

# The Perceptions of Women in Northern Ontario about Their Reproductive Healthcare

by

Lisa Morgan

A thesis submitted in partial fulfillment  
of the requirements for the degree of  
Doctor of Philosophy (PhD) in Interdisciplinary Rural and Northern Health

The Office of Graduate Studies  
Laurentian University  
Sudbury, Ontario, Canada

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# **THESIS DEFENCE COMMITTEE/COMITÉ DE SOUTENANCE DE THÈSE**

**Laurentian Université/Université Laurentienne**

Office of Graduate Studies/Bureau des études supérieures

Title of Thesis

Titre de la thèse

The Perceptions of Women in Northern Ontario about Their Reproductive Healthcare

Name of Candidate

Nom du candidat

Morgan, Lisa Ann

Degree

Diplôme

Doctor of Philosophy

Department/Program

Département/Programme

Ruran and Northern Health

Date of Defence

Date de la soutenance October 15, 2021

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## **ABSTRACT**

With a goal to improve service provision, this study examined the experiences of women in Northern Ontario with respect to their uptake of reproductive healthcare services. As part of my mixed methods study, women in Northern Ontario completed a survey, offered in English and French, about their reproductive healthcare experiences, and a portion of participants were also interviewed. A multimodal recruitment strategy and maximum variation sampling was applied, with a goal of collecting the experiences of a diverse group of women.

Analysis was based on 173 completed surveys and 19 semi-structured qualitative interviews. The interview data is grouped under five conceptual constructs, with “gender” as an overarching construct, found to be a factor in the remaining four: the characteristics of good care; the relationship with the provider; the care environment, and administrative practices. Additionally, respondents felt that midwives excelled at providing quality reproductive healthcare and would favour increased access to midwives for reproductive health care throughout their lives.

For the survey data, I used descriptive statistics and multivariate linear regression models to determine whether residency, language, education, income, overall health, access to care, having a family physician, and preferring female providers (independent variables) were associated with the perceived quality of reproductive healthcare services and choosing a midwife. Most survey participants rated their reproductive healthcare experiences as fair to good overall but indicate room for improvement in the relationships with their providers and administrative support. Women residing rurally, without a family physician, and lower socioeconomic status are statistically more likely to prefer a midwife for reproductive healthcare.

The survey results indicate a preference for female healthcare providers by the majority of interviewees.

Changes driven by strong health policy may be required to engage women in recommended reproductive healthcare more fully. Although northern geography will always present challenges that may not be subject to amelioration, other factors preventing women from accessing care are more amenable to change, and as argued here, this is a right of women and an obligation on the part of governments to provide equitable access for all Canadians to healthcare services.

**Key Words:** reproductive healthcare, patient-centred care, relational care, scopes of practice, access, acceptability of care, health equity, north, Northern Ontario, cervical cancer screening, healthcare service quality, gender.

## **CO-AUTHORSHIP STATEMENT**

I declare that this thesis represents my original work. I was guided throughout by my academic committee, which changed several times throughout my PhD journey. I acknowledge the early inputs to my work by my original supervisor, Dr. Susan James. Other members of my team at the time included Dr. Philippa Spoel, and Dr. Rachel Ellaway. Dr. Jennifer Johnson replaced Dr. Spoel in August 2013 in order to allow for expert guidance with respect to feminist theories and research methods. Dr. James was replaced by Dr. Elizabeth Wenghofer prior to ethics approval in May 2014. Dr. Sylvie Larocque replaced Dr. Ellaway in 2018 when Dr. Ellaway relocated to the University of Calgary. The literature search, survey tool and interview guide development, data collection and analysis were conducted by L. Morgan.

For the manuscript ‘Ratings by Women of their Reproductive Healthcare Service Quality in Northern Ontario’, L. Morgan and E.F. Wenghofer developed the data analysis strategy and worked through several drafts of the manuscript prior to sharing with J.L. Johnson and S. Larocque for further comments. The team worked together on final revisions in preparation for publishing.

For the manuscript ‘Cervical Cancer Screening Experiences & Preferences for Midwives in Northern Ontario’, L. Morgan and E.F. Wenghofer developed the data analysis strategy and worked through several drafts of the manuscript prior to sharing with J.L. Johnson and S. Larocque for further comments. The team worked together on final revisions in preparation for publishing.

For the manuscript ‘Perceptions about Reproductive Healthcare Services in Northern Ontario: A Qualitative Description’, L. Morgan developed the data analysis strategy with the guidance of R.H. Ellaway, and later with the help of S. Larocque and J.L. Johnson. There were

in-depth discussions with J.L. Johnson and S. Laroque separately and as part of full committee meetings to guide the development of my qualitative themes and recommendations. The manuscript was shared with J.L. Johnson and S. Larocque for revisions prior to sharing with E.F. Wenghofer for final edits in preparation for publishing.

L. Morgan drafted this thesis document under the direction of E. F. Wenghofer (doctoral supervisor), J.L.Johnson, and S. Larocque (thesis committee members). E. F. Wenghofer assisted with table of contents creation and formatting.

I am aware of Laurentian University's Policy on Authorship and I certify that I have properly acknowledged the contribution of other researchers to my thesis. I certify that this thesis, and the research to which it refers, is the product of my own work.

## **ACKNOWLEDGEMENTS**

I would like to start by expressing my appreciation to my supervisor, Dr. Elizabeth F. Wenghofer, and to the rest of my thesis committee, Drs. Jennifer L. Johnson and Sylvie Larocque. I appreciate your patient and steadfast support in turning this healthcare professional into a researcher and an academic. Thank you for your thoroughness in reviewing and improving my writing. Your insights have helped me to think systematically about health policy and healthcare in northern settings. I look forward to collaborating as colleagues in future.

The ten year journey, and ultimate completion of this thesis and my PhD would not have been possible without the love and support of my family and friends. My daughters Kyra and Lia inspire me to reach for my dreams as I set an example of lifelong learning for them and my grandchildren. My husband Ronald gave great hugs, and took care of everything and everyone so that I could focus on my education. I would like to thank Oxana Mian for statistical methods tutoring. Sophie, Gar, Leigh, and Lia: Thank you for the long hours spent proofreading my thesis and for the supportive conversations along the way.

Finally, I would like to thank the School of Rural and Northern Health for providing an academic home for the research that is important to me and midwifery, and for the opportunity to study part-time, allowing me to pursue further education while continuing to teach the next generation of midwives. I would like to thank the women of Northern Ontario who took the time to complete my survey and speak to me about their experiences. It is my hope that through our combined efforts, we can contribute to changes leading to a more safe and equitable system of reproductive healthcare for all.

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## CHAPTER 1: INTRODUCTION

The goal of this research was to analyse the factors that encourage or limit women's uptake of reproductive health services and investigate whether having the option to receive these services from a midwife would be an acceptable alternative. An appreciation of the factors preventing adherence to recommended healthcare and screening could lead to innovations able to improve the perceived quality. Studies have shown that adherence to medical advice is directly related to the perceived quality of the service and the resulting health outcome (O'Connor, Shewchuk & Carney, 1994; Sandoval, Brown, Sullivan & Green, 2006). If service quality perceptions are critical in determining behavioural intentions, we can hypothesize that women's perceptions of their reproductive healthcare quality affect their decisions to engage in recommended reproductive healthcare programs (Dagger, Sweeney & Johnson, 2007). This study seeks to understand the experiences of women accessing reproductive healthcare.

My study primarily uses the word 'woman' to refer to a person with female reproductive organs, requiring appropriate reproductive healthcare based on their biological risks. For example, people with a cervix require cervical cancer screening, regardless of their gender identity. I acknowledge that the term 'women' refers to gender, and the word 'female' may be more appropriate when discussing clinical care. Health Canada clarifies that sex refers to the biological characteristics, such as anatomy and physiology or the functioning of organs and hormonal activity that distinguish females and males (Health Canada, 2003). Some of the available measures of sex include reproductive organs, secondary sex characteristics such as breasts, physiology, the hormonal and endocrine systems, and genetics, which involves the chromosomes (Johnson, Greaves & Repta, 2007). Feminist scientists argue that the western

model of medicine and science has reinforced a two-sex model in tandem with contemporary political and social acceptance of male/female aligning with fairly rigid and fixed social behaviours and status (Lorber, 1993). In the 1990s, science had not caught up with the complexity of human genetics and hormones, nor grappled with the embeddedness of scientific inquiry in social relations of power (Lorber, 1993). Science, politics, social and religious institutions have all insisted on a two-sex model that conveniently reinforces a hierarchical gender system with only two genders (Lorber, 1993). In contrast, gender identity describes how we see ourselves, reflected as female, male, or a third gender (e.g., two-spirited) (Johnson et al., 2007). Gender identity develops in the face of societal messages about the correct gendered role for our presenting sex (Johnson et al., 2007). The development of a better understanding and measures of sex and gender will lead to increased knowledge about their interactions (Johnson et al., 2007). The word woman/women will be used throughout the thesis for clarity but for reasons of inclusiveness, ‘people/person(s)’ will be substituted when speaking in more general terms and the word ‘participant’ when referring to the people who completed my survey or interview.

When considering changes to health policies, there is a need to appreciate the current climate of fiscal restraint, particularly in healthcare, while maintaining quality and timely access to services (Ministry of Health and Long-Term Care, 2010; Drummond, 2012). Healthcare savings may be realised, and consumers may benefit from timely access to quality care through expanded scopes of practice for healthcare practitioners (Government of Ontario, 2012). Healthcare providers residing and working in rural, remote, and northern communities need tools and policies that support providing a wide range of services to meet the populations' needs. Of the current reproductive healthcare providers (i.e., physicians, nurses, nurse practitioners, and midwives), midwives specialize in providing reproductive healthcare, which is their sole focus.

This concentration on reproductive health care lends expertise to the work of midwives. Many providers of this care work under limited scopes of practice. Although appropriate for some settings, areas experiencing shortages of healthcare providers may benefit from expanded scopes of practice to meet the population's needs. This study examines the enablers and barriers to seeking reproductive healthcare in Northern Ontario and collects the opinions of participants on the acceptability of midwives providing this care.

## **1.1 The Research Problem**

There is a gap in timely access to reproductive healthcare services for Northern Ontario residents, suggesting a clear need for a redesign of how these services are delivered. Current policies affect populations unevenly, with Indigenous peoples and those residing in rural, remote, and northern areas being particularly vulnerable to difficulties accessing healthcare (Bourassa & Peach, 2009, Matsumoto, Bowman & Worley, 2012, Angus, Lombardo, Lowndes, et al., 2013). The intersection of stressors exacerbates the problems with timely access to quality care. Perhaps with changes to the health policies that guide reproductive healthcare, the gap in access to care in northern settings can be narrowed, reflecting a more equitable approach to care delivery.

Few research studies focus specifically on women's reproductive health in northern settings, despite acknowledgment that rural, remote, and northern residency contributes to unequal access to health services due to challenging geography and climate (Health Canada, 2014). In rural and northern areas of Ontario, women have the lowest life expectancy in the province, and they experience limited access to healthcare practitioners and services (Liepert & George, 2008). Access is not the only barrier, as the prevalence of ageist, sexist, and racist beliefs and stereotypes interfere with healthcare seeking and diagnosis and treatment

recommendations in the North (Chrisler, Barney, & Palatino, 2016). Other barriers that impact women's uptake of reproductive healthcare include lack of knowledge, perception of low risk, feelings of embarrassment, fear of diagnosis, anxiety, expectations of pain, other health problems, limited access to female physicians, lack of communication with one's physician, transportation problems, and lack of time (Akinlotan et al., 2017). Policies and programs should appreciate the geographical, sociopolitical, economic, and personal factors that may hamper access to services (Columbien, Busza, Cleland, & Campbell, 2012). As we do not have a complete understanding of these factors affecting women seeking reproductive healthcare in Northern Ontario, this study intends to gather this information to inform health policy.

## **1.2 Research Questions**

The primary goal of my research was to examine strategies to increase the uptake of reproductive health services in Northern Ontario.

This study addresses five research questions:

1. How do women perceive their reproductive healthcare?
2. How do women's perspectives of their reproductive healthcare influence their use of reproductive healthcare services?
3. What elements of a woman's reproductive healthcare experience enable her to engage more fully in recommended care?
4. What elements of a woman's reproductive healthcare experience act as a barrier to obtaining care?
5. Do women view midwifery care as an acceptable alternative to current providers or options for reproductive healthcare?

I aimed to analyze the factors that encourage or limit women's uptake of reproductive health services and whether having the option to receive these services from a midwife would be an acceptable alternative. Midwives may be suitable care providers for providing reproductive healthcare outside of childbearing, especially for vulnerable populations living in low-resource settings. Midwives already possess the necessary skill set to deliver all elements of reproductive healthcare, are already present in many of these communities, and are appreciated by the clients they serve.

### **1.3 Thesis Structure**

After presenting an overview of the project, including the research problem and the research questions, this overview of the thesis structure is provided to guide the reader. In Chapter 2, the literature review looks at the healthcare system more generally, including the history of health policy and current health policies guiding the delivery of care provincially. An examination into the theoretical frameworks that guide my research are presented alongside the literature review for Women's Healthcare and Feminist Research Methods. Chapter 2 also touches on Indigenous healthcare, as not addressing this topic would be remiss in an investigation into healthcare delivery in the north. Rural, remote, and northern healthcare and Reproductive Healthcare is the focus of my thesis and background information about their unique challenges can also be found as part of the literature review. The theoretical underpinnings of quality in healthcare, measuring perceptions of care and the development of the measurement tool for my study conclude Chapter 2. Chapter 3 outlines the adopted methodology for my study with a careful look at the choice of mixed methods, with particular attention to surveys and interviews. Recruiting and ethics, and the qualitative and quantitative analysis plans

complete Chapter 3. Chapter 4 is the first chapter presenting the study findings in the format of a publishable paper, exploring the survey results specific to participant's ratings of their reproductive healthcare experiences. Chapter 5 focuses specifically on Northern Ontario women's preferences with regards to cervical cancer screening. This paper also explored cervical screening frequency compared with national and provincial averages, reasons for adherence to recommended screening intervals, and preferences for female providers for care. Chapter 6 presents the results from the qualitative portion of the study, collected through semi-structured interviews. I sought to expand on the information gained through the survey. I was interested in following up on opinions about the care environment and preferences for gender, type, and location of providers for reproductive healthcare. As this research specifically sought to gauge the acceptance of midwives for providing reproductive healthcare outside of pregnancy, I asked each interviewee about their knowledge of midwives and their opinions about the quality of the care they provide. The inclusion of these three papers differs from the 'traditional thesis format' but is meant to encourage the timely dissemination of results. Chapter 7 will provide an overview of the findings from the survey and interviews and consider the combined results.

Recommendations are offered for changes to the existing reproductive healthcare delivery system and an expanded role for midwives. Concluding thoughts will include the health policy implications of following through with any suggested changes.

In summary, efforts to make reproductive healthcare more available throughout Ontario, including its most remote areas, may benefit those persons residing in Northern Ontario. Efforts are complicated by a climate of fiscal restraint and limited by health policies that are not evidence-based. Perhaps the evidence is not applied due to the power of the current political forces, or the evidence is absent; the healthcare delivery system's performance and its

functioning require closer scrutiny in northern environments. Recent changes to healthcare include the introduction of nurse practitioners and physician assistants, as the system attempts to adjust to changing conditions. Consumers can be in the driver's seat in guiding future changes. Health planners in Ontario claim to want to hear from the recipients of care, valuing their inputs on the best care. Timely access to care is a pressing concern. This research brings the voices of the recipients of reproductive healthcare in Northern Ontario to the forefront to guide change. Changes may result in improved access to services and improved health for women.

## **CHAPTER 2: LITERATURE REVIEW & THEORETICAL BACKGROUND**

In this chapter, I outline literature that elaborates or supports a better understanding of the research problem, which is that there is a lack of understanding of women's perceptions of reproductive healthcare in the north. In this review, I demonstrate that there is a deficit in literature about the women's views on reproductive healthcare in Ontario's northern, rural, and remote areas. I present this literature to demonstrate that reproductive healthcare in the north can be greatly enhanced by considering the voices of women in Northern Ontario.

This chapter starts with a look at our healthcare system from the early guiding health policies to the current policies directing the provision of care. Following on, I discuss women's healthcare and why a policy framework emerged around the category woman and their reproductive needs. I trace the shift from women's healthcare to feminist research where I adopt an intersectional gender lens; I indicate how the lack of an intersectional gender lens demonstrates neglect of women's interests, especially in northern areas. The literature on the importance of studying women's healthcare in northern, rural, and remote settings and the specific problems that exist for reproductive healthcare services follows. This chapter concludes with a look at the concept of quality in healthcare and the theoretical frameworks around measuring perceptions of care or gauging satisfaction with care. Specifically, the choice of adapting the Hierarchical Model of Health Service Quality (HMHSQ) tool for my study is explained along with its operationalisation as a survey and as an interview guide. It is my intention that the reader will be given an appreciation for the problems faced by women when accessing care. This may fill the gaps in our knowledge about their challenges and clarify the approach my study takes to fill this knowledge gap.

Any framework fit for examining reproductive healthcare in a low resource setting like Northern Ontario benefits from an appreciation of feminist health planning, the role of agency, and the psychological underpinnings of accessing required or recommended care. These psychological underpinnings are 'perceptions,' and they have long been an interest of commercial enterprises, now backed by several decades of exploration into its application to healthcare settings. The adaptation of an existing robust tool to capture perceptions of satisfaction with reproductive healthcare may guide changes to care provision that may stress the medical paradigm, potentially ushering in consumer mediated changes.

## **2.1 The Healthcare System**

When accessing care, consumers have a right to healthcare services and health promotion programs in agreement with the Universal Declaration of Human Rights (United Nations, 1948) and the International Covenant on Economic, Social, and Cultural Rights (United Nations, 1976). According to the International Covenant, the right to health is an inclusive right, extending to timely and appropriate healthcare, and the right to access other determinants of health (United Nations, 1976). Along with water, sanitation, food, and housing, the list includes access to health-related education and information, including sexual and reproductive health information, and participation in health-related decision-making (United Nations, 1976). It is imperative to recognise that patient autonomy dictates that health consumers have the right to decide what care is best for them (Rosenthal & Shannon, 1997). What we experience as illness may be shaped by our cultural and moral values, experienced through interaction with one's social circle and visits to healthcare professionals, and influenced by beliefs about health and illness (Lorber & Moore,

2002). In the future, healthcare policy should aim to support patient autonomy, reflected by access to governance and choice in accessing a wide range of health-enhancing supports.

According to the World Health Organization (WHO), the definition of a health system is a collection of activities whose primary purpose is to promote, restore, or maintain health (WHO, 2000). The goal of a health system is the delivery of effective, preventative, and curative health services to the entire population equitably and efficiently (WHO, 2000). The United Nations Committee on Economic, Social and Cultural Rights noted that governments are obligated to ensure the availability, accessibility, acceptability, and quality of health services (Committee on Economic, Social and Cultural Rights, 2000). Governments meet their obligations through health policies designed to ensure accessibility and quality. The resulting health system, funded by taxpayer dollars, needs to be responsive to their needs. More flexible health policies will be required to promote, restore, or maintain vulnerable populations' health, including those residing in rural, remote, and northern environments.

### ***2.1.1 History of Healthcare Policy in Canada***

Any examination into the factors affecting uptake of recommended health services benefits from an appreciation of the historical policies that inform the current delivery system. Greenhalgh (2011) defines policy as "the authoritative exposition of values" (p.92). The *Canada Health Act* (CHA) of 1984 is foundational to Canada's publicly funded healthcare system. The Act ties funding to adherence with Medicare's critical principles of universality, comprehensiveness, portability, accessibility, and public administration (Department of Justice, 1985). From Simpson's (2012) examination of deficits in Canada's healthcare system, the author reminds us that Medicare is a payment system for physicians and hospitals and not a social

service system to promote healthy lifestyle choices, reduce income inequalities, or limit accidents. The CHA resulted from acrimonious meetings with ministers, accusations of bad faith, new financial arrangements, threatened and actual withdrawal of services by physicians, and a national debate over user fees and extra-billing (Simpson, 2012). The Act reiterated the principles of Medicare but did not prevent the spread of private medical care nor stop the increase in costs, causing both the provinces and the federal government to launch another round of studies and commissions in the 1990s to diagnose what ailed Medicare and how to fix it (Simpson, 2012). Current policies do not prioritise Medicare's key principles of universality: comprehensiveness, portability, or accessibility (Simpson, 2012). Under the domain of medicine, the current health system claims to follow scientific best practices but must reconcile its value-laden delivery with its failure to recognise the needs of the patient (Greenhalgh, 2011).

To guide change, provincial and federal governments have examined Canadian's perceptions of their current healthcare system. A survey done for the Romanow Commission in 2002 found that, although attached to their current healthcare system, only 37% of respondents thought the system was fine the way it was (Romanov, 2002). A 2006 federal government-sponsored Healthcare in Canada survey sought to understand how Canadian perceptions had changed since the Romanow Commission, including whether Canadians saw the system as improving or deteriorating, and how they viewed governments' performance on healthcare issues (Soroka, 2007). The results indicated that 57% of respondents reported receiving quality healthcare, while 55% favoured complete rebuilding or making significant repairs to the healthcare system (Soroka, 2007). A 2011 Deloitte survey of consumer satisfaction found that only 32% of Canadians were satisfied with the performance of the healthcare system, while 57% gave a failing grade for wait times (Simpson, 2012). Healthcare system reform is complex and

complicated as it attempts to adapt to existing incentives and constraints. Some worry that if the stressors remain the same, the system will remain unchanged (Simpson, 2012). Change may only come from revising incentives and removing constraints, in line with the goals of my study to identify enablers to maximize their effect and minimize barriers. Legislation, regulation, and health policy are the tools required to make the necessary changes, with consumer input to identify strategies to improve access to reproductive health promoting services.

### **2.1.2 Current Ontario Healthcare Policies**

In response to underwhelming consumer faith in the current system, successive governments during the last decade have actively sought health consumer input. In response, the *Patients First: Action Plan for Healthcare* introduced four key objectives: improving access; delivering better coordinated and integrated care in the community; supporting the needs of people and patients; and protecting our universal public healthcare system by making evidence-based decisions on value and quality to sustain the system for generations to come (Government of Ontario, 2016). This input was in response to the *Drummond Report* (2012), where the authors urged policymakers to center the system on the patient. The *Drummond Report* suggested that policies should have evidence of effectiveness and efficiency and that there should be a heightened focus on preventative care to be eligible for public funding (Drummond, 2012). The report also asserted that quality care and cost restraint could co-exist (Drummond, 2012). In seeking efficiencies, the *Drummond Report* considered the roles of multiple professions, suggesting that health service provision could be shifted to lower-cost caregivers (Drummond, 2012). This suggestion agrees with recommendations outlined in *Ontario's Action Plan for Healthcare* (2012), which stated that the 'right care' means care provided by the appropriate healthcare professional. The Ontario government has taken steps to expand the scope of practice

of several healthcare professionals, such as nurse practitioners and pharmacists, to contribute fully to the benefit of patients (Government of Ontario, 2012). The current Conservative government continues to claim its exploring ways to fully maximize the available range of healthcare professionals and their skills in the province (People's Health Care Act, 2019).

