research directions* (B3-B7). *Centres of Excellence for Women’s Health,* 1-322.

Sutherns, R., McPhedran, M., & Haworth-Brockman, M. (2004). Introduction. In Sutherns, McPhedran, & Haworth-Brockman (Eds.), *Summary report remote and northern women’s health: Policy and research directions* (A3-A7). *Centres of Excellence for Women’s Health,* 1-322.

Turcotte, M. (2011). Women in Canada: A gender-based statistical report. *Statistics Canada, Catalogue no. 89-503-X*.

United Nations Women. (2014). *Beijing declaration and platform for action: Beijing +5 political declaration and outcome*. Report prepared by the United Nations for Fourth World Conference on Women, Beijing, China.

Varcoe, C., Hankivsky, O., & Morrow, M. (2008). Introduction: Beyond gender matters. In Morrow, M., Hankivisky, O., & Varcoe, C. (Eds.), *Women’s Health in Canada: Critical Perspectives on Theory and Policy* (pp. 3-30)*.* Toronto, ON: University of Toronto.

William, A. & Kulig, J. (2012). Health and place in rural Canada. In Kulig, J. & Williams, A. (Eds.), *health in rural Canada.* (pp. 1-20). Vancouver, B.C.: UBC Press.

Worthington, C., McLeish, K., & Fuller-Thomson, E. (2012). Adherence over time to cervical cancer screening guidelines: Insights from the Canadian National Population Health Survey. *Journal of Women’s Health 21*(2), 199-208. doi: 10.1089/jwh.2010.2090.

Young, K. & Chatwood, S. (2011). Health care in the North: what Canada can learn from its circumpolar neighbours. *Canadian Medical Association Journal 183*(2), 209-214.

Young, K., McNicol, P., & Beauvais, J. (1997). Factors associated with human papillomavirus infection detected by polymerase chain reaction among urban Canadian Aboriginal and Non-Aboriginal women. *Sexually Transmitted Diseases, 24,* 293-298.

Young, K., Ng, C., & Chatwood, S. (2015). Assessing health care in Canada’s North: what can we learn from national and regional surveys? *International Journal of Circumpolar Health 74*, 1-14.

1. ‘Significantly worse’ adheres to the language of the study in question, as participants were evaluated on a scale where they were significantly better, the same as, or worse than the other peer groups. [↑](#footnote-ref-1)