Perhaps in response to healthcare consumers, or more likely due to austerity measures, the Ontario government has shown itself to be open to discipline substitution. As part of the *Excellent Care for All Act* (2010), task-shifting to other care providers was introduced, as implementation may lead to less reliance on physicians alone to meet the demands of the population. Through appropriate planning and management, a healthcare workforce with the correct number and mix of caregivers is possible, tailored to the needs of the people (Excellent Care for All Act, 2010). Several Canadian jurisdictions have passed legislation to expand healthcare professionals' scope of practice to give patients more options for care and allow health professionals to deliver more services (Simpson, 2012). These examples act as proof that altered incentives and the removal of regulatory constraints can lead to innovation in the cadres of healthcare professionals permitted to provide reproductive healthcare by expanding their associated scopes of practice.

The current Conservative government in Ontario introduced the *People's Health Care Act* (2019) with the stated aim of establishing a new model of integrated public healthcare delivery which would put each patient at the centre of a connected care system anchored in the community and respectful of regional differences (People's Health Care Act, 2019). Of note was acknowledging the need to address francophone and Indigenous needs in healthcare planning. The Act recognised the *French Language Services Act* (1990) requirements in the planning, design, delivery, and evaluation of healthcare services for Ontario's French-speaking

communities. The role of Indigenous peoples in the planning, design, delivery, and evaluation of health services in their communities was also upheld in this piece of legislation (People's Health Care Act, 2019). The *People's Health Care Act* (2019) mandated the dissolution of the 14 Local Health Integration Networks (LHINs) created under the Local Health System Integration Act (2006). This was a curious change as the LHINs were created to ensure a more regionalized approach to the planning, funding, and delivery of healthcare in Ontario, which is the same goal of the health teams that would replace them. Following the restructuring, the *Connecting Care Act* (2019) led to the creation of regional health teams to streamline care, with a goal to reduce wait times. The current government touts the advantage as making a wide variety of different health-care organizations accountable together for patients within a geographic region for the first time in the province, despite few details about how they will be governed, funded, or function (Ontario Health Coalition, 2021). Six of Ontario's largest health agencies merged into one central Ontario Health agency (People's Health Care Act, 2019). Cancer Care Ontario was part of this merger. Specific to reproductive healthcare, the elimination of Cancer Care Ontario could affect cervical cancer screening promotion and data analysis. Other changes under the current government include the defunding of the College of Midwives of Ontario, removing the updated sexual education curriculum, requiring that teachers revert to the 1998 version, and the cancellation of drug coverage to youth under 25 years of age, limiting access to birth control and treatments for sexually transmitted infections (STIs) (*Connecting Care Act*, 2019). Funding for the Health System Research Fund was also cut along with all funding to the Mowat Centre (Whaley, 2020). The closing of the Mowat Centre ended decades of evidence-based, applied public policy research on crucial foundational policies, including the effects of rural versus urban residency (Whaley, 2020). The implications of these changes for rural and northern communities

could include reduced access to birth control and sexually transmitted infection (STI) treatment medications, higher professional fees for midwives, and a lack of research into the effects of future changes to rural and northern communities specifically. Health leaders will need to remain vigilant and, if necessary, advocate for the rural and northern communities they represent (Whaley, 2020).

### **2.1.3 Women's Healthcare and Feminist Research**

Women's health is a political, social, and economic matter (Boscoe, Basen, Alleyne, et al., 2004). The women's health movement was the first to apply new visions, new information, new research approaches, and service evaluation to improve women's experiences seeking health services (Boscoe et al., 2004). Many have argued that addressing what women themselves see as key priorities in their reproductive healthcare experiences may allow for more effective delivery of services to those most affected by its' quality (Liepert & Reutter, 2005). Key informants should include those who receive a particular form of care. Their aversions, experiences, and preferences may shape whether they access care. There has been a historical reluctance to allow lay voices to inform the provision of services in general, and those having to do with women's reproductive health. The 1960's, 1970's and 1980's saw the birth of the women's health movement in Canada with a focus on the healthcare delivery system and the social determinants of health to increase women's participation (Boscoe et al., 2004). It was clear that improving the health of women meant paying attention to education, housing, the environment, and economic and social policies (Boscoe et al., 2004). These early actions led to the formation of the Canadian Women's Health Network (CWHN) and the 1999 release of its *Report from Consultations on a Framework for Sexual and Reproductive Health* (CWHN, 1999). The report emphasized the importance of engaging with groups at particular risk or the doubly disadvantaged (CWHN,

1999). Such groups include women with disabilities, immigrant women, women of colour, Indigenous women, adolescent and older women, the poor, and those living in rural or isolated areas (CWHN, 1999). The resulting knowledge base could inform and support the approaches to patient education, health promotion and healthcare (CWHN, 1999). Some advances were realised such as limited alternative delivery models for providing care to women who are considered ‘hard to reach’, but sadly, despite proven effectiveness, most programs remain marginalised by inadequate funding, if they still exist at all (Boscoe et al., 2004). The CWHN could not secure a stable source of funding and closed its doors in 2017 (CWHN, 2021).

Currently, some initiatives exist to provide health care to the most vulnerable. Community-governed primary care models exist to serve socially disadvantaged and Indigenous peoples and nurse practitioner-led clinics are more prevalent, although still concentrated in southern Ontario (Lavis, 2016). The Ministry of Health and Long-Term Care funds four centres to provide women-specific health services but three are in Toronto and the third in Peterborough, with no centres in Northern Ontario (MOHLTC, 2021). Access to midwives has improved, as their numbers have grown, and midwife staffed birth centres are now an option in Toronto and Ottawa (Lavis, 2016). Unfortunately, access to care is still dependent on where you live, as the misdistribution of providers favours urban over rural environments and southern over northern (Lavis, 2016). Finally, workforce planning is not regionally sensitive and continues to focus primarily on doctors and nurses, resulting in challenges for northern residents in accessing reproductive healthcare (Lavis, 2016). As governments commit to putting patients in charge of directing change, northern women’s voices need amplifying to address unequal access to comprehensive reproductive healthcare services.

A feminist viewpoint appreciates that reproductive behaviour is embedded in social, political, and cultural contexts, and feminist guided research must embrace the diversity of multiple truths, multiple roles, and multiple realities. A decade ago, the Ontario provincial government funded a study into the inequities in health and health service access and outcomes, called the *Project for an Ontario Women's Health Evidence-Based Report* or POWER study (Clark & Bierman, 2009). The report led to the creation of a framework designed to improve women's health in Ontario, informed through conversations with provincial agencies and associations for the various health sectors, including hospitals, public health, community mental health, physicians, Local Health Integration Networks (LHINs), community health centres, community care access centres and the Agency for Health Promotion and Protection (Echo, 2011). The stated goals were a more holistic approach to care, supporting more women to take on leadership roles, endorsing women-specific services, promoting access to early intervention, prioritizing a higher quality of care, highlighting data specific to women, encouraging investment in prevention, and addressing the social determinants of health (Echo, 2011). In agreement with the current study, the framework advocates for adopting quality and accountability measures that include measuring women's perspectives to support the assessment of services (Echo, 2011). Despite advocating for patient consultations, health consumers were not consulted in the construction of the framework. This omission fuelled my interest in capturing women's opinions on their reproductive healthcare. Through the collective action of the people who choose to participate, a healthcare transformation may happen, resulting in a new system that is more responsive to women's needs. Revisions to care delivery should appreciate intersectionality, as marginalisation and discrimination is reproduced and amplified as women negotiate the multiple webs of power that constrain their lives (Sen, Reddy, & Iyer, 2018). Changes should lead to

removing constraints to action and hence, increased adherence to reproductive healthcare recommendations.

Recognizing that feminist research must respect the multiple identities of participants, operationalizing the concepts of sex and gender is an essential aspect of the research process. Studies that focus on women exclusively enhance the diagnosis, treatment, and prevention of diseases in women (Johnson et al., 2007). However, women are not a homogeneous population, so research needs to be diverse, recognizing the multiplicity of women's experiences and differences (Johnson et al., 2007). Multiple axes of social inequality intersect to produce a broad range of unequal outcomes, in both individual and population health (Hankivsky, Doyal, & Einstein, 2017). Both privilege and oppression are shaped by colonialism, imperialism, racism, homophobia, ableism, and patriarchy (Hankivsky et al., 2017). Some argue that the mixed methods approach and privileging the experiences and perspectives of affected populations will advance our understandings of why and how health is shaped so profoundly by context (Hankivsky et al., 2017). Mixed-methods research is ideal for examining both the breadth (quantitative) and depth (qualitative) of women's experiences (Johnson et al., 2007).

Gender is a multidimensional social construct that is culturally based and historically specific, meaning it is constantly changing (Johnson, Greaves, & Repta, 2009). Currently, the full spectrum of gender identities includes, but is not limited to, self-identified queer, questioning, gender nonconforming, agender, nonbinary, asexual, pansexual, bisexual, lesbian, gay, men who have sex with men (MSM), trans-sexual, transgender, two-spirited, and intersex (Centers for Disease Control and Prevention, 2018). The concept of gender is an analytic tool with gender defining power relationships and being constructed from them (Stewart, 1994). The collection of information on other aspects of social position (residency, income, and education)

were included in this study while avoiding the search for a unified women's voice (Stewart, 1994). Abandoning the idea of the 'universal woman' while engaging in feminist research requires that the researcher accommodate differences while preserving analytical power (Hekman, 1997). There is no one feminist viewpoint, known as essentialism, while postmodern relativism may not be helpful as it rejects all notions of a shared experience (Harding, 1986). My study seeks 'strong objectivity' which allows me to recognise social situatedness while seeking to generate objective knowledge (Hekman, 1997). In acknowledgement of the multiplicity and complexity of how gender and other factors intersect with reproductive healthcare, my research adopted a feminist theoretical approach to investigating women's experiences of accessing reproductive healthcare. Health research into women's lived experiences should adopt a feminist framework, which means that the research design encompasses feminist consciousness and theory as the foundation for explorations into women's health (Andrist, 1988). At its core, feminism accepts the essential validity of the personal experience and supports the belief that the distinction between the objective and subjective is false, as the lived experience is valid (Stanley & Wise, 1993). Other essential principles underlying feminist research are that the knowledge produced by the researcher should be helpful to the participants, the research method should not be oppressive, and the technique should be reflexive (Wuest, 1994). From the Sage Publication *Feminist Research Practice* (2007), we are reminded that a feminist standpoint epistemology is a unique philosophy of knowledge building that challenges us to see and understand the world through the eyes and experiences of oppressed people and apply the vision and knowledge to social activism and social change (Brooks, 2007). This approach seeks to repair the historical trend of women's misrepresentation and exclusion from the dominant knowledge canons (Brooks, 2007) while interrogating the influences of politics and the economy on women's

material experiences (Syed, 2021). Examining women's standpoints provides a window into the lived experiences of social actors but it is not privileged over men's standpoint because all knowledge is located and situated (Hekman, 1997). Women's experiences point to us flaws in larger economic and political systems and offer potential solutions (Brooks, 2007; Syed, 2021). Only by making women's concrete life experiences the primary source of our investigations can we succeed in constructing knowledge that accurately reflects and represents women (Brooks, 2007). Modern approaches to standpoint feminism stress that 'women' cannot be reduced to one group sharing one experience and a single perspective and acknowledges that different segments of society share varied realities (Hekman, 1997). Each woman's standpoint represents a unique lived experience and perspective constantly evolving and changing across space and time and should be valued as such (Brooks, 2007).

As a feminist researcher, I am reminded that individuals do not have experiences, but rather that subjects are constituted through their experiences, and I seek the production of this knowledge, not evidence or truth (Scott, 1991). My role is not the reproduction and transmission of knowledge arrived at through women's experiences, but the analysis of that production itself as I interrogate the process of knowledge creation (Scott, 1991). Standpoint feminism is a counter-hegemonic discourse, breaking from the paradigm of postmodernism, to create communally constituted knowledge (Hekman, 1997). While respecting the independent status of human agents, I seek common ground, arrived at through consensus among the participants, as we jointly construct the narrative of their reproductive healthcare seeking. The experiences of my participants are constructed through my reflections on those experiences. The results of my analysis are an interpretation, which requires the selective ordering of information into categories. Women's daily lives are constituted through shared concepts, and I wish to make a

persuasive argument in support of shared values, which allows women to unify and argue for a less repressive society (Hekman, 1997). This study benefits from remembering that any attempt to understand those who experience oppression requires adopting their standpoint to expose the authentic relations among human beings, which can play a liberatory role (Hartsock, 2004). The next step is to draw on what we have learned from women's experiences and direct this toward bettering the condition of women and creating social change (Brooks, 2007).

Researchers need to explore best practices for collecting consumers' opinions about their care to maximize their opportunities for input. In adopting a feminist standpoint approach, I recognise the limitations, including the danger of making invisible the experience of some members of society, especially Indigenous women, lesbians, or women of color (Hartsock, 2004). In line with most current research on the subject (Sen, Reddy, & Iyer, 2018), my study centres women's perceptions, capturing their attitudes through predefined domains in a quantitative survey, followed by interviews to capture their recall of experiences. The effort to uncover a feminist standpoint embraces diversity. This contrasts with the current delivery of reproductive healthcare, which assumes that all women can all be treated the same and that they will accept substandard forms of care governed by what costs less and troubles the status quo the least (Syed, 2021). My goal is to advocate for changes to the delivery of reproductive healthcare by offering communally constituted knowledge to support individualised quality care.

#### ***2.1.4 Reproductive Healthcare***

The five core reproductive health services include maternity care (antenatal, intrapartum, and postpartum care); family planning, including infertility services; abortion services; care for sexually transmitted infections and reproductive cancers; and the promotion of sexual health (WHO, 2002). Annual cervical cancer screening, once a mainstay of the 'well-woman' visit, is

no longer recommended for most low-risk women (Pascale, Beal, & Fitzgerald, 2016). This change has led many women and their healthcare providers to wonder if they should abandon this annual preventive health visit altogether (Pascale et al., 2016). The frequency of reproductive care visits mostly mirrors the recommended frequency of cervical cancer screening. The frequency of visits has recently changed based on new screening guidelines. Current guidelines recommend that most people of childbearing age attend screening every three years (Cancer Care Ontario, 2012, Canadian Task Force on Preventive Healthcare, 2013). Breast exams and screening for sexual complaints are often done during these check-ups or dealt with as needed. Acute needs typically precede access to a healthcare provider in cases of suspected sexually transmitted infections (STIs) or family planning. The literature that addresses reproductive healthcare tends to focus on cervical cancer screening recommendations (Canadian Task Force on Preventive Healthcare, 2013). A scoping review of the literature was undertaken to appraise the current state of evidence regarding a wide range of possible elements to identify priority areas for the annual gynecological visit (Pascale et al., 2016). The authors concluded that the annual visit provides an opportunity to educate women about the cancer prevention, the HPV vaccine, sexual health, STI prevention, a healthy diet, moderate alcohol intake, and maintaining a normal body mass index (Pascale et al., 2016). It may be beneficial to educate women regarding the warning signs for breast, cervical, ovarian, and endometrial cancers and for healthcare providers to have a high index of suspicion in women presenting with symptoms so that further screening for cancer can be offered (Pascale et al., 2016). Less research is devoted to the full spectrum of reproductive healthcare and even less to access in rural, remote, and northern settings in Canada.

The goals for a comprehensive reproductive health program include reductions in cervical cancer rates through detection of pre-cancerous lesions and reductions in unintended pregnancies and abortions through the universal provision of contraceptives. Prompt diagnosis and treatment for STIs are also important. However, reproductive healthcare is more than just clinical care - it is political and has causal powers at both an individual and population health level. To increase adherence to recommended preventative care, people must believe that the care they receive is effective and necessary. They need the authority and capacity to make decisions that are in their own best interests. The reproductive healthcare system is meant to support women's best interests and must rely on a solid evidence base and adequate resources to meet the goals of the system and the needs of consumers.

Reproductive healthcare does not sit in a vacuum but exists as part of a complex policy environment with multiple stakeholders, magnifying the difficulty encountered when lobbying for change (Wong et al., 2016). Determinants of reproductive health equity include the broader health system, gender and violence norms, women's role in society, stigma and discrimination related to education, social status, ethnicity, and social capital (Sudhinaraset, Afulani, Diamond-Smith, et al., 2018). Reproductive health care should be respectful of and responsive to individual women and their families' preferences, needs and values, and ensure that their values guide all clinical decisions (IOM, 2001). System level "deficiencies" that are seen as normal and accepted can lead to poor treatment of women, including violence against women in obstetric care settings because of broader gender inequality, which places women in subordinate positions and creates normative power differentials between providers and patients (Sudhinaraset et al., 2018). Although the task appears monumental, I seek to specifically explore how the program of

reproductive healthcare, and the policies that inform its provision, affect the recipients of this care, one group of stakeholders, women residing in Northern Ontario.

My study is critical for a complete understanding of how this northern environment may be contributing to decreased adherence to recommended preventative reproductive healthcare.

Evidence of the underutilization of available services and "non-compliance" with recommended practices shows in the national rate of cervical cancer screening (72%), which has not increased in decades (Statistics Canada, 2012, Canadian Task Force on Preventive Healthcare, 2013).

Cervical cancer is the fourth most common cancer in women worldwide but is also one of the most preventable cancers due to its simple detection by smear and prolonged pre-malignant stage (Rees, Jones, Chen, et al., 2018). Screening has markedly decreased cervical cancer rates in high-income countries, particularly when a nationwide system is implemented, but there is a marked disparity in the uptake of screening between different groups (Spadea, Bellini, Kunst, Stirbu, & Costa, 2010). The Ontario provincial rate for cervical screening is 64.9% (Cancer Care Ontario, 2020), which is well below the provincial target of 85%. Every year approximately 500 women in Ontario are diagnosed with cervical cancer, resulting in 140 deaths (Statistics Canada, 2012).

Within the last decade, Cancer Care Ontario has changed its recommendations about the frequency of cervical cancer screening. Once thought to be required annually, the best practice supports wider spacing between Pap tests, extending to every three years after 21 years, and only if sexually active (CCO, 2012). Increased intervals between screening appointments combined with non-adherence to the recommended schedule can result in less interfacing with the reproductive healthcare system in general. Cervical cancer screening and pelvic examinations are the most associated elements of the annual reproductive care visit, but they no longer warrant annual implementation for most women (Pascale et al., 2016). However, evidence suggests that

several other important and evidence-based preventive services, screenings, and interventions need to be an annual priority if we want to reduce a woman's risk of disease, disability, illness, and death (Pascale et al., 2016). The cervical screening landscape has changed dramatically over the last decade, with the introduction of a human papillomavirus (HPV) vaccine and new opportunities for screening using HPV testing, where self-sampling has proven to be equally effective (Marlow & Waller, 2017). Other changes to the delivery of reproductive healthcare services include the introduction of midwives and nurse practitioners to the healthcare landscape and expanded scopes of practice for nurses.

When considering the reasonable goals of further changes to reproductive healthcare delivery, any revisions should consider both technical competency and interpersonal relations, reflecting and reinforcing the shift in focus from demographic targets to a client-centered and reproductive rights approach (Tumlinson, Speizer, Curtis, & Pence, 2014). There is a need for conceptual clarity in defining, measuring, and analysing quality of care (Tumlinson et al., 2014). The above principles support this study's approach, as the voices of the recipients of care remain at the forefront to understand their values, preferences, and suggestions for improvements concerning the maintenance of their reproductive health. Collecting and measuring the experiences of people accessing care requires careful attention to robust methods for gathering this important information.

### ***2.1.5 Rural, Remote, and Northern Health and Healthcare***

Populations in rural and remote areas are often disadvantaged concerning available health resources, health literacy, access to healthcare, and health outcomes (Matsumoto et al., 2012; Mattison & Lavis, 2016). Population scarcity combined with harsh climatic conditions and limited health resources restricts access to health resources and care, ultimately affecting

outcomes (Angus et al., 2013). Rural Canadians have more inferior health status than their urban counterparts, with lower life expectancy and higher mortality rates (Pong, DesMeules, & Lagacé, 2009, Whaley, 2020). In rural and northern areas of Ontario, women have the lowest life expectancy in the province, and they experience limited access to healthcare practitioners and services (Liepert & George, 2008). A shortage of healthcare providers in rural communities poses a severe challenge to equitable healthcare delivery (Wilson et al., 2009). A shortage of French-speaking physicians to provide care to northern Francophone residents represents a substantial disparity in access when comparing the southern regions to the north of Ontario (Gauthier, Timony, & Wenghofer, 2012). The prevalence of ageist, classist, sexist, and racist beliefs and stereotypes interferes with healthcare seeking and diagnosis and treatment recommendations in the North (Chrisler et al., 2016). Reduced screening uptake among lower socioeconomic groups is well-documented, with levels lower than the national average, even within our universal healthcare system (Akinlotan et al., 2017). Along with women living in poverty, other excluded groups include ethnic minorities and women with lower levels of education (Limmer, LoBiondo-Wood, & Dains, 2014). Rural, remote, and northern residency contributes to unequal access due to challenging geography and climate (Health Canada, 2014) but exacerbating these challenges are limited health human resources providing discriminatory care based on low SES, gender, education, and race.

Interactions among gender, place, and health are emerging concerns in rural women's health in Canada, underscoring the complex and multidimensional nature of healthcare access for rural women (Greenwood & Cheers, 2002; Kornelson & Grzybowski, 2005; Leipert & Reutter, 2005; Sutherns, 2004). There is a desire for access to local, appropriate, continuous, relational, and empowering care (Sutherns & Bourgeault, 2008). Unfortunately, access is compromised in

rural settings due to multiple factors, including less service availability (including numbers of locations, hours, consistency, and variety of providers); a lack of economic and informational resources to make use of available services; and the questionable appropriateness of services provided (including gender, continuity of care, confidentiality, perceptions of quality, and cultural sensitivity) (Sutherns & Bourgeault, 2008). To complicate issues, interpreting accessibility to health facilities merely as physical distance to a doctor assumes that time, effort, and triggers to overcome spatial constraints are similar for every service user everywhere, overlooking the social determinants of health (Sutherns & Bourgeault, 2008). A more multifaceted understanding of access opens more avenues for improvement to the system than looking at service proximity alone, suggesting many possible points of intervention (Pescolido & Kronenfeld, 1995).

Improvements to health policies guiding delivery in rural and remote areas is needed as persistent health challenges are evident. Over the last fifty years, improving access to rural and northern health services has been a policy thrust, with some initiatives introduced in response to specific challenges and other system-wide policies have been tailored to rural and northern realities (Whaley, 2020). As an example, in response to a physician shortage in Northern Ontario, the Northern Ontario School of Medicine (NOSM) opened their doors in 2006 (Whaley, 2020). To prevent the sole focus on physicians over other providers, Health Force Ontario was created with a broader mandate of planning, recruiting, retaining, transitioning, and distributing health professional across Ontario (Whaley, 2020). Before results could be realised, Health Force Ontario was absorbed into the super-agency Ontario Health, which may have positive effects because persistent rural and northern health challenges require a sustained and coordinated approach (Whaley, 2020). Ideally, a rural lens with a focus on the social determinants of health

should be applied to all health policy, accompanied by a single point of accountability within the provincial government on healthcare delivery in rural and northern areas of the province (Whaley, 2020). Rural and northern health policy needs to be clear about the problems it is addressing and needs to be seen as value-added by stakeholders, and not perceived as reducing existing services (Whaley, 2020). The implications of recent health policy changes for northern communities remains unclear. Health leaders will need to remain vigilant and continue to advocate for their needs. Rural women's voices can contribute to the acceleration of changes to health policy to increase adherence to recommended healthcare by making care more accessible and acceptable.

### ***2.1.6 Indigenous Healthcare***

Indigenous peoples living in Northern Ontario often face challenges associated with geographic remoteness, low population density, challenging climate conditions, and lack of infrastructure, resulting in barriers to accessing services (Mattison & Lavis, 2016). Currently, 2% of Ontario's population is Indigenous. However, this proportion is exponentially growing as the median age is within the reproductive window (28 years) and they have a higher birth rate (Mattison & Lavis, 2016). With Indigenous peoples comprising an increasing share of the population, the challenge to policymakers and healthcare providers is the assurance of a holistic, community-based Indigenous healthcare system within a western-dominated health system (Morgan & Wabie, 2012).

Despite being the original inhabitants of ancestral land, colonization and assimilation efforts have resulted in health systems that have contributed to poorer health outcomes for Indigenous peoples than their non-Indigenous counterparts (Owais et al., 2020). Community-based, culturally appropriate care was undermined when the organization of care became isolated

from other aspects of community life after colonial governments started taking an interest in healthcare provision (Benoit, Carroll & Westfall, 2007). "Indian agents", medical doctors, and Christian missionaries assumed power, granting them the authority to threaten and punish midwives and other healers (Benoit et al., 2007). The absence of these culturally appropriate healthcare providers has resulted in the sexism, racism, and colonialism that continues to impact the health status of Indigenous women (Bourassa & Peach, 2009) cumulatively and negatively. Colonialism depends on the oppression of one group by another, beginning with a process described as "othering." Women who bear their "otherness" in more than one way suffer from multiple oppressions, leaving them more vulnerable to assaults on their well-being than if they suffered from one form of oppression (Bourassa & Peach, 2009). Legislation in Canada results in multiple oppressions that disempower Indigenous women, conferring risks to their health (Bourassa, McKay-McNabb, & Hampton, 2004). Health policy reform would benefit from a better understanding of the structural elements of the current system that have contributed to poorer health outcomes for Indigenous peoples. Reform needs to focus on the needs of indigenous women concerning their reproductive healthcare, as they are particularly vulnerable due to multiple oppressions.

The challenge for policymakers and healthcare providers is creating a holistic, culturally safe, community-based, Indigenous reproductive healthcare system (Morgan & Wabie, 2012). The Native Women's Association of Canada (NWAC) made recommendations for a healthcare system that meets these objectives, stressing that providers need to understand the importance of Indigenous women's roles in teaching young women about the physical aspects of womanhood and holding related ceremonies (NWAC, 2007). Encouragement increased financial support, and more opportunities need to be made available to Indigenous women to pursue healthcare careers

(NWAC, 2007). Training Indigenous providers will encourage cultural safety, but for care to be truly respectful, all providers will need to tackle the deep-rooted biases they may hold against the people they serve (Sen, Reddy, & Iyer, 2018). Encouraging dialogue between Indigenous and non-Indigenous care providers could result in more culturally sensitive care (NWAC, 2007). Advocates ask that researchers conduct studies specific to First Nations, Inuit, and Métis women, acknowledging their traditions and roles in individual, family, and community health, as quality care would combine traditional and Western medical approaches (NWAC, 2007). Finally, immediate, substantial improvements to the social, economic, and political conditions in which Indigenous women and their families reside are needed (NWAC, 2007). The required system changes presented by this national Indigenous women's association are far from being realised. Funding for Indigenous-led research, training for providers in cultural humility and creating safe healthcare spaces- including accepting traditional approaches to health and healing, and the dedication of resources for education, training, and recruitment of indigenous healthcare workers need to become a priority.

Despite the need for a better understanding of the needs of Indigenous women concerning their reproductive healthcare, my research was not able to capture their experiences due to many reserves in Northern Ontario. The limited financial resources and the short timeframe for the study did not allow trust-building with each community to conduct ethical research. My Indigenous participants were limited to randomly choosing to respond to my survey, as no recruiting of indigenous participants was conducted. The support and authentic participation of Indigenous communities in Indigenous-led research needs to be funded and conducted (Morgan & Wabie, 2012). Community-based participatory action research occurs within northern communities (e.g., work done by the Centre for Rural and Northern Health (CRaNHR) as an

example, see <https://www.cranhr.ca/indigenoushealth>) that aims to/gives these communities the capacity and tools to conduct this vital work. There are many opportunities to incorporate traditional Indigenous communication and healing strategies in a reproductive health service that is genuinely responsive and sensitive to the needs of Indigenous women, their families, and communities (Morgan & Wabie, 2012). I hope that any changes my study proposes would remove common barriers for the benefit of all until Indigenous-specific perspectives and solutions drive further change.

## **2.2 Quality Healthcare**

In seeking improvements to reproductive healthcare delivery, the primary goal would be the provision of quality healthcare more generally. The Institute of Medicine (IOM) defines the quality of care as the degree to which health services increase the likelihood of desired health outcomes and are consistent with current knowledge (Katz, Soodeen, Bogdanovic, Coster, & Chateau, 2006). The WHO reminds us about the collective recognition that quality health services should be effective by providing evidence-based healthcare services to those who need them and safe, by reducing the risk of unnecessary harm associated with accessing healthcare to a minimum (WHO, 2018). Healthcare encounters should be people-centred and adopt the perspectives of individuals, carers, families, and communities as participants in, and beneficiaries of, trusted health systems organized around the comprehensive needs of the recipients, rather than individual diseases (WHO, 2018). By extension, quality reproductive healthcare services need to be effective at producing the desired outcomes, delivered safely consistent with best practices, and people centred. As healthcare systems move away from their historical paternalistic origins, consumers are playing more active roles in their care through choice and autonomy, enabled by providers prioritizing the relationship as much as the care task,

termed person-centred care (PCC) (Lines, Lepore, & Weiner, 2015). The Institute of Medicine's (IOM) often cited definition of person-centred care (PCC) entails the medical care processes that ensures that decisions regarding the care received respects each person's wants, needs, and preferences, and for which the patient has the education and support to make decisions and participate in their care (Adams, Sarnak, Lewis, et al. 2018). This care adheres to the following four constructs: respect and dignity; information sharing; participation; and collaboration (Adams et al., 2018). My study addresses the third tenet by engaging with the individuals accessing the care for their perspectives.

The quality improvement literature usually conceptualises two principal dimensions of quality in healthcare, "technical quality" and "service quality" (Tabrizi, Wilson, & O'Rourke, 2008). Technical quality refers to the clinical or disease-specific aspects of care and deals with what the customers receive relative to what is known to be effective, and primarily reflects issues related to the healthcare providers (Tabrizi et al., 2008). Technical quality appears to address the first two WHO tenets of effectiveness and safety. Service quality refers to how health consumers perceive the services and the environment (Tabrizi et al., 2008). Service quality agrees with the third WHO tenet. Tabrizi and colleagues (Tabrizi et al., 2008) propose a third principal dimension, "customer quality," to incorporate aspects of the healthcare user's responsibility in health systems and their capacity for self-management and contribution to improving quality of healthcare services. The concept of "customer quality," as a new paradigm, leads a fundamental shift where the customer is not a passive recipient of healthcare but an active and competent participant in healthcare (Tabrizi et al., 2008). In addition to being person-centred, my study aims to recognise the agency of the participants and seeks to empower consumers of care to be part of improving reproductive healthcare services.

Perceptions of quality in healthcare are not gender neutral. There is literature to suggest that women and men experience healthcare differently and may evaluate their experiences based on different factors (Kolodinsky, 1998). It must also be noted that the experiences of men or women are not homogenous based on their sex, although similarities among female or male participants may allow for some generalisation (Hekman, 1997). Kolodinsky concluded that the direction of effects for most independent variables was similar, but effect sizes differed by gender (Kolodinsky, 1998). The quality of communication with providers may be a more important determinant of women's satisfaction than men's (Roter & Hall, 1998). The content of the medical encounter is an area where both men and women put the most emphasis when assessing their experiences, but women may be more concerned about informational content, continuity of care, and a multidisciplinary approach, while men may be more concerned about the personal interest shown in them (Weisman et al., 2000). Focus groups conducted with over 50 women provided evidence that some aspects of care valued by women are not included in standard surveys of patient satisfaction (Weisman et al., 2000). Women want providers that are familiar with their medical histories, who initiate discussions of sensitive topics, who signal their openness to discussions of treatment options which include complementary or alternative therapies, and who respect women's opinions and ability to make decisions about their care (Weisman et al., 2000). Women prefer comprehensive services and prompt reports of test results (Weisman et al., 2000). Based on the literature about perceived quality in healthcare, we may expect the participants in my study to prioritise communication, person-centred continuity of care, and an openness to receiving care from a team of health professionals. Measuring these fewer tangible aspects of care requires adopting or adapting a tool designed to capture process measures, generally accepted as the most helpful quality indicators (Brook, McGlynn, &

Shekelle, 2000). Process measures use the process of accessing and receiving healthcare as the indicator of quality and considers the actions of physicians, other healthcare professionals, and administrative staff (Varkey, Reller, & Resar, 2007). Any survey tool adaptable to my study, needs to robustly capture satisfaction ratings and be gender-sensitive to satisfaction as a process and not just a product.

### **2.3 Measuring Perceptions of Care**

Managing consumer perceptions of healthcare is essential because more positive evaluations of the healthcare encounter led to increased satisfaction, as well as an increase in intentions to return for healthcare in the future (Bowers et al., 1994; O'Connor, Shewchuk & Bowers, 1992; Taylor & Baker, 1994; Woodside, Frey & Daly, 1989). Positive evaluations result in improved compliance with advice and treatment regimes (Hulka, Cassel, Kupper, et al., 1976) and, according to Brown, Nelson, Bronkesh, & Wood (1993), decrease turnover and reduce malpractice lawsuits (O'Connor & Trinh, 2000). Solicitation of consumer feedback may be a condition for accreditation and the identification and meeting of patient expectations are part of many quality improvement initiatives (O'Connor et al., 1994). Regrettably, women have been largely absent from patient satisfaction research, and instruments have not been developed with consideration for gender issues nor analysed for gender differences (Weisman et al., 2000). A feminist approach would promote a constructionist, instead of a reductionist framework, moving beyond a list of issues and towards a deeper understanding of the contextual aspects of seeking care (Turris, 2005). A feminist worldview discourages binaries while focusing on satisfaction as a process and not a product, exploring meaning and meaning making (Turris, 2005). Researchers informed by a feminist epistemology need to examine the context of people's lives and how that context shapes experiences of care and the social values attached to help-seeking and

expectations of healthcare (Turris, 2005). The development of gender-sensitive tools may improve quality analysis of healthcare delivery models to optimize satisfaction in healthcare for women.

### ***2.3.1 The Hierarchical Model of Health Service Quality***

I am examining quality in healthcare as a means of determining the path to better health outcomes for consumers. Because few reliable and valid instruments are available, measures can be adopted without aligning to the complexities of the healthcare setting. Service quality is likely a multidimensional, higher-order construct with quality perceptions specified at an abstract level. Some researchers believe that service quality comprises several primary dimensions represented by a higher-order quality construct with sub-dimensions that combine attributes into subgroups, making service quality a third-order factor to the sub-dimensions (Dagger et al., 2007). As leaders in measuring satisfaction in healthcare, Dagger, Sweeney, and Johnson suggest that consumers assess service quality at global, dimensional, and sub-dimensional levels. Each level influences perceptions at the level above (Dagger et al., 2007). Dagger, Sweeney, and Johnson (2007) launched a qualitative study to confirm the contextual appropriateness of the suggested primary dimensions and develop the sub-dimensions thought to underpin them. The aims of their study were to conceptualize the service quality construct, develop a scale to measure quality from a consumer perspective, assess the psychometric properties of the scale, and examine the effects of conceptualization on satisfaction and intention (Dagger et al., 2007). They confirmed the primary dimensions as interpersonal, technical, environmental, and administrative. Interpersonal quality was composed of the relationship and dyadic interplay between consumers and their caregivers. Technical quality is the outcome of the service process, encompassing

expertise, professionalism, and competency. The environment included the general atmosphere, and administrative included anything that facilitated the production of the core service while adding value to the consumer (Dagger et al., 2007). Composite indicators were added to the primary dimensions as sub-dimensions, which was initially suggested by Hau and Marsh (2004). Parasuraman, Zeithaml, and Malhotra (2005) supported the work of Hau and Marsh (2004) and confirmed that the sub-dimensions fit the criteria. These sub-dimensions had emerged in previous studies, but without complete conceptualization, their place in the overall structure had been questionable (Ware, Davies-Avery & Stewart, 1978, Ware, Snyder, Wright & Davies, 1983; Parasuraman, Zeithaml & Berry, 1985, Donabedian, 1988, 2005, Wiggers, Donovan, Redman & Sanson-Fisher, 1990, Doran & Smith, 2004, Zineldin, 2006). The nine sub-dimensions are interaction, relationship, outcome, expertise, timeliness, operation, support, atmosphere, and tangibles (Dagger et al., 2007). Through confirmatory factor analysis (CFA), the authors reported a good fit of the dimensions to the data. All indicators served as strong measures of their respective constructs in exploratory and confirmatory studies (Dagger et al., 2007). The authors established the psychometric properties of the scale and concluded that the model fit the data well because the primary dimensions had a significant and positive impact on service quality perceptions (Dagger et al., 2007).

These advancements resulted in a new conceptual framework and a new conceptualization of healthcare service quality. The authors had created a reliable and valid scale to measure perceptions from a consumer perspective that predicts satisfaction and behavioural intentions as service quality outcomes (Dagger et al., 2007). These revelations confirmed the work of Woodside, Frey, and Daly (1989), Dabholkar, Shepherd, and Thorpe (2000), and Hightower, Brady, and Baker (2002) by giving credence to the hierarchical (third order) service

quality construct. Service quality perceptions mediate the relationship between the primary dimensions and behavioural intentions (Dagger et al., 2007). Specifically, each of the primary dimensions significantly affects perceived service quality and behavioural intentions (Dagger et al., 2007). Service quality and the primary dimensions are predictors of behavioural intent (Dagger et al., 2007). This mediation mechanism implies that service quality perceptions are critical in determining behavioural intentions (Dagger et al., 2007). The new conception of healthcare service quality hypothesizes that consumers evaluate service quality at a global level, a dimensional level, and a sub-dimensional level. Each level drives perceptions at the level above, leading the authors to conclude that quality improvement needs to address the sub-dimensions, thereby improving ratings for the dimensions and the global rating (Dagger et al., 2007).

The Hierarchical Model of Health Service Quality (HMHSQ) represents an integrated model of health service quality based on consumer outcomes (Dagger et al., 2007) (Appendix A). Unlike earlier iterations that focused on developing generic service quality models, the HMHSQ is focused on context-specific service quality models, offering a new conceptualization of health service quality. The HMHSQ model provides a valid and reliable scale designed to measure quality perceptions from the consumer's perspective (Dagger et al., 2007). The designers of the tool claim that a strong association exists between service quality and behavioural intentions, and satisfaction is the mediator in the relationship. Both service quality and customer satisfaction are critical strategic objectives because, as constructs, they help ensure positive behavioural intentions. The model was developed and tested at general practice and oncology clinics in Australia. This model for assessing satisfaction with care has never been used in the setting of reproductive healthcare, to my knowledge. Also, the Canadian health consumer

may differ from the Australian health consumer in ways that are not yet evident. There should be a reciprocal relationship between the theory and the data to prevent the framework from becoming a container into which the data is poured (Lather as cited in Creswell, 2009). I intend to apply the HMHSQ as the conceptual framework. This framework led to the HMHSQ survey tool, which appears to be the best tool developed to date. Through adaptations to the tool and careful analysis of responses, I seek to refine the conceptual model through the study, serving to advance knowledge of the measurement of health service quality while simultaneously making suggestions for changes to reproductive healthcare delivery.

## **Summary**

From the literature, we can summarise a range of potential barriers to accessing reproductive healthcare, including rural, remote, and northern geography, and its accompanying lack of providers. These factors intersect with gender, ageism, poverty, racism, and lower education levels, along with personal or sociocultural aversions to reproductive healthcare. The frame for analysis is the provision of reproductive healthcare within the health system. The patient-professional interaction connects the patient's lived experiences with the medical system. It is clear from both the United Nations and the World Health Organization that patient satisfaction, public participation in decision-making, and accountability should be critical aims of health systems, distinct from economic and clinical goals (Kruk & Freedman, 2008).

Details presented concerning the organization of healthcare, particularly reproductive healthcare in a northern setting, show a gap in our knowledge regarding the experiences of those seeking this care. Our current healthcare system cannot claim to deliver practical, preventative, and curative health services to the entire population equitably and efficiently, as outlined by the WHO (WHO, 2000). Disparities in healthcare exist as part of the broader historical and

contemporary context of social and economic inequality, prejudice, and systemic bias (Goddard & Smith, 2001, Johnson, Saha, Arbelaez, et al., 2004). Good health policy can remedy disparities in access to healthcare by increasing participation in preventative care. In recognition of the autonomy of health consumers to make their own best choices, my study intends to examine the enablers and barriers to seeking reproductive healthcare in Northern Ontario and collect the opinions of participants on the acceptability of midwives providing this care.

Challenges to the medical paradigm are inevitable as systems, including health systems, need to evolve to meet the needs of consumers. The reproductive healthcare consumer in Northern Ontario should be consulted according to principles of feminist inquiry to inform service delivery. Barriers to access to services may exist because the research has not been done locally to determine women's reproductive healthcare needs. The adoption and adaptation of the HMHSQ, developed after decades of formative consideration but minimal testing, allowed me to trial the tool in a rural, remote, and northern Canadian setting, specific to perceptions of reproductive healthcare, to advance theoretical knowledge in the field. The following chapter describes the mixed method approach utilized to obtain an understanding of factors affecting women seeking reproductive healthcare in Northern Ontario. Perceptions of health service quality positively impact health service satisfaction and a positive effect on behavioural intentions (Dagger et al., 2007). By collecting information on perceptions of reproductive health service quality, improvements may increase satisfaction, leading to increased uptake of recommended reproductive healthcare. A transformation of the current reproductive healthcare delivery system may be necessary, resulting in a revised strategy that is more responsive to women's needs. The removal of constraints to action may increase uptake of recommended reproductive health services for women.

## **CHAPTER 3: METHODOLOGY**

This chapter starts with a reminder about the research questions, followed by an examination into the mixed methods approach applied to the design of my study. Following that is a description and justification for the data collection methods, and an explanation of the quantitative and qualitative analysis plans. Chapters 4, 5, and 6 are papers intended to be published independently and present the results of the quantitative and qualitative data analysis, as outlined in this chapter. After separate analysis, the quantitative and qualitative results were combined to address the research questions and create a fuller picture of the current system for accessing reproductive healthcare, allowing for discussion and recommendations for changes, found in Chapter 7.

### **3.1 Research Questions and Researcher Reflexivity**

Before discussing the methodological choices that guided my study, I wish to remind the reader of the research questions that my study sought to answer.

1. How do women perceive their reproductive healthcare?
2. How do women's perspectives of their reproductive healthcare influence their use of reproductive healthcare services?
3. What elements of a woman's reproductive healthcare experience enable her to engage in recommended care more fully?
4. What elements of a woman's reproductive healthcare experience disable her from obtaining the services she desires or requires?

5. Do women view midwifery care as an acceptable alternative to current providers or options for reproductive healthcare?

A mixed methods approach was required to answer these questions with numbers one and five to be addressed by the survey and questions one, two and five best addressed through interviews. Questions three and four, which seek to determine which elements of a woman's reproductive healthcare experience enable or prevent her from engaging in recommended care, required further interpretation following separate data analysis. The combination of quantitative and qualitative derived data at the interpretive level permits triangulation, to achieve or ensure corroboration of data, or convergent validation, and complementarity, to clarify, explain, or otherwise more fully elaborate the results of analyses (Sandelowski, 2000). I acknowledge that how I, as the researcher, interpret the data, depends on my background, which can't help but affect what I chose to investigate, the angle of investigation, the methods judged adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions (Malterud, 2001). Before delving into the study methods, I need to situate myself within the structure being examined to make my point of view clear.

### ***3.1.1 Personal Statement/Situating the Researcher***

I have been a provider of reproductive healthcare for more than two decades, which has caused me to believe that the current system may require change. I have experience living in rural, remote, and northern settings. However, I have only practiced midwifery in rural and semi-urban settings and have never practiced in Northern Ontario. I am biased about the exceptional care that I believe most midwives provide. Midwives take time with people, consider themselves health educators, and convey health information within the treatment

encounter. Most midwives try to be empathetic and compassionate. Many midwives are women and bring their situated knowledge to the profession, including a personal desire for sensitive reproductive healthcare. This midwife-led research may lead to innovations in the provision of care. Innovation can be an idea, technology, research discovery, or a way of working that is new and which requires a change of hearts, minds, structures, and systems to become the new normal (Greenhalgh, 2011).

I developed a reflexive journal, a diary where a researcher makes regular entries during the research process. In these entries, I recorded my methodological decisions and the reasons for them, the logistics of the study, and my reflections on what is happening in terms of my values and interests (Barry, Britten, Barber, Bradley, & Stevenson, 1999). The health policies that guide reproductive healthcare may require examination and revision, and I acknowledge that this study included my values and interests. I feel well-situated to approach this work with a commitment to accurately presenting the feedback from reproductive healthcare consumers in Northern Ontario and to inform changes to health policy in the most responsible way possible. (Trustworthiness Protocol included as Appendix B).

### **3.2 Mixed Methods as the Best Approach**

In my study of the experiences of accessing reproductive healthcare in Northern Ontario, the quantitative study complemented the qualitative study. Together, they represent a mixed-methods approach to studying the phenomenon. The decision to use a mixed-methods approach was arrived at after careful consideration to use quantitative surveys to provide breadth and qualitative interviews to provide depth to survey responses. Studies of disadvantaged populations often require large-scale aggregate data along with evidence from experiences because measurable facts are still expected to inform evidence-based policy (Reiger & Liamputpong,

2010). The literature reports three main concerns with previous examinations of satisfaction in healthcare: the privileging of survey methodology, the influence of confounding variables, and the challenge of separating various aspects of the experience (Turris, 2005). As the area under investigation represents vulnerability concerning gender and geography (rural, remote, and northern), the analysis of additional information such as income, education, and language is an example of applying a social justice lens with attention to the social determinants of health.

The Hierarchical Model of Health Service Quality (HMHSQ) informed the survey tool, and served as the conceptual framework, representing a hypothesis about how healthcare is perceived and measured from the consumer viewpoint (Dagger, Sweeney, & Johnson, 2007) (Appendices C & D). This investigation used purposeful sampling for the qualitative data collection to ensure that the selected individuals had experienced the central phenomenon, identified as a woman and residing in Northern Ontario. Participants in the qualitative arm of my study identified their willingness to be interviewed after the survey. Most studies rarely speak to collecting qualitative data as a methodological approach for studying patient satisfaction (Aharony & Strasser, 1993). The interview was essential for seeking more details about the areas explored in the survey. There are several types of mixed methods sampling. My study adopted sequential sampling, where the survey informed the interview.

Regarding the weighting of the two arms of the study (i.e., quantitative and qualitative) and in line with feminist research principles, priority was given to the qualitative portion. Qualitative methods may be judged as less oppressive and less concerned with finding a “truth”, while remaining aligned to the goal of emancipation of the socially marginalised (Reiger & Liamputpong, 2010). Mixing the two data types did not occur until after data collection, data analysis, and interpretation individually. As previously established, it may be more accurate to

label my study as a mixed-methods approach employing a sequential transformative strategy, meaning that the data collection design included applying a theoretical lens (e.g., gender and social science theory) overlaying the sequential procedures. The transformative methodological belief system incorporates issues of power, in terms of interrogating both the research methods themselves and the interventions that may or may not be in the researcher's control (Mertens, 2010). In accordance with feminist research designs that seek social change, my study aims to transform the health system, even in a small way, with a sequential mixed-methods approach, with a survey followed by interviews. This methodology seeks to interrogate power.

### ***3.2.1 Surveys***

For my study, all 73 questions from the Hierarchical Model of Health Service Quality (HMHSQ) survey tool were combined with demographic questions and questions specific to reproductive healthcare access and made available in English and French (Appendices F & G). Respondents rated their care on each item using a 7-point Likert scale. Items from various sub-dimensions appeared in random order on the survey. Respondents may have been embarrassed about sexual health questions, but careful wording hopefully encouraged reluctant respondents, although it is acknowledged that it may have been challenging to collect accurate information about a subject that embarrasses many people.

The study used responses from the Canadian Community Health Survey (CCHS) for comparison of demographic information (Statistics Canada, 2012). Termed representivity, the survey sample seeks to represent a miniature version of the population of Northern Ontario. If the sample is similar with respect to known variables, it should also be similar with respect to other survey variables (Bethlehem, 2010). Similar to the CCHS, the frequency of cervical cancer screening was answered on an ordinal scale. In line with advice about designing internet-based

surveys, fonts were 12-point, using a serif script such as Times New Roman, and the line length did not exceed three to five inches (Dillman, Smyth, & Christian, 2014). Minimizing response errors was the goal in choosing to confine the survey to a web-based version. Questions were presented identically across the platform to ensure that respondents perceived a shared mental stimulus, termed unified mode construction (Dillman et al., 2014). Clear instructions about accessing the web survey were on the backside of the research information cards. Internet-based surveys can suffer from slow modem speeds, unreliable connections, high connection costs, low-end browsers, and unclear instructions for participants (Bethlehem, 2010). For these reasons, there was careful consideration of coverage, sampling, nonresponse, and measurement when crafting the survey questions and recruiting for participation, aiming for an adequate number of diverse respondents to have confidence in the results.

The reliability of the survey results depended on solid survey construction, which requires a firm grasp on what is essential to measure and how the questions are asked, based on what information is needed to evaluate the hypothesis. Most survey questions made use of latent variables represented by multiple measures of the same construct through multi-item scales, as found in the HMHSQ tool (Dagger et al., 2007). This approach is borrowed from classical test theory, which proposes that the way to minimize random measurement errors and maximize reliability and validity is to employ multi-item scales (McQuitty, 2004). Structural equation modeling evaluated the extent to which the observed variables assessed the latent variables in terms of reliability and validity and the HMHSQ performed well in this regard (Dagger et al., 2007). Additional questions were added to the survey to collect demographic information and to ask specifically about current and preferred providers, frequency of cervical cancer screening and preference for female providers.

In testing the survey design, it was essential to consider comprehension (the ease of interpretation), retrieval (the ease with which the respondent can recall the information), and reporting (the ability to formulate a response in the format required) when authoring the questions (Dillman et al., 2014). It was important to write questions that would be interpreted the same by all respondents, aided using non-technical, unambiguous language that was non-oppressive (non-sexist, non-racist) (Dillman et al., 2014). Closed-ended questions were favoured for the survey to allow for statistical analysis of the data. For piloting the survey, it was administered to a small group of women to determine if it required revisions. Individuals responded to the questions and articulated their thoughts about the language and the phrasing to ensure that the questions were straightforward. For these purposes, in June 2014, 11 women gathered and were asked first to complete the survey while being timed to gauge the time required. The range of time was 8:50 minutes to 17:00 minutes, with a median time of 13:00 minutes. Based on this exercise, survey completion was estimated at 10-20 minutes. The participants reread the survey and the 'consent to participate' and made notes about any areas where they felt that the wording was confusing or awkward. These notes resulted in a minor change to wording in the consent form and several changes to the survey wording. An "other" option was added to the first question. The clinic's "opening hours" were changed to "operating hours" based on a participant's suggestion. Two separate reviewers commented on the wording of this question: "The extent to which my care has produced the best possible outcome is satisfying" I have changed this to "My care has produced the best possible outcome." The survey asked if women had a "regular medical doctor." One participant questioned this description. The survey was changed to inquire whether one has a family physician, as this was suggested as being more precise. A version of the survey in French was sent to three native French speakers.

Errors and typos were corrected, and some words were changed to improve comprehension.

Survey participants were asked to provide an email address or a postal address if they would like to receive a summary of the results. Finally, respondents were asked if they were willing to be interviewed as the final survey question, which required careful consideration of the interview questions.

Before data collection, the minimum sample size required to achieve the desired power level with the given model was determined. Power and sample size analysis optimizes the resource usage and design, improving chances of conclusive results with maximum efficiency (McQuitty, 2004). No matter how high the power, it is advisable never to use  $N < 100$ , and larger sample sizes have considerable and important advantages for estimation (McQuitty, 2004). My study adopted the standard convention for this statistical compatibility with the two-sided 95% confidence interval (CI). MacCallum, Browne, and Sugawara (1996) recommend the following pairs of values, which correspond to tests of close fit,  $CI = 0.05 – 0.08$ . Generalizing the findings based on the sample to the larger population requires that the sample be representative, which has historically required that the study use probability sampling. Because of the specific group of women, a non-probability sample had to be chosen, which still allowed speculation about how the findings may apply to the broader population. The survey was launched in the summer of 2014 while the interviews would be conducted later in early 2015.

### ***3.2.2 Interviews***

Investigations into reproductive healthcare lie at the intersection of personal, political, and scholarly interests, making this a particularly challenging and emotionally complex area of research (Reiger & Liamputpong, 2010). In recent decades, research into reproductive healthcare has been undertaken with the explicit goal of highlighting the voices of women as ‘reproducers’

and bringing their agency to bear on health policy and clinical practice (Reiger & Liamputpong, 2010). Few studies have turned their lens on the reproductive healthcare experiences of women residing in northern environments. The interviews could result in a complex picture of accessing reproductive healthcare in the north, reporting from multiple perspectives, identifying the many factors involved, and generally sketching the larger picture that emerged. To make the most of this opportunity to speak with members of this more isolated population about their participation in reproductive healthcare, the study employed an interview guide with structured questions about the elements captured in the HMHSQ and questions about their reproductive healthcare experiences (Appendix C). The guide also served as a checklist at the end of the interview, ensuring all topics had been investigated.

Feminist researchers are particularly concerned with mitigating hierarchy in the interests of more faithful accounts that come closer to the informants' experiences (Rice, 2009). However, dilemmas of power and difference could remain despite de-centring myself, revisiting my own biases, and imagining becoming the other (Rice, 2009). It can be argued that the interview is a co-construction of meaning (Smith & Elger, 2014). Strategies adopted included giving back the transcript to the respondent to gain input and resolve possible disagreements between interpretations (Smith & Elger, 2014). Interviewees submitted additional comments and corrected misunderstandings. The interviews were semi-structured, meaning that open questions were predetermined but allowed the participant or researcher to pursue any subject in more detail. Another approach applied to these interviews was the critical incident technique (CIT), used when the researcher focused on the participant's memories of one or more specific incident(s) (Smith & Elger, 2014). According to seminal work by Flanagan from 1954, CIT involves individuals reporting from memory about extreme incidents that occurred in the past

(Butterfield, Borgen, Amundson, & Maglio, 2005). Flanagan spent some time gathering evidence supporting the accuracy of recalled incidents, suggesting that accuracy can be deduced from the level of full, precise details given by the participant (Butterfield et al., 2005). Flanagan advocated for individual interviews as a way of obtaining recalled data in the form of critical incidents (Butterfield et al., 2005). The inherent flexibility of CIT has allowed for evolution of the technique, and it is now used to explore personal experiences and examine psychological constructs, adaptable for use across a myriad of disciplines and research questions. My study employed retrospective self-report, or CIT, by asking participants to describe both their best and worst experiences when accessing reproductive healthcare.

When examining the processes of accessing reproductive healthcare, one must be sensitive to how this care differs from other areas in healthcare. The differences may be due to the intimate contact and conversations required for quality provision. However, the paternalistic underpinnings of biomedicine in our healthcare system cannot be ignored when exploring reasonings, triggering causal powers, and ultimately, informing agency. Research on emotion and memory shows that the activation of emotions affects the ways in which individuals reconstruct previously experienced situations (Muramatsu & Hanoch, 2005). Environmental cues trigger emotional responses, but how agents construct or view the environment, affects what emotion is likely to be activated (Muramatsu & Hanoch, 2005). Researchers argue that emotions have causal relevance and can be studied as a network of interacting cognitive and physiological processes (with neural underpinnings) that produce stable and predictable behavior patterns (Muramatsu & Hanoch, 2005). An explanatory account of agency requires us to uncover mental processes or mechanisms predictive of judgment and decision making in the real world (Muramatsu & Hanoch, 2005). In appreciation of this history and its legacy, the following

methodological considerations were incorporated into the design. All interview participants volunteered after completing the survey and were informed that an interview would involve deeper questioning into the same subject areas, notably birth control, sexual health and illness, and abortion. This warning was intended to limit any surprise in response to the nature of the questions. Survey data was not linked with interview data to ensure the anonymity of survey responses. The interview was conducted at the participant's chosen location, with most preferring to be interviewed in their own homes via telephone. All participants were provided with their transcripts to review for accuracy. These steps were intended to provide assurances of safety and confidentiality and built the trust required for a candid discussion about a long taboo and challenging subject matter.

### **3.3 Ethics Approval & Consent**

Ethics approval was obtained from the Laurentian University Ethics Board (REB File No. 2014-01-09) and the certificate can be found in Appendix D. Written materials explaining the purpose of the study and the interview, along with a consent form, were provided to survey participants and one week in advance of the interview (Available as Appendix E). The consent form provided a summary of the study, a short biography of myself, described the nature of participation and the dissemination plans, and gave assurances of confidentiality. The form was signed and returned to the interviewer before starting the interview, and verbal consent was also obtained. Before starting the interview, interviewees gave verbal permission to record the interview, and interviewees were informed that they could end the interview at any time. Community-specific trauma resources were provided to each participant to use if discussing this subject matter resulted in un-wellness and help was needed. A unique code was assigned to each

interview, and pseudonyms were used for publication to protect participant's identities. The participants reviewed their transcript before analysis to provide corrections and clarifications.

### **3.4 Analysis Plan**

Details regarding the specific plans for data analysis can be found in Chapters 4, 5, and 6, which are intended to be published as stand-alone documents. The plans relied on careful consideration of the goals for the research. The following sections provide details into the analysis plan to build trust in the results.

#### ***3.4.1 Quantitative Data Analysis Plan***

Quantitative data was collected using a survey, offered in English and French, and administered through Laurentian's RedCap secure survey platform (Appendices F and G), before being exported into SPSS for analysis. The data was prepared for analysis through a process known as data cleaning. The first step was to examine the frequency distributions for the total number of participants, including their demographic information. Any data from participants that reported non-northern postal codes (postal codes that do not begin with the letter 'P') were excluded. It was not possible to gather complete postal codes for participants due to ethics concerns around confidentiality. Some surveys did not contain enough answered questions for the data to be usable (listwise deletion). A codebook documented all question-and-answer options. These procedures minimize errors while increasing the efficiency of the analysis. The statistical analysis allowed me to determine the probability or likelihood of associations based on the findings. More specific descriptions of statistical tests can be found in the associated papers found in Chapters 4 and 5.

### ***3.4.2 Qualitative Data Analysis Plan***

The approach to qualitative data analysis used in my study drew on the tenets of qualitative description (QD), often used to examine healthcare and nursing-related phenomena (Sandelowski 2000). The approach also incorporated constructivist grounded theory (CGT) (Charmaz 2012) data analysis techniques. Because it was consistent with the study goals, the decision was made to use techniques from other qualitative traditions, including the constant comparative analytic approach that is usually associated with grounded theory (Sandelowski, 2000).

Considering the context of the research environment requires that we answer the 'where,' 'when,' and 'why,' while attention to the processes of accessing care allows us to attempt to answer the 'who' and 'how' questions (Kim, Sefcik, & Bradway, 2017). After organising the qualitative data into more focused categories, an overview of the findings allowed me to consider the factors that interact with accessing reproductive healthcare, including individual, institutional, interpersonal, and infrastructural (community, healthcare system, politics/government, organisations, structural, geography) considerations. I paid attention to expressions about the existing norms guiding elements of clinical care, gender, facilities, and care providers. I looked for emergence, reflecting an appreciation for the changing context, and sought to specifically identify enabling and constraining contexts. I looked for care seeking processes including the reasoning (beliefs, attitudes, values) in response to the healthcare encounter, the social systems that change the resources or opportunities available to participants, and the causal powers, such as the opportunity to speak, question, reason, and make decisions. Self-efficacy or agency was a critical factor in decision-making, and I looked for interactions among the opportunities or resources provided when seeking care and the responses of

participants. The results need to appreciate that accessing healthcare exists within an open system and is, therefore, unpredictable. Finally, any conclusions must acknowledge the complexity of care-seeking by looking at social effects (stigma, fear), behavioural impact (risk aversion/seeking, motivation), and beliefs (view of selves). The results of this careful analysis of the interview transcripts can be found in Chapter 6.

## **Summary**

My study employed a mixed-method design, including an online survey followed by interviews with a subset of survey participants. A mixed-methods approach was adopted to provide depth and breadth to the topic of reproductive healthcare experiences in Northern Ontario. The qualitative interviews examined women's perceptions of their reproductive healthcare in Northern Ontario. The quantitative survey explored women's ratings of the quality of their reproductive healthcare in Northern Ontario, as well as their preferences for the location of care. The datasets were combined at the interpretive level of the research. The combined discussion and conclusions are in Chapter 7. The following three papers, included in Chapters 4, 5, and 6, look at study aspects. Chapter 4 outlines the quantitative data analysis techniques adopted to answer the first research question about reproductive healthcare consumers' ratings of the care they receive. Chapter 5 also explores the quantitative data collected but attempts to delve deeper into cervical cancer screening issues specifically. Chapter 6 brings us the voices of the reproductive healthcare consumers by offering consumers' reflections on their care in their own words. The interviews augmented the survey responses and provided the depth required to understand the factors affecting access and acceptance with enough clarity to recommend changes to the system. The combined analysis of the surveys and interviews is found in the

Chapter 7, along with recommendations for changes to Ontario's current system of reproductive care provision.

## **CHAPTER 4: RATINGS BY WOMEN OF THEIR REPRODUCTIVE HEALTHCARE SERVICE QUALITY IN NORTHERN ONTARIO**

(Morgan, L., Wenghofer, E., Johnson, J.L., and Larocque, S.)

### **Abstract**

**Purpose:** This study explores Northern Ontario women's ratings of service quality concerning their reproductive healthcare. This information is valuable in guiding future health policy decisions by acknowledging the consumer of care as the unit of analysis, thus involving women in service design.

**Methods:** Participants included adult women residing in Northern Ontario. The Hierarchical Model of Health Service Quality (HMHSQ) acted as both a conceptual framework and an aid to developing the data collection tool. The resulting survey, offered in French and English, asked participants to rate their reproductive healthcare experiences. Descriptive statistics and multivariate linear regression models determined whether residency, language, education, income, overall health, and access to care (independent variables) were associated with the dependent variable, perceived quality of reproductive healthcare services.

**Results:** One hundred and seventy-three survey responses were included for analysis. Respondents reported good to excellent overall health and fair to good perceptions of availability and quality concerning their general healthcare. Significantly, participants assigned lower ratings for the relationship with their reproductive healthcare provider and the available administrative support. The perceived availability of health services and perceptions of overall health were

significant predictors of reproductive healthcare quality. There was no significant relationship between rurality, education, income, and language and reproductive healthcare quality ratings.

**Conclusions:** The findings demonstrate a positive relationship between overall health and access to services and higher ratings for reproductive healthcare. Areas for improvement include women's relationships with their providers and the support provided to them by the office's administrative staff. As we consider strategies to maximize adherence to reproductive healthcare guidelines and recommendations, we need to examine access to services, the provider pool's skill set, and best administrative practices.

**Key Words:** reproductive healthcare, northern, healthcare providers, satisfaction, quality of care.

## **4.1 Introduction**

This research seeks to understand women's opinions in Northern Ontario, Canada, about their reproductive healthcare. The five core reproductive health services include maternity care which includes antenatal, intrapartum, and postpartum care; family planning including infertility services; abortion services; care for sexually transmitted infections and reproductive cancers; and the promotion of sexual health (WHO, 2002). Access to the full spectrum of reproductive healthcare prevents morbidity and mortality, empowers women and adolescents to make reproductive decisions that are best for them, and supports the advancement of women in society (Espey, Dennis, & Landy, 2019). Encouraging individuals to adopt protective behaviour, and reduce risky practices are vital goals of reproductive healthcare. However, such efforts must appreciate the geographical, sociopolitical, economic, and personal factors that may be hampering access to services (Columbien et al., 2012). As this study represents the opinions of people from Northern Ontario, Canada only, it was guided by an appreciation of the limitations of a lower resource northern setting and included social, economic, and personal factors when considering barriers to reproductive service access.

Populations in rural and remote areas are often disadvantaged concerning available health resources, health literacy, access to healthcare, and health outcomes (Matsumoto et al., 2012). In Northern Ontario, 10% of the province's population resides in 90% of the landmass, with harsh climatic conditions and limited health resources (Angus et al., 2013). Due to acknowledged difficulties in providing and accessing healthcare in rural, remote, and northern Canada, one can speculate that the provision of reproductive healthcare to women in Northern Ontario may suffer the same stressors. However, we know very little about reproductive healthcare services for women in rural and northern settings. According to Sutherns (2005), an absence of gender

analysis, the aggregation of rural and urban responses, and the exclusion of rural perspectives have made rural women largely invisible in the Canadian health literature. Rural health research is essential to redress the disadvantages of people concerning their geography while appreciating how context intersects with the social determinants of health (Sutherns, 2005). Rural health research needs to integrate differences, distances, and contexts to minimize health inequities (Matsumoto et al., 2012). In addition, people live within complex and differing social, economic, and environmental circumstances, and the relationships between their gender, poverty, and discrimination, can result in health inequalities, intensified by policies and services that reinforce and complicate these vulnerabilities (Angus et al., 2013). Any research focusing on rural, remote, and northern healthcare should seek ideas to minimize health inequalities by implementing services and policies that accept and account for vulnerabilities.

This study seeks to collect and analyse perceptions of care in response to reproductive healthcare experiences. Perceptions of care are directly related to decisions to seek care, change providers, and comply with recommended treatments, which makes perceptions an essential factor to consider in evaluations of healthcare effectiveness (Dagger et al., 2007). The participants are the experts on their own healthcare needs and experiences. The participants' perceptions help us understand their insights about accessing reproductive healthcare in a northern environment.

My study uses ratings of reproductive healthcare quality that were collected using a validated tool called the Hierarchical Model of Health Service Quality (HMHSQ) survey tool. There were 73 survey questions in the HMHSQ. These questions were combined with demographic and general health questions, to determine the factors affecting reproductive healthcare access. Knowledge gained from this study can guide improvements to the current

delivery model in order to align with women's expectations while supporting public health initiatives to encourage cervical cancer screening compliance, decrease unwanted pregnancies and abortions through improved access to birth control, and decrease the spread of sexually transmitted infections (STIs) through timely diagnosis and treatment.

This study may provide a foundation for improving the current reproductive healthcare system by acknowledging the consumer of care as the unit of analysis, thus involving women in service design to inform future health policy. Specifically, this paper examines how women rate the availability and quality of their reproductive healthcare experiences in their northern communities and looks at the factors influencing these perceptions.

## **4.2 Methods**

This paper represents one component of a larger study, examining women's perceptions of their reproductive healthcare in Northern Ontario. The larger study employed a mixed-methods design and included an online survey followed by personal interviews with a subset of survey participants, as presented in the qualitative portion of this study, available separately (see Chapter 6). This larger inquiry also analysed women's perceptions of their cervical cancer screening in Northern Ontario, and these results can be found in a separate publication (see Chapter 5). This paper focuses on the ratings for the availability and quality of reproductive healthcare.

### ***4.2.1 Data Collection Tool***

The Hierarchical Model of Health Service Quality (HMHSQ) was the conceptual framework that guided the study and informed the development of the assessment tool (Appendix A). The HMHSQ survey measures the service quality perceptions or a consumer's judgment or impression about an entity's overall excellence or superiority (Dagger et al., 2007).

The HMHSQ questions monitor the quality of services delivered to customers or patients (Dagger et al., 2007). Exploratory factor analysis and structural equation modeling by the scale developers (Dagger et al., 2007) examined the research measures and confirmed the reliability and validity ( $df = 542$ , RMSEA = 0.09, 0.08, 0.08). The measurement model resulted in a good fit to the data, and all indicators served as strong measures of their respective constructs in exploratory and confirmatory studies (Dagger et al., 2007). The scale can be used to benchmark across multiple functions within a single organization, across multiple locations, or within a particular industry; furthermore, any of these situations can also be compared across time (Dagger et al., 2007). According to the guiding theories behind the HMHSQ, service quality can be measured at three levels (see Table 1): the overall level (with a global measure of service quality), the primary dimension level (i.e., technical, interpersonal, environmental, and administrative), and at the sub-dimension level, resulting in a hierarchical structure (Dagger et al., 2007). The English survey can be found in Appendix F and the French version in Appendix G.

Survey respondents answered all 73 questions from the HMHSQ tool using a 7-point Likert scale, with "1" indicating strong disagreement and "7" indicating strong agreement. The questions were grouped by their associated dimensions and sub-dimensions and can be found in Appendix H. The questions were randomly ordered for the survey. Mean scores were calculated for each dimension and sub-dimension (Appendix I). Four additional questions were added which explored the perceptions of participants' general health and healthcare service access to determine whether associations existed between perceived wellness and availability of general services and the quality of reproductive healthcare services received. Survey participants rated their general health, the availability of services, and the quality of services available in their

communities from poor to excellent on a 7-point Likert scale continuum. Four demographic questions determined residency (urban, rural, and northern), language, education, and income. Respondents were also asked whether they had a family physician. The Forward Sortation Area (FSA) of the Canadian postal code was used to identify northern and rural or urban respondents. Postal codes beginning with a "P" were northern, and if the "P" is followed by a "0", they were northern and rural, while "P" followed by any other number identified a respondent as northern and urban (Statistics Canada, 2016). Survey participants identified whether they were "culturally or linguistically francophone." Affirmative answers denoted someone as French-speaking, while the remaining cohort was assumed to speak English. Survey participants reported their highest level of education with choices including primary school, high school, college or university, Master's level degree, or Ph.D. Survey participants were asked to indicate their annual household income from the following categories: 0-\$24,999, \$25,000-\$49,999, \$50,000-\$99,999, \$100,000-\$199,999, and > \$200,000. By collecting additional information about primary language, residency, education, and annual family income and examining the intersectionality of these factors with the female sex, this research supports analysis of the interaction between select demographic variables and perceptions of quality of care.

Table 1: The Primary Dimensions and Sub-Dimensions of Service Quality

<b>Global Dimension:</b> overall perceptions of service quality for a broad indication of an organization's service quality performance	
<b>Primary Dimensions</b>	<b>Sub-Dimensions</b>
<b>Technical</b> - the outcome of the service process: what a customer receives as the result of interacting with the healthcare provider; and reflects the professionalism and competency of a service provider in delivering a service	<p><b>Outcome</b> - the experiences over a series of service encounters</p> <p><b>Expertise</b> - a provider's competence, knowledge, qualifications, and skills, reflecting the ability of a care provider to adhere to high standards.</p>
<b>Interpersonal</b> - the dyadic interplay between consumers and their caregivers	<p><b>Interactions</b> - the manner of the service provider, defined as their attitude and behavior in the service setting. This also includes the communication between the provider and patient, reflecting the interactive nature of the interpersonal process and the transfer of information between a provider and a client. The degree of interaction is measured as the level of two-way communication.</p> <p><b>Relationship</b> - the closeness and strength of the bond between a provider and a client. The relationship encompasses a high degree of mutuality and ongoing, interpersonally close interactions in which trust and mutual liking exist.</p>
<b>Environmental</b> - the complex mix of features that shape consumer service perceptions	<p><b>Atmosphere</b> - the background characteristics of the service environment. These elements generally exist below consumers' level of awareness and affect the pleasantness of the surroundings.</p> <p><b>Tangibles</b> - the physical elements of the service environment that exist at the forefront of awareness. They comprise the design, function, or layout of the space along with the signs, symbols, and artifacts.</p>
<b>Administrative</b> - anything that facilitated the production of the core service while adding value to the consumer	<p><b>Timeliness</b> - the factors involved in arranging to receive medical services such as appointment waiting lists, waiting time, the ease of changing appointments, and hours of operation</p> <p><b>Operations</b> - the facilitation of core service production through the general administration of the clinic and the coordination, organization, and integration of medical care</p> <p><b>Support</b> - the feeling of being genuinely cared for at all levels</p>

#### 4.2.2 Study Recruitment and Sample Size

Survey respondents were women residing in Northern Ontario using non-probabilistic convenience sampling. The sample size calculation was based on a population estimate of 300535 women over 18 years, residing in Northern Ontario (Statistics Canada, 2012). The number of completed surveys to maintain 95% statistical power was 150 – 384. Eligible

participants included females with female reproductive organs, 18 years or older, and residing in Northern Ontario at the study time. For this study, the words "woman/women" will refer to sex, as opposed to gender, recognizing that a participant's gender identity may differ from their anatomical, physiological, or genetic assignment. When examining women's reproductive healthcare, 'women/woman' will refer anatomically and physiologically to participants with reproductive organs and corresponding hormonal and endocrine systems (Health Canada, 2003).

Respondents obtained information about the study via information packages distributed to local health centres, public health offices, women's shelters, fitness centres, and parenting support drop-in centres in 24 of the largest towns or cities in Northern Ontario. The two hundred information packages consisted of an information card with internet access instructions, guiding participants to a website developed for this study ([reproductivehealthcare.ca](http://reproductivehealthcare.ca)). All questions were answered online. The survey was hosted on RedCap, as administered through Laurentian University. The primary researcher was interviewed by CBC radio in Sudbury and Thunder Bay, and the study website address was provided. The survey link was in a newsletter sent out by the Ontario Women's Health Network. The website address was displayed across the back window of a vintage trailer, inviting women to answer the survey. Recruitment materials are in Appendix J.

#### ***4.2.3 Analysis***

The descriptive analysis provided an overview of the study population. Chi-square tests determined how well the survey participants matched the population of Northern Ontario concerning residency, language, and education. Chi-square tests determined whether rural vs. urban participants and Francophone vs. Anglophone participants differed in their income levels, education, and having a family physician. Descriptive statistics for overall health ratings,

availability of healthcare services, and perceived quality of general healthcare services were calculated. Descriptive statistics were also calculated for global, primary, and sub-dimensional ratings of quality of reproductive healthcare. Independent-samples t-tests compared the mean scores for the primary dimensions and the mean scores for overall health, availability, and perceived quality of general health services between rural vs. urban participants and Francophone vs. Anglophone participants. Analysis of variance (ANOVA) compared the mean scores for the primary dimensions and the mean scores for overall health, availability, and perceived quality of general health services among the three levels of education and the three levels of income. ANOVAs explored the relationship between the ratings for reproductive healthcare quality with the ratings for perceived overall health, perceived availability of services, and perceived quality of general healthcare services.

A series of linear regression analyses focused on the primary dimensional ratings of quality of reproductive healthcare. The dependent variables were the continuous scores for the four primary dimensions (i.e., technical, interpersonal, environmental, and administrative). A separate linear regression was conducted for each of the four primary dimensions (technical, interpersonal, environmental, and administrative). The independent variables in all regression models included residency (urban vs. rural), language (Anglophone vs. Francophone), level of education, annual family income, ratings of overall health, availability of services, quality of general healthcare services, and having a family doctor. Because family income was divided into three categories, a reference category had to be determined and the other two categories were ‘dummy coded’ for statistical robustness. The education category was collapsed into the two categories of ‘no post-secondary’ and ‘attended post-secondary’. Backward stepwise conditional

entry was used in each model, whereby entry/exit criteria were  $F \geq 0.05$  for entry and  $F \leq 0.1$  for removal. All analyses used IBM SPSS Standard Statistics 26.0.

#### ***4.2.4 Ethics approval***

Ethics approval was obtained from the Laurentian University Ethics Board in May 2014 (REB File No. 2014-01-09).

### **4.3 Results**

A total of 191 Northern Ontario women responded to this online survey. Ten respondents were excluded due to non-northern postal codes, while eight respondents were excluded due to insufficient responses (less than 10% of questions answered). These exclusions resulted in a final sample of 173 Northern Ontarian respondents.

Most people found out about the survey via means other than the ten choices provided. The two radio interviews with the Canadian Broadcasting Corporation (CBC) resulted in 60 people (35% of total participants) responding. The second most effective way of reaching participants was Facebook. Postings on both personal and group Facebook accounts resulted in 42 participants (24%).

#### ***4.3.1 Respondent Demographics***

A comparison of the demographic information of the survey participants and the population in Northern Ontario is in Table 2. The proportion of survey participants living rurally was 28.9%, compared with the portion of the population of Northern Ontario that reside rurally, which is 34.0%. Chi-square tests confirmed that the survey respondents did not differ significantly from the population of Northern Ontario [ $\chi^2 = 2.083$ ,  $p=0.149$ ] concerning the ratio of urban residency compared with rural residency. Chi-square tests for language concluded that survey participants differed significantly from the population of Northern Ontario [ $\chi^2 = 20.790$ ,

$p < 0.001$ ], with more people identifying as Francophone (31.2%) than the general population (18.0%). In order to match the comparator (Statistics Canada, 2012), the education category was collapsed into secondary school and post-secondary, which included graduate school. There were no respondents with only a primary school education. The survey sample was significantly more educated than the population of Northern Ontario [ $\chi^2 = 13.615$ ,  $p < .001$ ], with 83.8% enrolled or graduated from post-secondary institutions, including graduate-level studies, compared with 70.9% in the general population of Northern Ontario. Whether the survey participants differed for household income could not be determined because the survey and the comparator (Statistics Canada, 2012) did not share the same quintiles. Future analysis should attempt to match the nationally defined income quintiles.

Table 2: Independent Demographic Variables

Independent Variables	Category	Survey Participants		*Population of Northern Ontario (%)	Participants vs Population N. Ontario
		Number	%		
Participants		173	100	N=300535	
Residency	Rural	50	28.9	34.0	$\chi^2 = 2.083$
	Urban	123	71.1	66.0	$p = 0.149$
Language	Francophone	54	31.2	18.0	$\chi^2 = 20.790$
	Non-Francophone	119	68.8	82.0	$p < .001$
Education Level	High School	28	16.2	29.1	$\chi^2 = 13.615$
	College or University	97	56.1 + 27.7 = 83.8	70.9	$p < .001$
	Graduate	48			
Family Doctor	Yes	148	85.5	90.1	$\chi^2 = 4.175$
	No	25	14.5	9.9	$p = 0.041$

\*Statistics Canada (2012) Canadian Community Health Survey, 2012 [public-use microdata file]. Ottawa, Ontario: Statistics Canada. Health Statistics Division, Data Liberation Initiative [producer and distributor].

Most respondents (148, 85.5%) report having a family doctor, leaving 25 (14.5%) without a family doctor. This differed significantly from the population in Northern Ontario [ $\chi^2 = 4.175$ ,  $p = 0.041$ ], with fewer survey participants having a family doctor compared with the overall population (90.1%). The number of rural (84.0%) and urban (86.2%) participants with a family doctor were comparable [ $\chi^2 = 0.017$ ,  $p = 0.896$ ]. While more Francophones (92%) had a family doctor than Anglophones (84%), the difference was not significant [ $\chi^2 = 0.37$ ,  $p = 0.543$ ].

To examine the association between the independent demographic variables, Chi-squared tests for independence were performed and indicated a significant association between living rurally and lower levels of education [ $\chi^2 = 6.593$ ,  $p=0.037$ ]. Despite this, living rurally did not appear to affect income [ $\chi^2 = 3.144$ ,  $p=0.208$ ]. Participants identifying as Francophone did not demonstrate significant differences with respect to education [ $\chi^2 = 0.828$ ,  $p=0.661$ ] or income [ $\chi^2 = 1.109$ ,  $p=0.574$ ], compared with Anglophone participants.

#### ***4.3.2 Perceptions of General Overall Health, Availability and Quality of General Health Services***

Women rated their overall health and the availability and quality of services in their communities (Table 3). Overall health responses were clustered around the relatively high mean value (mean 5.39, standard deviation (SD) 1.184), signifying that respondents feel relatively healthy overall. Availability of services and perceived quality of general healthcare services rated lower (mean 4.15, SD 1.396 & mean 4.29, SD 1.397) and had a flatter distribution. There was more variation in these responses, both lower and higher scores, that is not evident in the overall mean

Table 3: Frequency Distribution for Perceptions of Overall Health, Availability of Healthcare Services and Quality of General Healthcare Service Responses (n=173)

Item	Percent Reponses in each Likert Category (n)							Mean Likert Score	SD
	1	2	3	4	5	6	7		
Overall Health	6.9 (12)	4.0 (7)	19.7 (34)	20.8 (36)	34.7 (60)	11.6 (20)	1.7 (3)	5.39	1.184
Availability of Services	2.9 (5)	8.7 (15)	17.9 (31)	18.5 (32)	35.8 (62)	11.6 (20)	4.6 (8)	4.15	1.396
Perceived Quality of General Healthcare Services	0.6 (1)	1.2 (2)	5.8 (10)	9.2 (16)	36.4 (63)	28.3 (49)	18.5 (32)	4.29	1.397

#### ***4.3.3 Perceptions of Reproductive Healthcare Service Quality***

Interpersonal quality (4.55, SD 1.739) was rated higher than technical quality (4.51, SD 1.770), environmental (4.40, SD 1.655), or administrative (4.34, SD 1.745) quality. Of note were ratings for interpersonal relationships and administrative support, as these were lower than the other dimensions and sub-dimensions (Table 4).

Table 4: Quality of Reproductive Healthcare Dimensional Scores

Dimension / Sub-Dimension	Number	%	Mean Likert Score	SD
ALL RESPONDENTS	173	100		
Global Score	173	100%	4.43	1.83
Technical	168	97.1	4.51	1.77
Outcome	171	98.8	4.55	1.59
Expertise	167	96.5	4.68	1.64
Interpersonal	171	98.8	4.55	1.74
Interactions	169	97.7	4.56	1.70
Relationship	169	97.7	<b>3.73</b>	1.97
Environmental	170	98.3	4.40	1.66
Atmosphere	170	98.3	4.40	1.57
Tangibles	171	98.8	4.17	1.64
Administrative	169	97.7	4.34	1.745
Timeliness	171	98.8	4.29	1.92
Operations	168	97.1	4.59	1.41
Support	168	97.1	<b>3.78</b>	1.69

The factors influencing the ratings for reproductive healthcare include residency (rural vs. urban), language (Francophone vs. Anglophone), income, education, overall health, perceived quality & availability of general healthcare, and whether one has a family physician. Tables 5 through 8 combine the sub-dimensions and the variables for overall health, perceived quality & availability of general healthcare for ease of comparison but care must be taken when interpreting this grouping. The ratings for interpersonal relationships and administrative support were less than 4.0 and were the only two sub-dimensions that were below average. T-tests and ANOVAs determined whether residency, language, education, or income affected these sub-dimensions. Independent-samples t-tests demonstrated no significant differences in quality ratings for rural and urban dwelling participants (Table 5) or Francophone and Anglophone participants (See Table 6). There were no significant differences in the mean ratings of

reproductive healthcare quality based on education (Table 7). For income, there were no significant associations between income and mean ratings of reproductive healthcare quality.

Table 5: T-Tests for Residency with Ratings of Quality of Reproductive Healthcare and Ratings of Overall Health, Availability, and Perceived Quality (n=173)

Quality Care Dimension	Rural (N=50)		Urban (N=123)		Mean Difference	CI (95%)		p Value
	Mean	SD	Mean	SD		Lower	Upper	
Interpersonal	4.69	1.686	4.495	1.763	0.658	-0.384	0.769	0.512
Technical	4.62	1.805	4.486	1.756	0.450	-0.452	0.720	0.653
Environmental	4.367	1.554	4.405	1.701	-0.138	-0.588	0.511	0.890
Administrative	4.470	1.685	4.294	1.772	0.600	-0.403	0.755	0.549
Overall health	5.26	1.397	5.440	1.088	0.179	-0.213	0.571	0.369
Availability	3.92	1.470	4.240	1.362	0.317	-0.147	0.782	0.179
Quality of services	4.100	1.488	4.370	1.357	0.266	-0.196	0.728	0.258

Table 6: T-Tests for Language and Ratings of Quality of Reproductive Healthcare and Ratings of Overall Health, Availability, and Perceived Quality (n=173)

Quality Care Dimension	Francophone (N=54)		Anglophone (N=119)		Mean Difference	95% CI		p Value
	Mean	SD	Mean	SD		Lower	Upper	
Interpersonal	4.710	1.815	4.478	1.705	-0.894	-0.796	0.331	0.417
Technical	4.602	1.850	4.490	1.733	-0.384	-0.685	0.462	0.701
Environmental	4.512	1.677	4.340	1.650	-0.632	-0.709	0.365	0.528
Administrative	4.494	1.742	4.277	1.749	-0.755	-0.782	0.349	0.451
Overall health	5.460	1.128	5.350	1.211	-0.110	-0.494	0.274	0.573
Availability	4.350	1.291	4.050	1.437	-0.301	-0.753	0.151	0.190
Quality of services	4.350	1.376	4.260	1.411	-0.091	-0.545	0.362	0.691

Table 7: ANOVA for Education and Ratings of Quality of Reproductive Healthcare and Ratings of Overall Health, Availability, and Perceived Quality (n=173)

Quality Care Dimension	High School (N=28)		College/University (N=97)		Graduate (N=48)		F Value	p Value
	Mean	SD	Mean	SD	Mean	SD		
Interpersonal	4.130	1.412	4.630	1.726	4.640	1.924	0.999	0.370
Technical	4.143	1.662	4.576	1.704	4.646	1.947	0.806	0.448
Environmental	3.810	1.503	4.526	1.634	4.469	1.742	2.129	0.122
Administrative	3.946	1.431	4.424	1.746	4.417	1.902	0.870	0.421
Overall health	2.857	0.651	2.990	0.621	3.104	0.660	1.360	0.259
Availability	2.179	0.863	2.433	0.676	2.426	0.651	1.510	0.224
Quality of services	2.071	0.766	2.557	0.736	2.458	0.743	4.644	<b>0.011</b>

Table 8: ANOVA for Income and Ratings of Quality of Reproductive Healthcare and Ratings of Overall Health, Availability, and Perceived Quality (n=171)

Quality Care Dimension	<\$50,000 (N=54)		\$50,000-99,999 (N=63)		>\$99,999 (N=54)		F Value	p Value
	Mean	SD	Mean	SD	Mean	SD		
Interpersonal	4.190	1.443	4.520	1.757	4.940	1.911	2.545	0.081
Technical	4.161	1.570	4.548	1.768	4.889	1.892	2.343	0.099
Environmental	4.154	1.447	4.407	1.806	4.682	1.645	1.384	0.253
Administrative	3.994	1.586	4.482	1.724	4.543	1.916	1.633	0.198
Overall health	2.907	0.591	3.000	0.648	3.093	0.680	1.126	0.327
Availability	2.296	0.792	2.381	0.658	2.491	0.669	1.016	0.364
Quality of services	2.407	0.790	2.413	0.710	2.537	0.794	0.511	0.601

T-tests demonstrated that residency (rural vs. urban) (Table 5) and language (Francophone or non-Francophone) (Table 6) do not significantly affect ratings for overall general health, availability of health services, and quality of general health services. ANOVAs showed that higher education is significantly associated with increased ratings for the quality of

general healthcare services (Table 7). There were no significant associations with income (Table 8).

ANOVAs showed significant differences in the mean ratings of reproductive healthcare quality for the continuous independent variables of overall health (Table 9), availability (Table 10), and the perceived quality of general health services (Table 11). With respect to the perceived quality of general health services, the Kruskal–Wallis test, or one-way ANOVA on ranks, was used to compare the independent samples of varying size, meaning that the data was skewed or did not meet assumptions of normality. Tukey's post hoc analyses indicated that those persons reporting excellent overall health, good to excellent availability, and good to excellent quality of services rated the quality of their reproductive healthcare higher across all dimensions.

Table 9: ANOVAs for Ratings of Overall Health & Ratings of Quality of Reproductive Healthcare (n=173)

Quality Care Dimension	Poor (N=3)		Fair (N=26)		Good (N=112)		Excellent (N=32)		F Value	p Value
	Mean	SD	Mean	SD	Mean	SD	Mean	SD		
Interpersonal	3.000	1.732	3.987	1.639	4.507	1.721	5.302	1.649	3.911	0.010
Technical	3.000	1.732	3.846	1.754	4.516	1.729	5.250	1.663	4.028	0.008
Environmental	2.779	1.575	3.872	1.555	4.350	1.594	5.125	1.720	4.138	0.007
Administrative	3.111	1.836	3.699	1.628	4.344	1.745	4.990	1.643	3.270	0.023

Table 10: ANOVAs for Ratings of Availability Health Services & Ratings of Quality of Reproductive Healthcare (n=172)

Quality Care Dimension	Poor (N=19)		Fair (N=70)		Good (N=80)		Excellent (N=3)		F Value	p Value
	Mean	SD	Mean	SD	Mean	SD	Mean	SD		
Interpersonal	3.667	1.934	4.400	1.781	4.848	1.561	6.444	1.649	3.989	0.009

Technical	3.605	1.789	4.274	1.782	4.906	1.636	6.556	1.663	5.088	0.002
Environmental	3.509	1.664	4.152	1.649	4.744	1.556	6.444	1.720	5.391	0.001
Administrative	3.474	1.694	4.064	1.740	4.750	1.636	6.333	1.643	5.282	0.002

Table 11: ANOVAs for Ratings of Quality of General Health Services & Ratings of Quality of Reproductive Healthcare (n=173)

Quality Care Dimension	Poor (N=20)		Fair (N=63)		Good (N=82)		Excellent (N=8)		Kruskal Wallis H Value	p Value
	Mean	SD	Mean	SD	Mean	SD	Mean	SD		
Interpersonal	3.667	1.761	4.124	1.730	4.976	1.571	5.750	1.771	16.828	<0.001
Technical	3.192	1.714	4.056	1.617	5.067	1.606	6.000	1.623	28.203	<0.001
Environmental	3.650	1.546	3.958	1.598	4.803	1.546	5.500	1.976	17.658	<0.001
Administrative	3.517	1.353	3.844	1.686	4.844	1.636	5.250	2.369	18.837	<0.001

There were concerns about multi-collinearity in the regression model in evaluating the relationships between the general health independent variables of availability and perceived quality. Perceptions about the availability of general healthcare and perceptions about the quality of general health services were closely correlated ( $R=0.688$ ). Therefore, this study chose one variable, the availability of health services, to avoid issues of collinearity. Availability of health services was selected as the most crucial factor of the two considering how the relative scarcity of services can result in poor access and stretched services, leading to compromised health (Gregory, 2009). In addition, non-existent services cannot be measured for quality, requiring consideration of access before quality.

The backwards stepwise regression models were significant for each of the reproductive health quality primary dimensional scores: environmental ( $F = 13.57$ ,  $p < 0.001$ ); technical ( $F = 13.10$ ,  $p < .001$ ); administrative ( $F = 11.91$ ,  $p < 0.001$ ); and interpersonal ( $F = 12.56$ ,  $p < 0.001$ ). Availability of health services and overall health were significantly positively associated with the

four dimensions of quality reproductive healthcare (Table 12). Generally, healthy individuals and those with an available healthcare provider have more positive experiences in accessing reproductive healthcare services. Collinearity Statistics for Tolerance remained  $> 0.10$ , indicating that multi-collinearity was not an issue in these models. None of the other independent variables included in the models were significant.

Table 12: Linear Regression Results of Factors Influencing Perceived Quality of Reproductive Healthcare (n=173)

Quality Care Dimension	Significant Variables Remaining in Final Step of the Model	Unstandardized Coefficients		Standardized Coefficients	p Value	Adjusted R Square
		B	Std. Error	Beta		
<b>Technical</b>	Availability	0.350	0.092	0.277	<0.001	0.124
	Overall Health	0.300	0.109	0.199	0.007	
<b>Interpersonal</b>	Availability	0.327	0.090	0.263	<0.001	0.119
	Overall Health	0.305	0.108	0.206	0.005	
<b>Environmental</b>	Availability	0.323	0.086	0.272	<0.001	0.128
	Overall Health	0.302	0.102	0.213	0.004	
<b>Administrative</b>	Availability	0.332	0.091	0.266	<0.001	0.113
	Overall Health	0.283	0.108	0.191	0.010	

\* Independent Variables – **residency** (rural/urban); **language** (Francophone/Anglophone); **education** (Post-secondary yes/no); **income** [\$50,000 - \$100,000 (ref.), <\$50,000 (low), >\$100,000 (high)]; **family doctor** (yes/ no), **Female provider** (yes/no)

Further interpretation of the regression data demonstrated that higher ratings of overall health and availability of services are associated with increased ratings for all service quality dimensions. Between 11.6% and 13.7% of the variation in the care ratings, dimensions may be explained by these two variables alone.

#### 4.4 Discussion

This study primarily sought to determine how women in Northern Ontario perceive the quality of their reproductive healthcare and the factors that influence these perceptions. Before

this investigation, we knew very little about the perceptions of women regarding their reproductive healthcare in Northern Ontario. Results show that respondents reported good to excellent overall health and fair to good perceptions of availability and quality for their general healthcare. Of the women who participated in this survey, nearly 86% reported having a family doctor, with no difference in the rate between rural and urban respondents. This finding was not consistent with what one might expect based on the practice patterns of family physicians in the north; 71% of family physicians practice in urban settings where only 59% of the population resides (Wenghofer, Timony, & Gauthier, 2014). The perceived availability of health services and perceptions of overall health were significant predictors of reproductive healthcare quality ratings. General healthcare quality ratings did not affect ratings for reproductive healthcare. This study did not find differences between rural and urban residents when accessing reproductive healthcare services, contrary to literature stating the opposite. Historically, a shortage of healthcare providers in rural communities posed a serious challenge to equitable healthcare delivery and living in a rural environment was associated with making sacrifices in terms of perceived quality (Wilson et al., 2009; Sutherns, 2004). Access to acceptable general and reproductive healthcare services did not appear problematic for rural or urban residing women in this study as their quality ratings are similar for these services.

Francophone respondents did not report lower perceptions of overall general health or less availability of general health services. Their perceptions about the quality of their reproductive healthcare did not differ from their Anglophone counterparts. However, we do not know if these participants were accessing or attempting to access health services in French or that this would be their preference. Nevertheless, this result was unexpected as there is a shortage of French-speaking physicians available to provide care to northern Francophone residents,

representing a substantial disparity when comparing the southern to the northern regions of Ontario (Gauthier et al., 2012). As this study made no comparisons to southern health, there are no conclusions about whether access is reduced in the north. In summary, Francophones and Anglophones rated their reproductive healthcare similarly.

Ratings for perceived quality of reproductive healthcare services, broken down into the domains of environmental, technical, administrative, and interpersonal quality, received similar ratings by survey participants. However, when we break down the interpersonal domain into its sub-dimension of 'relationship' and the administration domain into its sub-dimension of 'support,' the significance of the lower ratings associated with the patient-provider relationship becomes more evident (Table 4). Respondents may be indicating that their relationship with their provider is not close, and a strong bond does not exist (Dagger et al., 2007). In contrast, high scores may indicate trust and mutual liking (Dagger et al., 2007). Within the administrative context, support represents an augmented service element that adds value to the core service, otherwise known as 'going above and beyond' (Dagger et al., 2007). Ratings were lower, suggesting that the administrative support may be adequate, but exceptional actions are not typical. By understanding women's reproductive healthcare experiences in Northern Ontario, this study concludes that providers could pay more attention to developing a relationship with clients/patients. Administrative staff can be encouraged to support the clients/patients and improve care receiving experiences.

Given that respondents rated the relationship with their provider lowest among all sub-dimensions, examining the principles of a person or patient-centred care (PCC) and its applicability to reproductive healthcare is required. PCC encompasses the characteristics inherent in many sub-dimensions, expressly continuity of care, relationship, and support. PCC is

based on a deep respect for patients as unique living beings that should expect to be listened to, informed, and involved in their care (Epstein & Street, 2011). This approach is responsive to patient needs and preferences, addressing their biopsychosocial needs and preferences alongside their medical needs, acknowledging the patient as the expert on their experience, resulting in a partnership with their provider (Majid, Kandasamy, Farrah, & Vanstone, 2019). A meta-synthesis, conducted to examine the conditions contributing to Ontario women's inequitable access to care, found that women identify limited opportunities for fruitful discussions due to insufficient time allotted for appointments (Angus et al., 2013). That study also reported judgemental encounters, which caused some women to lose trust, discontinue attendance, or withhold information from providers (Angus et al., 2013). These are termed "barriers to care" and are defined as systemic features of care policies or delivery systems that block efforts to obtain care and health information (Angus et al., 2013). The authors suggested that providers can mediate these barriers by allowing time for questions and information sharing, becoming culturally responsive, and working to identify institutional and personal biases (Angus et al., 2013). In summary, PCC is an essential aspect of quality care, and PCC is associated with improved healthcare utilization and outcomes (Larson, Sharma, Bohren, & Tuncalp, 2019). Women residing in Northern Ontario may benefit from an increased focus on PCC to build a relationship with their provider, potentially resulting in increased engagement with the recommended reproductive healthcare.

#### ***4.4.1 Study Limitations and Future Research***

The survey tool developed in this study adapted an existing service quality measuring instrument called the HMHSQ. The model was developed and tested at general practice and oncology clinics in Australia. This model for assessing satisfaction with care has never been used

in reproductive healthcare, and the Canadian health consumer may differ from the Australian health consumer in ways that are not yet evident. The model can be refined through this study, serving to advance knowledge of the measurement of health service quality. The survey was offered in two languages, but despite professional translation of the English survey into French and piloting with native French speakers, back translation was not performed so comprehension of questions in French cannot be assured. The 2012 Canadian Community Health Survey (CCHS) was the main demographic comparator with my interviewees (Statistics Canada, 2012). The CCHS only covers 98% of the population, leaving out Indigenous peoples living on reserve, Canadian Forces members, and some remote areas. The lack of participation among Indigenous women justifies the need for an Indigenous-led study to capture their experiences with receiving reproductive healthcare. Also, respondents to the CCHS are 12 years or older, and the interview respondents were 18 years of age or older. Future research should consider adopting the identical divisions as the CCHS (i.e., income, education, racial background) for ease of comparison. The results of this study do not necessarily represent the experiences of all women in Northern Ontario.

Future research should include studies of men and their reproductive healthcare, as this field is under-informed and neglected. Perhaps more informative would be a broader study into people's reproductive healthcare experiences, inviting participation, regardless of gender identity, to capture the experiences of men, women, and people who do not easily identify with either, as in some queer, trans+ and non-binary people. There are good reasons to suggest improvements 'for women' or 'for men.' However, care must be taken to not exclude the group in between whose reproductive healthcare experiences are also essential to optimize. Finally, the current

study could be repeated after changes to health policy and the provision of reproductive healthcare in Northern Ontario to see if care experiences improve.

## 4.5 Conclusion

This study investigated the perspectives of women in Northern Ontario about their reproductive healthcare. Residency (rural vs. urban), language (Francophone or non-Francophone), education, and income do not significantly affect overall general health and availability of services or the perceived quality of reproductive healthcare services. The quality of the current reproductive healthcare services in Northern Ontario is rated favourably by the participants in this study, but aspects of the care encounter may be improved by nurturing the provider-patient relationship and augmenting the service to make consumers feel supported.

The findings of this study contribute to filling a significant knowledge gap about reproductive healthcare among rural, remote, and northern populations of women in Ontario. According to the Hierarchical Model of Health Service Quality (Dagger et al., 2007), improving women's perceptions regarding the quality of care may increase satisfaction with services and inform behavioural intentions to engage in recommended care. Ideally, increases in perceived reproductive healthcare quality could lead to an increased uptake of screening for reproductive cancers, a decrease in STIs, and an increase in birth control use, with the latter resulting in a decrease in abortions and unintended pregnancies. An effective reproductive healthcare service aims to achieve well-being for all persons. The voices of the care consumers should guide changes to maximize adherence to guidelines and recommendations and meet population health goals.



# **CHAPTER 5: CERVICAL CANCER SCREENING EXPERIENCES & PREFERENCES FOR MIDWIVES BY WOMEN IN NORTHERN ONTARIO**

(Morgan, L., Wenghofer, E., Johnson, J.L., and Larocque, S.)

## **Abstract**

**Purpose:** This study explored Northern Ontario women's preferences regarding cervical cancer screening to improve service provision.

**Methods:** Women in Northern Ontario completed a survey about their reproductive healthcare experiences. Descriptive statistics and multivariate logistic regression models determined whether residency, language, education, income, family physician, and preferring females for cervical screening are associated with preferring a midwife for cervical cancer screening.

**Results:** A total of 173 survey responses were analysed. Most participants were following provincial cervical cancer screening guidelines, with 86.6% of women indicating that their last pap test was within three years, compared with the Ontario provincial rate of 64.9%. Women state that liking one's healthcare provider is the primary reason for complying with recommended cervical screening guidelines. The most common reason for not complying is "too embarrassed or modest" to engage in this type of personal care. Most women access cervical cancer screening at their physician's office (61.5%), but a significant percentage (29.4%) would like to access this screening at a midwifery clinic. Women with lower family incomes and rural women without a family physician are most likely to prefer a midwife for screening.

**Conclusions:** The findings demonstrate interest among consumers in accessing cervical cancer screening in midwifery clinics. Rural women without family physicians and women with lower incomes may particularly benefit from this option.

**Key Words:** reproductive healthcare, northern, healthcare providers, satisfaction, quality of care, cervical cancer, Pap screening

## **5.1 Introduction**

Cervical cancer is the fourth most common cancer in women and one of the leading causes of mortality globally (Majid et al., 2019). Cervical cancer screening effectively reduces the incidence and mortality associated with cervical cancer because it can detect abnormalities when they are still in the pre-cancerous stage with high sensitivity and specificity (Murphy et al., 2012). The current provincial cervical cancer screening guidelines recommend screening every three years, after the age of 21, or once sexually active (Cancer Care Ontario, 2020). The Ontario provincial rate for cervical screening is 64.9% (Cancer Care Ontario, 2020), which is well below the provincial target of 85%. Cancer Care Ontario reports wide geographical variation in the percentage of women overdue for cervical screening throughout Ontario. In particular, there is a high percentage of women overdue for cervical screening in the Greater Toronto Area and sections of Northern Ontario (Cancer Care Ontario, 2020). They report differences in cervical cancer screening in urban and rural areas and hypothesize that individual, physician, and system factors as responsible (Cancer Care Ontario, 2020). Cancer Care Ontario states that given geographical differences in cervical cancer screening, developing locally relevant policies and programs in partnership with community service providers could improve access to services and reduce screening disparities (Cancer Care Ontario, 2020). For policies and programs to increase compliance with cervical cancer screening to succeed, they must appreciate the geographical, sociopolitical, economic, and personal factors that may be hampering access to services (Collumbien et al., 2012). Disparities in reproductive healthcare access can result in unacceptable health inequities, including higher cancer rates, more unwanted pregnancies, and abortions due to lack of access to birth control, and the increased spread of sexually transmitted infections. Access to the full spectrum of reproductive healthcare prevents morbidity and

mortality, empowers women and adolescents to make reproductive decisions that are best for them, and supports women's advancement in society (Espey et al., 2019).

Earlier studies have investigated cervical screening in Canada but issues of access and acceptance of cervical cancer screening in rural and northern environments is not well studied. An absence of gender analysis, the aggregation of rural and urban responses, and the exclusion of rural perspectives have made rural women largely invisible in the Canadian health literature (Sutherns, 2005). The available literature clarifies that gender, combined with poverty and discrimination, can result in health inequalities, intensified by policies and services that reinforce and complicate women's vulnerabilities (Angus et al., 2013). Populations in rural and remote areas are often disadvantaged concerning available health resources, health literacy, access to healthcare, and health outcomes (Matsumoto et al., 2012; Mattison & Lavis, 2016). Population scarcity combined with harsh climatic conditions and limited health resources restricts access to health resources and care, ultimately affecting outcomes (Angus, et al., 2013). Rural health research is essential to redress the disadvantages of people because of geography while appreciating the way context intersects with the social determinants of health. Rural health research needs to integrate differences, distances, and contexts to minimize health inequities (Matsumoto et al., 2012). By collecting additional information such as ethnicity and culture, education, geographic location, and annual family income, and by examining the intersectionality of these factors with female gender, the research aims to recognize that the person cannot be extricated from the layering of identities that define them, highlighting marginalisation and oppression across social structures (Hawke, 2021). The entire field of reproductive healthcare needs to be better informed, with attention to the barriers experienced by vulnerable members of the population.

Disparities in cervical cancer incidence are associated with varying participation rates in screening programs, with rurality recognised as a risk factor due to limited healthcare providers and the long distances required to travel for care (Majid et al., 2019). Other factors that impact cervical cancer screening rates include availability of provider, particularly female healthcare providers; convenient hours and locations; knowledge of the importance of screening for health; whether the woman has any specific concerns; provider offers screening services; liking one's provider; modesty/ fear of embarrassment; fear of discomfort due to the 'procedure'; and fear of bad news (Akinlotan, Bolin, Helduser, et al., 2017). Cervical cancer screening is within the scope of practice of midwives but can only be performed on pregnant women or women within 6 weeks of giving birth, as clearly stated in the provincial regulatory documents (Midwifery Act, 1991). Midwives need to perform screening and diagnostic tests to determine cervical and vaginal health, including collecting specimens to evaluate for the presence of sexually transmitted infections (STIs), vaginal infections, and cytological changes (College of Midwives of Ontario (CMO), 1994). Midwives need to be able to recognize variations from wellness for reproductive health and symptoms of pathology for referral (CMO, 1994). Midwives already possess the core competencies to provide cervical cancer screening outside of pregnancy and the knowledge and skills to deliver all aspects of reproductive healthcare.

The scope of midwifery practice in Ontario is "... the assessment and monitoring of women during pregnancy, labour and the postpartum period and of their newborn babies, the provisions of care during normal pregnancy, labour and the postpartum period and the conducting of spontaneous normal vaginal deliveries." (Midwifery Act, 1991). This restrictive definition limits midwives' care for women during pregnancy, birth, and postpartum and does not include the full spectrum of reproductive healthcare. This omission prevents midwives from

offering family planning, including infertility services, abortion counseling and care, diagnosis and treatment of sexually transmitted infections and reproductive cancers outside of pregnancy, and the promotion of sexual health (WHO, 2002). In its document addressing core competencies of midwives, the CMO states that the entry-level midwife should be capable of providing midwifery care as defined by the International Definition of a Midwife, which extends into gynecology, family planning, and childcare (ICM, 1973). The knowledge and skills already possessed by Ontario midwives allow for an easy transition to the provision of reproductive healthcare outside of pregnancy and childbirth.

Healthcare policy changes initiated during the 1990s led to a reduction of medical school enrolment and restrictions on the recruitment of international medical graduates (Malko & Huckfeldt, 2017). The chronic under-supply of primary care physicians is reflected in the low interest among medical students in a family medicine career and the shortage of physicians in rural areas (Malko & Huckfeldt, 2017). Simultaneously, midwifery was integrated into the healthcare system in 1993, in almost the exact manner proposed by midwifery advocates. The enactment of midwifery legislation was a triumph for grassroots feminist organizing, gender equity, and reproductive autonomy (Nestel, 2006). Bourgeault, Declercq, and Sandall (2001) theorize that the government's support for midwifery was forthcoming for two reasons. The argument that midwifery was cost-effectively suited the state's current efforts towards rationalizing healthcare. Second, the government could be seen as progressive in supporting women's issues (Bourgeault et al., 2001). Austerity still exists in our healthcare system and expanding the scope of midwives into the provision of reproductive healthcare would be a progressive step by governments, again demonstrating their attention to feminist issues while addressing the under-supply of primary healthcare providers.

There is a documented need in the literature to understand the elements that contribute to satisfaction in reproductive healthcare for women (Weisman et al., 2000). Also, under the current climate of fiscal restraint, particularly in healthcare, there exists interest in examining alternatives for care while maintaining quality (Drummond, 2012; Ministry of Health and Long-Term Care, 2010,). Alternatives may be realised through expanded scopes of practice for allied healthcare practitioners (Government of Ontario, 2012). This study seeks improvements to the current system of reproductive healthcare for women in Northern Ontario. This exploration into the perceptions of cervical cancer screening is motivated by a concern that women's voices have not been adequately considered when planning service delivery, especially women from northern environments. Knowledge gained from this study can guide improvements to the current delivery model to align with women's preferences while supporting public health initiatives to encourage cervical cancer screening compliance. Early diagnosis and treatment of cervical cancer can reduce the morbidity and mortality of this reproductive cancer. This study provides a firm foundation for improving the current cervical cancer screening system by acknowledging the consumer of care as the unit of analysis, thus involving women in service design to inform future health policy.

## **5.2 Methods**

This paper represents one component of a larger mixed-methods study, examining women's perceptions of their reproductive healthcare in Northern Ontario. This larger study employed a mixed-method design and included an online survey followed by personal interviews with a subset of survey participants, as presented in the qualitative portion of this study, available separately (see Chapter 6). This larger inquiry also analysed women's perceptions of quality concerning their reproductive healthcare, and these results can be found in a separate publication

(see Chapter 4). This paper focuses on the portion of the survey data that addressed only the cervical cancer screening aspect of reproductive healthcare.

### ***5.2.1 Data Collection Tool***

The tool adapted for this investigation was a survey consisting of demographic questions, scales to indicate satisfaction with general and reproductive health services, and additional questions to create a clearer picture of participant's experiences (Appendices C and D). By collecting additional information such as ethnicity and culture, education, geographic location, and annual family income, statistical analysis could make explicit any significant relationships between cervical cancer screening and these demographic variables. Additional questions designed specifically for this portion of the study were intended to collect information about the participant's preferences for a female provider for cervical cancer screening, frequency of screening, location of most recent care, location preferences for future care, whether one has a family doctor, and familiarity with midwifery care. The survey was administered online on a secure RedCap platform.

### ***5.2.2 Study Recruitment and Sample Size***

Eligible survey participants included anyone who self-identified as female, was 18 years or older, and resided in Northern Ontario at the study time. For this study, the words "woman/women" refer anatomically and physiologically to participants with female reproductive organs and corresponding hormonal and endocrine systems, recognizing that their gender identity may differ from their anatomical, physiological, and genetic assignment (Health Canada, 2003). Information packages were distributed to local health centres, public health offices, women's shelters, fitness centres, and parenting support drop-in centres in 24 of the largest towns or cities in Northern Ontario. The two hundred information packages consisted of internet access

instructions, guiding participants to a website developed for this study, ([reproductivehealthcare.ca](http://reproductivehealthcare.ca)). The website address was provided during two CBC radio interviews in Sudbury, Thunder Bay, and a newsletter sent out by the Ontario Women's Health Network. Recruitment materials can be found in Appendix J. The sample size calculation was based on a population estimate of 300,535 women over 18 years, residing in Northern Ontario (Statistics Canada, 2012). 150 – 384 completed surveys would maintain 95% statistical power (Creative Research Systems, 2012).

### ***5.2.3 Analysis***

This paper focused on the extent to which residency, language, income, education, general practitioner (GP), acknowledged cervical cancer screening enablers and barriers, preference for female providers, and experience with midwives (i.e., former, current, or never a client), affect one's preferences for a midwife as a provider of cervical cancer screening, termed the independent variables. Descriptive statistical analysis provided an overview of the study population. Pearson's chi-squared tests demonstrated how closely the survey participants matched the population of Northern Ontario for residency, language, education, and having a family doctor. Descriptive statistics were calculated for all questions associated with cervical cancer screening rates, reasons for adherence or lack of, and current and preferred locations of screening. Chi-squared tests for independence looked for significant associations between the independent variables and cervical cancer screening frequency. Chi-squared tests for independence determined whether there was a significant relationship between "women who want a midwife for cervical cancer screening" and the variables of residency, language, education, income, and having a family physician. Logistic regression analysis examined the

factors associated with the dependent variable of preferring a midwife as the provider of cervical cancer screening.

Two logistic regressions were calculated for the same dependent variable, independent variables, and model structures. The first included all women in the sample, and the second focused only on those who have never been cared for by midwives. It is essential to examine this group independently to determine if cervical cancer screening by midwives is favoured outside of persons who have experience with midwives. If the expansion of a provider's scope of practice improves care access for the population, the provider must first be an acceptable alternative for a broad spectrum of the population rather than just a selective group. Backward stepwise conditional entry was used in each model, whereby entry/exit criteria were  $F \geq 0.05$  for entry and  $F \leq 0.1$  for removal. Because family income was divided into three categories, a reference category had to be determined and the other two categories were 'dummy coded' for statistical robustness. The education category was collapsed into the two categories of 'no post-secondary' and 'attended post-secondary'. Odds ratios (ORs) and 95% confidence intervals (CIs) were calculated for all significant predictors. All analyses were completed using IBM SPSS Standard Statistics 26.0.

#### ***5.2.4 Ethics Approval***

Ethics approval was obtained from the Laurentian University Ethics Board in May 2014 (REB File No. 2014-01-09) (See Appendix D).

### **5.3 Results**

A total of 191 Northern Ontario women responded to the online survey. Ten respondents were excluded due to non-northern postal codes, while eight respondents were excluded due to insufficient responses (less than 10% of questions answered) resulting in a final sample size of

173 which was sufficient to maintain 95% power. A comparison of the demographic information of the survey participants and the population in Northern Ontario revealed that more survey respondents identified as francophone, were significantly more educated, and fewer survey participants had a family doctor. The proportion of urban to rural residents was comparable between the survey participants and the population of Northern Ontario (Statistics Canada, 2012).

Results specific to cervical cancer screening are found below in Table 13. Just over 1/3 of respondents indicated that it was not important if a female performed their cervical screening (35.3%), leaving nearly 2/3 responding yes to preferring females (46.2%) or maybe (18.5%). Among survey respondents, 87.2% indicated that their last pap test was within three years. When asked the reason for compliance with guidelines, 67.6% responded that they follow the recommendations because they like their caregiver, 12.0% were encouraged by the clinic's convenient hours, and 8.0% recognized that it is essential for their health. The remaining responses fell into the "other" category, with no short answers provided. The primary reasons for not following the suggested frequency for cervical cancer screening were too embarrassed or modest (25.0%) or not believing it is necessary (20.0%). Other reasons for non-compliance included as survey choices were "having no caregiver", "being too uncomfortable", and not wanting bad news (15.0%). The remaining 40.0 % of responses fell into the "other" category, with no short answers provided. Most respondents have never been cared for by a midwife (65.1%), while 34.9% are current or former clients of midwives.

Most women access Pap screening at their doctor's office (61.5%), with the nurse practitioner clinic indicated as second most common (12.4%), followed by midwifery clinics

(6.5%), community health centre (5.3%), public health office (4.1%), sexual health centre (3.0%), walk-in clinic (2.4%), and other (4.7%).

Women indicated where they would most prefer to access cervical cancer screening. Most still preferred their physician's office (42.9%), although this number is significantly smaller than the percentage of women currently receiving screening at their doctor's office (61.5%). The preference for screening by a nurse practitioner (NP) remained nearly unchanged from the proportion accessing screening from NPs (12.4% to 13.1%). The largest increases were for midwifery clinics, as 29.8% of respondents indicated that they would prefer to access screening from a midwife. The remaining locations chosen were sexual health centres (7.1%), community health centre (3.0%), walk-in clinics (2.4%), public health offices (1.2%), and one person stating a preference for a gynecologist's office. A Chi-square test for independence indicated a significant association between preferring a midwife for screening and rural residence [ $\chi^2 = 5.148$ ,  $p=0.023$ ]. However, it was not significantly associated with language, education, income, whether one has a family doctor, and whether one prefers females for reproductive healthcare. Chi-square tests revealed no significant difference between adherence to recommended screening intervals between rural women and urban women.

Table 13: Survey Questions with Responses

Survey Question	N	Responses to Categories (%)				
Is it important to you to have a female perform your gynecological exams (e.g. Pap testing)?	173	<b>Yes</b>		<b>No</b>		<b>Maybe</b>
		80 (46.2%)		61 (35.3%)		32 (18.5%)
When was the last time you had a Pap test? (Check mark the most accurate response.)	172	<b>Never</b>	<b>&lt; 1 year</b>	<b>1-3 years</b>	<b>3-5 years</b>	<b>&gt; 5 years</b>
		4 (2.3%)	61 (35.5%)	89 (51.7%)	13 (7.6 %)	5 (2.9 %)
If you have had a Pap test within the last 3 years, you	150	<b>Convenient hours</b>	<b>Important for my health</b>	<b>Provider offered</b>	<b>I like my provider</b>	<b>Other</b>

Survey Question	N	Responses to Categories (%)							
are following recommended screening guidelines. How have you been encouraged to have your pap?  Note: The following options received zero (0) responses: female provider; convenient location; & 'I was worried about something'.		18 (12.0%)	12 (8.0%)	2 (1.3%)	100 (66.7 %)	18 (12.0%)			
If you have not had a Pap test in the last 3 years, why not?  Note: The following options received zero (0) responses: Hours do not suit work/life & I did not know that I needed one.	20	<b>Embarrassed and/or modest</b>		I do not believe that it is necessary	No provider, uncomfortable, do not know what this is & do not want bad news		Other		
What is your experience with midwives? (Choose one only)	172	<b>Former client of a midwife</b>				<b>Current client of a midwife</b>		<b>Never cared for by midwives</b>	
		46 (26.7%)				14 (8.2%)		112 (65.1%)	
Where did your most recent Pap Screening take place? (Choose one only)	169	<b>Doctor Office</b>	<b>Walk-In Clinic</b>	<b>NP Clinic</b>	<b>CCHC</b>	<b>Sexual Health Centre</b>	<b>Public Health Office</b>	<b>Midwifery Clinic</b>	<b>Other</b>
		104 (61.5%)	4 (2.4%)	21 (12.4%)	9 (5.3%)	5 (3.0%)	7 (4.1%)	11 (6.5%)	8 (4.7%)
Where would you like your next Pap Screening to take place? (Choose one only)	168	<b>Doctor Office</b>	<b>Walk-In Clinic</b>	<b>NP Clinic</b>	<b>CCHC</b>	<b>Sexual Health Centre</b>	<b>Public Health Office</b>	<b>Midwifery Clinic</b>	<b>Other</b>
		72 (42.9 %)	4 (2.4%)	22 (13.1 %)	5 (3.0 %)	12 (7.1%)	2 (1.2%)	50 (29.8 %)	1 (0.6%)

A backward stepwise logistical regression determined the effects of residency, language, education, income, having a family doctor, and preference for females for cervical cancer screening (six independent categorical variables) on all respondents' preference for midwives as screening providers. The model was statistically significant, [ $F = 19.347$ ,  $p=0.004$ ]. The final model explained 10.9% (Cox and Snell R Square) and 15.5% (Nagelkerke R Square) of the variance in preferring midwives for cervical screening. As shown in Table 14-Model 1, rurality,

and not having a family doctor were statistically significant in the model with odds ratios of 2.352 and 0.327 (or inversely, 3.058). Thus, respondents who live rurally were over twice as likely to prefer a midwife for cervical cancer screening. Those without family doctors were more than three times as likely to choose a midwife for cervical cancer screening, controlling for all other factors in the model.

Table 14: Logistic Regressions of Factors Influencing Preference for Midwife as Provider of Cervical Cancer Screening in all Respondents\*

Model	Dependent Variables	Independent Variables Remaining in Final Step of Model	Odds Ratio (OR)	95% Confidence Interval (CI)	p-Value
Model 1	Preferring Midwife – All Respondents(N=173)	Residency – Rural	2.352	1.413 – 3.917	0.001
		Family Doctor	0.327	0.127 – 0.842	0.021
Model 2	Preferring Midwife – Only Respondents who were Never a midwifery client (N=112)	Residency – Rural	3.354	1.176 – 9.566	0.024
		Family Income: \$50,000 - \$100,000 (ref.)	---	---	---
		<\$50,000 (low)	4.536	1.051 – 19.569	0.043
		>\$100,000 (high)	2.374	0.471 – 11.975	0.295

\* Independent Variables – **residency** (rural/urban); **language** (Francophone/Anglophone); **education** (Post-secondary yes/no); **income** [\$50,000 - \$100,000 (ref.), <\$50,000 (low), >\$100,000 (high)]; **family doctor** (yes/ no), **Female provider** (yes/no)

A second stepwise backward logistic regression was repeated, focusing on women who have never been cared for by midwives but indicated a preference for midwives for cervical cancer screening (Model 2). The same six independent categorical variables were contained in the model. For family income, the range of \$50,000 - \$100,000 was used as the reference range, chosen because the most respondents fell into this category. The second model was statistically significant [ $F = 17.090$ ,  $p=0.009$ ] and explained between 10.9% (Cox and Snell R Square) and 19.6% (Nagelkerke R Square) of the variance in preferring midwives for cervical cancer

screening in this sub-group. As shown in Table 14-Model 2, there were two significant independent variables in the model and they are rurality and family income. Low family income (<\$50,000) had an odds ratio of 4.536, indicating that people with lower incomes are more than four times more likely to choose a midwife for cervical screening. Rural residency had an odds ratio of 3.354, indicating that women who reside rurally are more than three times more likely to choose a midwife for cervical screening.

## **5.4 Discussion**

This investigation is part of a larger study to determine how women in Northern Ontario perceive their reproductive healthcare. Before now, we knew very little about the perceptions of women regarding their cervical cancer screening access and preferences in Northern Ontario. Although the survey participants were more likely to be Francophone and more educated than the population of Northern Ontario, some generalisations are offered cautiously. The current provincial cervical screening guidelines recommend screening every three years, after the age of 21, or once sexually active (Cancer Care Ontario, 2020). The provincial rate for cervical screening is 64.9%, which is well below the provincial target of 85% (Cancer Care Ontario, 2020). Rates for adherence to recommended cervical screening intervals appear higher than the provincial average (87.2% vs. 64.9%). Factors that appear to be associated with improved screening rates include liking one's reproductive healthcare provider, convenient hours, recognised importance, and being offered. Most respondents who were non-adherent did not provide a reason, but one quarter did note that embarrassment and modesty were involved and 20% stated that they did not think it was necessary. Some did not know what this was, did not have a provider, or were avoiding bad news. These findings agree with older studies, where women feel deterred from undergoing cervical cancer screening due to the lack of availability of

a provider, lack of awareness of test indications or benefits, fear of embarrassment, or consider themselves to not be at risk (Cooper, 2011). Because two thirds of the participants in this study were adherent to recommended screening guidelines because they liked their provider, offering more choice in providers could allow for this finding to be more common.

In my study, it was important to ask participants about where they are currently obtaining screening and where they would prefer to access screening because cervical cancer screening effectiveness may be related to the place and provider (Rodriguez-Gomez et al., 2020). Most survey participants' access cervical cancer screening at their physician's office (61.5%) but far fewer (42.9 %) state this as their first choice. Notably, while only 6.5% of respondents currently access cervical cancer screening at a midwife's office, nearly a third of them (29.8 %) would choose a midwife if available. In my study, preferring a midwife for cervical cancer screening is more likely among rural people, earning lower incomes, with no family physician. As previously outlined above, living rurally may compromise access to care, particularly access to francophone providers, and fewer people residing in rural and northern environments have a family physician (Mattison & Lavis, 2016). Non-physician providers, which would include midwives, available to provide screening for rural women and those without family doctors, may improve cancer screening participation among underserved communities and ethnic minorities (Bellhouse, McWilliams, Firth, Yorke, & French, 2018; Roland et al., 2017;). Having a choice of midwifery care may increase adherence to recommended screening intervals among these often difficult to reach populations.

This study found that lower-income women and women residing rurally, who have never been cared for by a midwife, were more likely than women with higher incomes or urban women to prefer a midwife for their cervical cancer screening. Cancer Care Ontario (CCO, 2020) reports

that cervical screening rates are lowest for women living in the lowest income neighbourhoods and rise steadily as income increases and that cervical cancer is more common among women living in low-income neighbourhoods. In 2009–2011, only 58% of women ages 20 to 69 living in the lowest income neighbourhoods were screened for cervical cancer, compared to 70% of women living in the highest income neighbourhoods (CCO, 2020). Women with low income and less education, who are older, speak a foreign language, or not Canadian-born, are less likely to be screened for cervical cancer (CCO, 2020). Possible explanations include lack of knowledge of cervical cancer screening, lack of time, language barriers, and cultural factors (CCO, 2020). These findings may also indicate biases among support staff and care providers against lower-earning people, leading to lower ratings. Studies from the U.S. have found that those in the lowest income brackets often reported discrimination in healthcare (LaVeist, Rolley, & Diala, 2003, Hausmann, Jeong, Bost, & Ibrahim, 2008). A systematic review by Spadea and colleagues (2010) of interventions to improve cervical and breast cancer screening among lower socioeconomic groups found that personal beliefs, fears and attitudes, and poor communication between patients and physicians hindered attendance to screening (Spadea et al., 2010). In their systematic review of implicit bias among healthcare professionals, FitzGerald, and Hurst (2017) found that physicians and nurses shared the same bias levels as the wider population. These biases influenced diagnosis and treatment decisions, with persons of low socioeconomic status (SES) particularly vulnerable to receiving less thorough care. Low SES patients in the US were more likely than high SES patients to have a sexually transmitted infection or an unintended pregnancy as well as to be less knowledgeable in general, due to lower rates of regular care providers (Dehlendorf et al., 2010). As midwives would appear to be an agreeable option for low-income women, adding midwives to the list of providers available to care for this under-

screened population may represent an important step towards health equity. These findings highlight the need for all healthcare professionals to address their own biases and pledge to contribute to alleviating systemic disparities.

Participants showed a clear preference for females for cervical cancer screening. Socially constructed norms around modesty and privacy may contribute to the discomfort and embarrassment experienced by some women when samples are collected by a male practitioner (Majid et al., 2019). Rurality may exacerbate these feelings, as there may be fewer opportunities to receive care from a female practitioner (Majid et al., 2019). A narrative review of 54 English-language articles found using combinations of search terms related to immigrant, refugee, or Muslim women, reported that a preference for female providers may be higher among these women and although many report that they will accept a male provider, psychological stress, delays, or avoidance may result (Aubrey, Chari, Mitchell, & Mumtaz, 2017). Because many women originate from religious-cultural environments in which seclusion and separation of genders is the norm, it is likely that this informed the preference for female providers (Aubrey et al., 2017). In the long-term, the availability of female family physicians should improve as the total number of family physicians has increased by 21% between 2010 and 2014 (Mattison & Lavis, 2016), and 56% of first year medical students in 2017/18 were female (Association of Faculties of Medicine of Canada, 2018). Despite increases in numbers of female family physicians, increased access to non-physician providers from typically female health cadres could improve access to acceptable care by increasing the reproductive health human resources. The preference for a female care provider for reproductive healthcare, particularly cervical cancer screening, by many women is clear. However, other enabling factors, including providing a safe and welcoming space, should also be appreciated.

Situationally, midwives could expand their scope of practice, with little additional training required. The healthcare system is ripe for innovation, other practitioners, for example, nurse practitioners, have been successful at breaking similar new ground, and although there is bound to resistance from some physicians and their associations, all members of the Ontario healthcare system recognize that the status quo is unsustainable and concessions will be required (Mattison & Lavis, 2016). Midwives can ensure that the principles of woman-centred care and informed choice equate to quality within the system. If the current reproductive health workforce is not aligning with the needs of the population in Northern Ontario, changes are required. It is hoped that this study can help to inform those changes.

#### ***5.4.1 Study Limitations and Implications for Future Research***

Future inquiries of a similar nature would benefit from considering reflections on the shortcomings of this study design. The survey asked participants to indicate where they currently receive reproductive healthcare and where they would prefer to access this care. The interviews resulted in an awareness that people may choose care at their physician's office but may receive cervical cancer screening from a nurse or nurse practitioner within the physician's office. It would have been clearer to ask about current and preferred healthcare providers rather than locations. Participant's ages were not collected but should be in the future. This additional independent variable would have allowed examination for differences between younger and older women as they may have different experiences with screening and varying health priorities. Disparities about perceptions of care may exist among differently abled women or LGBTQ women, but this demographic information was not collected. Transgender men and non-binary people assigned female at birth (TMNB) who have a cervix are recommended to undertake cervical screening with the same frequency as cisgender women, but evidence suggests that

TMNB have lower odds of lifetime and up-to-date cervical screening uptake (Berner et al., 2021). Upon reflection, this study would have benefitted from including this breakdown within the analysis. The findings may not be transferable to other settings. The sample had more Francophone respondents than the general population, and the respondents were more educated than those in Northern Ontario. Despite these limitations, the conclusions from my study can be cautiously applied to the population accessing reproductive healthcare in Northern Ontario.

With an intended cervical cancer screening rate of 85%, Cancer Care Ontario may be interested in further research into the barriers and enablers to vulnerable populations accessing recommended care. Rural women with low incomes and without family physicians prefer midwifery care. Following expanding the scope for midwives and targeted outreach, a repeat examination confined to these groups could be considered. Future research should include studies of men and persons who identify as non-binary and their experiences accessing reproductive healthcare, as this field is under-informed and neglected.

## 5.5 Conclusion

This study investigated the perspectives of women in Northern Ontario about their cervical cancer screening experiences and preferences. Most participant's access screening at their physician's office, and nearly 2/3 of these respondents prefer this arrangement. Alternatively, many women in Northern Ontario want the option of accessing cervical cancer screening at a midwifery office, and this number is nearly five times the number currently being served by midwives. Because adherence depends on 'liking one's provider,' expanding midwives' scope to offer cervical cancer screening beyond pregnancy and postpartum should be considered, particularly for women with low household incomes and women living rurally without a family

physician. Many participants favour female providers of reproductive healthcare as this gender concordance is reported to reduce embarrassment. Midwives are largely female, as there is only one male out of more than 1000 midwives currently practicing in Ontario. This study contributes to filling a significant knowledge gap about reproductive healthcare among rural, remote, and northern women in Ontario. Future healthcare human resource considerations need to move beyond physicians and include non-physician providers in the health system and across sectors. The reproductive healthcare sector would benefit from midwives playing a more considerable role in providing reproductive healthcare.

# **CHAPTER 6: WOMEN'S PERCEPTIONS ABOUT REPRODUCTIVE HEALTHCARE SERVICES IN NORTHERN ONTARIO: A QUALITATIVE DESCRIPTION**

L. Morgan, J.L., Johnson, E. Wenghofer, and S. Larocque

## **Abstract**

**Purpose:** With a goal to improve service provision, this study examined the perceptions of women in Northern Ontario concerning their reproductive healthcare services.

**Methods:** A multimodal recruitment strategy and maximum variation sampling were applied to speak with a diverse group of interviewees. Nineteen participants agreed to a semi-structured interview. The approach draws on qualitative description (QD) tenets while incorporating constructivist grounded theory (CGT) data analysis techniques.

**Results:** This study helps us to understand the importance of the care environment, which encompasses the challenges resulting from the northern geography and limitations in the choice of providers and concerns about confidentiality. The relationship with the provider is enhanced through effective communication, which includes time for an exchange of information to grow familiarity, as required for person-centred care. Participants shared some characteristics of satisfactory care, including care provision that is non-judgemental and empathetic and includes time for education. This study reports a preference for female reproductive healthcare providers by most interviewees, mostly expressed as a more comfortable care arrangement. Finally, interviewees conveyed the importance of welcoming and flexible administrative practices and

staff. All interviewees had a family doctor, but many had their reproductive healthcare provided by non-physician healthcare providers, including midwives, nurses, and nurse practitioners, within and outside of their family physician's office. Respondents felt that nurses, nurse practitioners, and midwives excelled at providing quality care and would favour increased access. This investigation identified five conceptual constructs, including: gender, the characteristics of good care, the relationship with the provider, the care environment, and administrative practices.

**Conclusions:** Changes driven by strong health policy will be required to engage women more fully in recommended reproductive healthcare. Governments should consider expanding the scope of practice of nurses, nurse practitioners, and midwives towards providing comprehensive reproductive healthcare. Although northern geography will always present challenges that may not be subject to amelioration, other factors preventing women from accessing care are more amenable to change. The healthcare system is meant to provide reproductive healthcare to all, free from discrimination based on religion, gender, ethnicity, or residency. As argued here, there is an obligation on the part of government to provide equitable access for all Canadians to healthcare services.

**Key Words:** reproductive healthcare, patient-centred care, relational care, scopes of practice, access, acceptability of care, health equity.

## **6.1 Introduction**

This study examined perceptions of reproductive healthcare in Northern Ontario to look for avoidable or remedial differences among female adult residents concerning equitable access to reproductive health services. Future health policy, intended to guide the provision of reproductive healthcare, would benefit from understanding this complex environment accurately to ensure that the design, implementation, and translation of research is effective (Wakerman, Bourke, Humphreys, & Taylor, 2017). Equitable health outcomes are defined by the World Health Organization and exclude avoidable or remediable differences among groups of people, whether defined socially, economically, demographically or geographically (WHO, 2016). In Northern Ontario, the interplay of geography and demographics has led to poorer health outcomes for residents (Ministry of Health and Long-Term care - MOHLTC, 2010). Some issues include lowered life expectancy; increases in most chronic health conditions (circulatory diseases, cancers, diabetes); an exponentially higher First Nations population with all of the accompanying health disparities; a higher proportion of seniors within the population with an increased complexity due to comorbidities; limited access to home care; and higher rates of mental health and addiction disorders (North East Local Health Integration Network [NELHIN], 2011, Whaley, 2020). Cognisant of the effects of northern residency on health outcomes, investigations into how residing in Northern Ontario affects one's perceptions of reproductive healthcare quality can add to the body of knowledge available on this subject.

### ***6.1.1 Reproductive Healthcare Barriers in Northern Ontario***

According to the World Health Organization (WHO), the definition of a health system is a collection of activities whose primary purpose is to promote, restore, or maintain health (World Health Organization [WHO], 2000). The goal of a health system is the delivery of effective,

preventative, and curative health services to the entire population equitably and efficiently (WHO, 2000). The communitarian underpinnings of health systems were captured by the United Nations (UN) Committee on Economic, Social and Cultural Rights, which noted that governments are obligated to ensure availability, accessibility, acceptability, and quality of health services (Committee on Economic, Social and Cultural Rights, 2000). The five core reproductive health services include maternity care which includes antenatal, intrapartum, and postpartum care; family planning including infertility services; abortion services; care for sexually transmitted infections and reproductive cancers; and the promotion of sexual health (WHO, 2002). These elements form an essential component of our current health system, as the activities promote, restore, and maintain reproductive health.

For this study, the words "woman/women" will refer to sex, as opposed to gender, recognizing that a participant's gender identity may differ from their anatomical, physiological, and genetic assignment (Health Canada, 2003). Eligible participants included any persons with female reproductive organs. When examining women's reproductive healthcare, 'women/woman' will refer anatomically and physiologically to participants with reproductive organs and corresponding hormonal and endocrine systems associated with being female (Health Canada, 2003). The terms 'patient', 'client,' 'recipient of healthcare services', 'people/person', and 'women' are used interchangeably. All these terms refer to the participants in this study. Although the term 'patient' is least favourable, this is the term historically used in healthcare for the person who accesses health services. Because I come from a midwifery background, I shy away from the term 'patient', as I care for healthy, pregnant clients/people. Because they are not ill, I do not consider them "patients."

Historically, women's health focused on reproductive issues, defined by childbearing, menstruation, and menopause (Cohen, 1998). Reproductive healthcare became a structure within a health system, which means it is a socially constructed care framework. This socially constructed program of care stands accused of authoritarianism and fragmentation (Van Wagner, 2004). The effectiveness of this constructed program needs to be measured and understood with respect to the health consumer's perceptions about their own agency, defined as a person's socially mediated capacity to act (Einspahr, 2010). Individual agent's equitable access to health services will be constrained or enabled differently depending on their placement within society (Einspahr, 2010). The conditions under which people seek care, or their 'placement in society', is created by the effects of the social determinants of health (SDOH) (Einspahr, 2010).

Encouraging individuals to adopt protective behaviour and reduce risky practices are critical goals of reproductive healthcare. However, for any efforts to succeed, they must be guided by an appreciation for the geographical, sociopolitical, economic, and personal factors that may be hampering access to services (Collumbien et al., 2012). A systematic review synthesized the social determinants of health (SDOH) literature in the contemporary Canadian context of population and public health (Lucyk & McLaren, 2017). It stated that health equity is a modern overarching principle, referring to a social state wherein all members of a population have access to the best available opportunities for health (Lucyk & McLaren, 2017). This is in contrast to health inequity where the socially produced results of systematic societal processes contribute to the mal distribution of resources (Lucyk & McLaren, 2017). An intersectional approach, which considers the social determinants and their overlapping and cumulative nature, is imperative when examining a complex structure, such as reproductive healthcare.

Although interest in women's health is growing, few research studies focus specifically on women's health in northern settings (Leipert, Regan, & Plunkett, 2015). It is acknowledged that rural, remote, and northern residency contributes to unequal access to healthcare due to challenging geography and climate (Health Canada, 2014). Rural Canadians have poorer health status than their urban counterparts, with lower life expectancy and higher mortality rates (Pong et al., 2009, Whaley 2020). A shortage of healthcare providers in rural communities poses a severe challenge to equitable healthcare delivery (Wilson et al., 2009, Whaley 2020). In rural and northern areas of Ontario, women have the lowest life expectancy in the province, and they experience limited access to healthcare practitioners and services (Liepert & George, 2008, Majid et al., 2019). There is a shortage of French-speaking physicians available to provide care to northern Francophone residents, representing a substantial disparity when comparing the southern to the northern regions of Ontario (Gauthier et al., 2012). The prevalence of ageist, sexist, and racist beliefs and stereotypes interferes with healthcare seeking and diagnosis and treatment recommendations in the North (Chrisler et al., 2016). These general observances about health in Northern Ontario have not investigated women's health in enough depth or reproductive healthcare more specifically to determine the impact of northern residence on reproductive health outcomes.

It is clear from both the United Nations and the World Health Organization that patient satisfaction, public participation in decision-making, and accountability should be critical aims of health systems, distinct from economic and clinical goals (Kruk & Freedman, 2008). Besides living in the north, other barriers may impact women's uptake of reproductive healthcare and have been found to include lack of knowledge, perception of low risk, feelings of embarrassment, fear of diagnosis, anxiety, expectations of pain, other health problems, limited

access to female physicians, lack of communication with one's physician, transportation problems, and lack of time (Akinlotan, Bolin, Helduser, et al., 2017). Recognizing that further research can and should be done within identity-sharing groups, interviewing women currently accessing reproductive healthcare in Northern Ontario could enlighten stakeholders on whether these same issues are barriers. This approach also encourages the consumers of reproductive healthcare to report on their experiences which may equate to public participation in healthcare reform and accountability through stakeholder involvement. To determine whether this northern environment, its people, their culture, the providers, and the social determinants of health create barriers to accessing quality reproductive care in Northern Ontario, this study explores this issue through the following research questions: How do women perceive their reproductive healthcare? How do women's perspectives of their reproductive healthcare influence their use of reproductive healthcare services? What elements of a woman's reproductive healthcare experience enable her to engage in recommended care more fully? What elements of a woman's reproductive healthcare experience disable her from obtaining the services she desires or requires? Do women view midwifery care as an acceptable alternative to current providers or options for reproductive healthcare?

## **6.2 Conceptual Model**

The Hierarchical Model of Health Service Quality (HMHSQ) serves as the conceptual model as it represents an integrated model of health service quality based on consumer perceptions (See Appendix A). The authors assert that a strong association exists between service quality and behavioural intentions, and satisfaction is the mediator in the relationship (Dagger et al., 2007). This arrangement means that both service quality and customer satisfaction are critical strategic objectives because, as constructs, they help ensure positive behavioural intentions. This

model informed the interview guide (See Appendix C). The questions attempt to elicit information about satisfaction with reproductive healthcare services under multiple categories, including administrative practices, the care environment, perceived quality of care, and interpersonal relationships.

### **6.3 Research Design**

This paper represents one component of a larger mixed-methods study, examining women's perceptions of their reproductive healthcare in Northern Ontario. This larger study employed a mixed-method design and included an online survey followed by personal interviews with a subset of survey participants, represented here. A total of 191 Northern Ontario women responded to the online survey and after exclusions, 173 surveys were analysed. The quantitative part of this inquiry examined women's ratings of the quality of their reproductive healthcare in Northern Ontario, as well as their opinions about their cervical cancer screening specifically, found in separate publications (Chapter 4 and 5). The purpose of this qualitative portion of the study is to expand on the survey findings through an exploration into the views of women who would seek to access reproductive healthcare in Northern Ontario. Nineteen women volunteered to be interviewed. Both arms of this study strengthen the conclusions of the other, providing both the depth and breadth to understand reproductive care-seeking better.

The approach draws on qualitative description (QD) (Sandelowski 2000), often used to examine healthcare and nursing-related phenomena. Qualitative description (QD) is essential and appropriate for research questions focused on discovering the who, what, and where of events or experiences and gaining insights from informants regarding a poorly understood phenomenon (Neergaard, Olesen, Andersen, & Sondergaard, 2009; Sullivan-Bolyai, Bova, & Harper, 2005). Per QD tradition, the data collection strategy involved individual interviews using a semi-

structured interview guide, employing a purposeful sampling technique called maximum variation sampling, with an intent to obtain broad insights and rich information from a diverse group of participants. The approach incorporated constructivist grounded theory (CGT) (Charmaz 2012) data analysis techniques. Combining qualitative descriptions with the constant comparative analytic approach to data analysis provided insights into possible improvements to care provision.

When examining reproductive healthcare, one must be sensitive to how this care differs from other areas in healthcare. The difference may be due to the intimate contact and conversations required for quality provision, but the paternalistic underpinnings of biomedicine and our healthcare system cannot be ignored. Historically, women's bodies were pathologised because the male body was seen as the gender-neutral norm. Medicalization is the expansion of medical jurisdiction into the realms of other previously non-medically defined problems. It stands accused of serving the interests of medicine rather than the individual's experience of health and illness (Cahill, 2001). Examples in reproductive healthcare include menstruation, family planning, sexual health, and menopause. A biomedical representation of reproductive healthcare appears to give physicians a monopoly over the therapeutic aspects. It may undermine experiential means of knowing or situated knowledge, including considering the woman's expertise (Riska, 2003). In appreciation of this history and its legacy, the following methodological considerations were incorporated into the design. All interview participants volunteered after completing the survey and were informed that an interview would involve deeper questioning into the same subject areas, notably birth control, sexual health and illness, and abortion. This warning was intended to limit any surprise in response to the nature of the questions. Survey data was not linked with interview data to ensure the anonymity of

interviewees. Community-specific trauma resources were provided to each participant if discussing this subject matter resulted in un-wellness and help was needed. The interview was at the participant's chosen location, most preferring their own homes via telephone, and all participants were provided with their transcript to review for accuracy. These steps assured safety and confidentiality and built the trust required for a candid discussion about a long taboo and challenging subject matter.

## **6.4 Study Recruitment**

Survey respondents were women residing in Northern Ontario who have female reproductive organs and were 18 years or older. Respondents obtained information about the study via information packages which provided instructions on accessing and completing the survey. There were two CBC interviews about the study with the primary researcher resulting in 35% of participants. The study was also advertised on social media and shared on personal Facebook pages which resulted in 24% of participants. Survey questions were answered online. Interviewees volunteered by providing contact information following the survey. Interview participants were recruited until data saturation was achieved.

## **6.5 Ethical Considerations**

Written materials explaining the purpose of the study and the interview, along with a consent form, were provided to participants one week in advance of the interview. The consent form was signed and returned to the interviewer before starting the interview, and verbal consent was obtained. Before starting the interview, interviewees gave verbal permission to record the interview, and interviewees were made aware that they could end the interview at any time. A unique code was assigned to each interview and pseudonyms were used for publication to protect

participants' identities. Ethics approval was obtained from the Laurentian University Ethics Board (REB File No. 2014-01-09) and the ethics certificate can be found in Appendix D.

## **6.6 Data Collection**

The study design included interviews with women of varying ages, education, income, with or without a family doctor, French or English as a first language, urban or rural residence, and a mix of women currently or previously cared for by a midwife, along with those with no prior experience with midwives. A semi-structured interview guide was created and can be found in Appendix C. Interviews were conducted at the participant's chosen location, either in-person or over the phone. Interviews lasted approximately 30 to 45 minutes. All participants were provided with their transcripts to review for accuracy. Interviews were conducted with all eligible volunteers until data saturation was reached.

## **6.7 Data Analysis**

Transcripts were compared to identify overarching categories and sub-categories. This process is called "coding up" and has no predefined categories. Codes were developed from the data set through a process of abstraction (Charmaz, 2012). The process included three levels of coding – open, axial, and selective. Open thematic coding involved identifying and categorizing data at a basic comparative level through line-by-line analysis. NVIVO software was used to organize the codes. Once core categories began to emerge and no new categories surfaced, selective coding allowed for data relevant to the emergent core categories to be identified and grouped. I attempted to examine the data from differing viewpoints using axial coding to identify similarities and differences between established codes and demographic groupings. Using selective coding, I systematically populated the index categories with descriptive data, interpretive data (underlying processes), and reflexive data or memos. Memoing was used as a

complementary analytical technique to record thoughts, insights, and ideas to interrogate the data for potential concepts to develop themes (Charmaz, 2012). Core categories were collated into potential themes and reviewed to ensure they were consistent in the coded extracts and across the entire data set. The themes were classified into conceptual constructs. These steps ensured the robustness of the results, included in the "Trustworthiness protocol" (Appendix B).

## 6.8 Results

A total of 191 Northern Ontario women responded to the online survey of which 19 agreed to participate in interviews. The interview participants closely mirrored the urban/rural divide in Northern Ontario but differed by age. Most interviewees were in their 20's and 30's (78%) compared with the population that is mostly 40 years old or older (79.7%) (Statistics Canada, 2011). They were more likely to speak French as a first language (47% vs. 8%), and most were white (85.7%) as only one Indigenous and one Black person were interviewed. Other differences include that more interviewees are engaged in graduate studies, and 100% have a family physician, compared with 82% in the general population. One-third of participants have been cared for by midwives, while 2/3 reported no experience with this care provider. These differences are inconsequential, as qualitative research does not seek a representative sample but instead aims to listen and truthfully convey the opinions and experiences of the participants.

Five conceptual constructs were developed through analysis of the dominant themes and include: gender, the care environment; the relationship with the care provider; characteristics of quality care; and the administrative practices. Gender is a crosscutting construct as it spanned all conceptual constructs. Under 'characteristics of good care,' female providers were credited with superior listening skills and a gentler approach. For 'the relationship with the provider,' female providers were repeatedly, but not exclusively, credited with providing person-centred care

(PCC). For 'the care environment,' female providers were favoured for care provision to reduce embarrassment. Under 'administrative practices, many gendered policies exist including the need to have a female present in the room for 'intimate' clinical exams. Most administrative staff are female and exist as the frontline barrier or enabler to accessing all reproductive healthcare services. Pseudonyms replaced real names in the credits following each quote. The following quotes from the interview transcripts illustrate the emerging ideas about the interface between women and their reproductive healthcare in Northern Ontario.

#### ***6.8.1 Gender***

Most interviewees reported that the gender of their reproductive healthcare provider mattered, as more than three-quarters of the women interviewed stated a preference for a female provider, believing that their personal experiences with similar care make them better able to relate.

There are certain questions about reproductive health that one might not necessarily ask a male physician, not because he might not have the knowledge, as I assume male physicians do, but because it makes more sense to talk about menstrual cycles with a woman. As an example, if I was a physician and someone was talking to me about erectile dysfunction, I might not have a reference point to say 'oh that's totally normal, like it might statistically be normal but'...I have no personal experience to draw upon. In this way, I can understand that one could be more comfortable with a female physician just because they would be able to draw on their own experiences and backgrounds. (Galen)

Some respondents attributed certain characteristics of care with the sex of their provider, accruing female providers with advantages in some areas. Participants describe female providers as more empathetic, less judgemental, and better communicators.

I feel like maybe a female would understand me more .... and also being able to communicate in an effective way – communicate like maybe a woman might in a more empathetic way. (Vera)

They also reported apparent discomfort on the part of male physicians when providing reproductive healthcare.

I have had male doctors and they didn't always seem comfortable and I felt like it was obvious – they were just trying to get it done quickly. Their comfort level didn't seem to be there. I guess it wasn't necessarily a bad experience, it was just I sort of fed off of their, you know, discomfort with the whole procedure. It felt like it was rushed - we are going to get this over with as quickly as possible, just already assuming that I was anxious and uncomfortable, even though I wasn't. (Leanne)

Women described female practitioners as more patient and personable with a 'softer touch'. They are credited with more effective communication skills such as being good listeners.

I find it more comfortable to talk to a woman. I still have a family doctor, but I use mostly the women's healthcare nurse... he could have been a little more patient and a little, maybe softer touch and just someone who talks to you about the whole situation. Just the way he went about it was too clinical and just kind of the questions he asked me made me feel very uncomfortable about it too. (Kala)

Not all respondents stated a preference for female care providers for reproductive healthcare, as several interviewees reported good exchanges with male providers.

He was just a, I don't want to say jolly fellow, but he was just like a nice guy. Just explaining; 'Oh yes indeed you did have a septated hymen. Usually we fix those surgically, but it seems it resolved itself.' He like dealt with the situation with like humour in a good way.' It was a good experience I mean, and then I got a PAP test at the same time. (Galen)

Some participants were very clear that the gender of the provider does not dictate the quality of care received.

I have had a male doctor the whole time I have lived in the north, but I also had a male doctor in Toronto, and he was, it was the personality not the sex. I know from my daughter, one of my daughters, she prefers a female practitioner just because of the whole, you know, having your hands between my legs, she is uncomfortable with the male a male physician. But I have also come in contact with female physicians that are just as disconnected from their patients. (Carys)

In summary, most of the women that I interviewed want a female provider for their reproductive healthcare, believing that they offer a higher quality of care, and that sex concordance translates into greater knowledge of female reproductive issues. Good experiences with male providers were also reported.

### ***6.8.2 The Care Environment***

Women reported feeling that the care environment, specifically the northern, rural, and remote locations where they were living and seeking care, contributed to lower quality experiences. They were making compromises with respect to their reproductive healthcare by virtue of their choice to live in a difficult setting (geography) and its concomitant shortage of skilled providers, particularly female providers, with limited choice. Compromises made by the participants included lower expectations of privacy in their encounters, with concerns equally divided between rural and urban residents.

So for public health, the first stigma is that you have to follow the green line so each clinic in our health unit has a line of colour so that you automatically, we call it the ‘itchy and scratchy’ clinic, know that green is ‘itchy and scratchy’ then you have to sit in a common waiting room and they call you into that clinic so I think that it is highly inappropriate and questions confidentiality practices. (Kira)

Some women feel that due to the small, interconnected population in Northern Ontario, privacy is not possible.

If a young girl came to me or a woman came to me and wanted a therapeutic abortion, I would be giving her the phone numbers to go to southern Ontario. I would be helping her plan to go to Toronto and not be encouraging her to do any therapeutic abortion up here. Everyone is related from Timmins to Sault Ste. Marie, you know, and so I would not at all be encouraging her up here. (Asha)

Women had the following to say about how northern geography affected their access to providers and the care that they were seeking.

It was a huge problem in this area. For 8 years I advocated to get a sexual health clinic for there's like 13 communities here, and a lot of transportation issues, a lot more unemployment, a lot lower average income. A lot of people on disability and can't get to appointments and a lot of them won't have doctors, because doctors will choose if they are going to pick people they will choose not to pick them. (Mona)

It may be harder to retain physicians in the Northern Ontario, particularly if the physician did not originate from a northern community.

They start their practice then they leave from sheer frustration or their families are not from here so they don't want to be stuck in Northern Ontario while their husband or their wife is working 15 hour shifts, so we lose them again. So the doctors that are here are the ones that are from here, have always been here, will always be here have never had to improve their practice. (Colette)

All women interviewed reported concerns about abortion access and provision in the north, and the privacy issues that accompany seeking 'controversial' care among small populations. Women report few locations and no options, as all abortions are provided in hospital, under the care of physicians. Women can be made to feel that they are doing something wrong, illegal, unreasonable, or invalid as abortion is often veiled in secrecy and referred to as 'the procedure'.

All the women that were having abortions that day were all put in a room together. All in our gowns and booties and like, next, next. ...and it wasn't even done one on one – they would call in 3 women at a time and say 'OK, you 3 are the next 3 and here you have to take this medication in the next 10 minutes. Take this now and then go back out into the waiting room. It was very clear that everybody in that room was there that day to have an abortion. (Mira)

Participants wondered about the skill level of northern providers, resulting in some women, with the financial and logistical means, to 'travel south' for access to quality care or to realise options for care.

I would choose to go south actually. I believe some of the newer OB/GYN's in Sudbury are offering unique and/or advanced skill sets, but it is not the norm. The main hindrance for getting highly trained specialists in Sudbury is simply that the volume is not here. It's unfortunate. I think the ones who offer that specialty stay

in those larger communities because they are going to hone their skills via patient volume alone. (Talia)

There are increased transportation costs resulting in financial hardship while accessing the full spectrum of reproductive health services. Financial barriers related to transportation precluded some women from obtaining needed care as they sometimes travel long distances to clinics and hospitals. Women report that travel grants are inadequate to cover the costs to obtain care outside one's home community and do not fund an accompanying person.

One of the recommendations that I was given by the Ob/Gyn that was frustrating was that if I had private funds I could go to Ottawa and other options would be available to me. We have had to send women to Sudbury but it is hard because the travel grants will not cover somebody to travel with them, and you know women that I tend to see in my practice, for them to commit to an appointment and multiple appointments and to travel is very unlikely so there is a huge barrier to care in our community....and sometimes that meant you have to go to Toronto". (Kira)

In summary, the care environment was largely expressed as difficult or deficient and encompassed the themes of northern geography, provider availability, quality and choice, and reduced expectations of confidentiality.

#### ***6.8.3 The Relationship with the Care Provider***

The relationship with the care provider emerged as central to opinions about the quality of care provided, with reference to the importance of two-way communication for relationship building and education. In contrast, many respondents described care that does not allow time for questions, and providers without the skills or interest in listening to their questions or concerns. The generous use of locums to fill gaps in coverage in the north further compromise's relationship building.

Many women reported difficulty communicating with their providers and named the lack of time available for the consultation as a barrier to good care. Women perceive that the time

allotted may not allow for questions or explanations, which made them feel rushed and resulted in frustration.

Like I would never have asked him any other questions because I probably wouldn't have gotten the chance to have opened my mouth and that's like the main reason why I don't go see him. (Marlie)

Women report wanting brochures or handouts if there is no time for education.

I was definitely bawling my eyes out at the visit. I think it was just the rushing and like, you know, not like I would have wanted her to sit and watch me cry or anything but like you know, there's a couple of questions that come up... Just a resource even, like a pamphlet or just something. But even something as simple as brochures. Like, I don't know, it would just be neat to walk out with something that, you know, I could read while waiting for the bus instead of crying. (Maya)

Many women reported turning to their peers and the internet for answers to their questions.

"Yes, I would probably speak to some friends and then I would probably Google information" (Raisa). "Need to educate yourself because providers do not" (Carys).

Patient-led communication allows healthcare providers to become aware of the issues of concern, information required, and preferences for care. Active listening could allow them to tailor their approach based on the patient's needs as they seek to create a safe space to build trust. Care providers are reminded to watch their choice of words so as not to induce more stress, fear or anxiety.

"Yeah he just sort of was really, I don't even know what the word is, but he just suggested all these awful things without any basis it seemed, which just made me worried" (Opal).

Francophone residents would like to access care from French speaking providers, which are difficult to find. Francophone community health centres have a mandate to serve the needs of Francophone residents. Meeting these needs may require provision of drop-in appointments offered in a welcoming environment.

I tried to go to a community health centre once, it's Francophone, but I walked in thinking you know maybe I could get French service provider or it was a clinic and they turned me away. So they said no, it's like a private clinic if you have doctor here it's the only way you can see one. (Maya)

Time allotted for active listening would be appreciated by patients but is not common.

Women reported feeling silenced, with no room to express their thoughts.

If I go in with questions they are answered, but the main problem I have had with our physician is that it always seems very rushed and we've had a lot of questions and concerns, both with myself and our kids that have been really quickly dismissed without any kind of investigation. (Mira)

Women appreciate that there is a shortage of providers and understand that they are in high demand but are "*not asking for long...just a couple minutes*". (Talia)

I asked for the gynecologist to stop, that I was in a lot of pain and was told to "tough it out". I appreciate that they were likely busy and needed to get the procedure done. I remember asking them to "give me a second" to breathe, began to cry, and I recall a blatant lack of sensitivity. (Talia)

The solution to a shortage of providers often requires the use of locums. Women find that locums result in fragmented care and hypothesize that locum providers may not want to prescribe or treat them, so as not to disturb the existing doctor-patient relationship.

It's usually people come up for a couple of years because they went into a medical program and they get subsidized if they will come up to our area and they stick around for 2 years and then they disappear. So even the people who do have doctors are often every 2 years getting a new doctor. Plus, being taken care of a lot of the time by locums, so they don't really establish a good relationship. That is true for me, I don't think in the 10 years I have been in this more close office, I have probably seen, the 8 or 9 times that I have gone in, probably 7 different doctors. Plus locums are hesitant to order things when they are just there for a short time. (Mona)

Continuity with one provider is favoured by all respondents because trust builds as familiarity increases. They report more confidence in their provider if they know their medical

history as well as their values. All women interviewed want continuity with one provider.

Fragmented care was reported as well as instances where the relationship with one's provider contributed to satisfactory care.

Because I've had to go to like walk in clinics here and there, and I just don't find you get the same level of care just because they don't know your background so much. Whereas I've had my family doctor for probably 10 – 15 years so she knows my history, she knows me by my name. I'm not just like another number or patient on the list, so I feel really comfortable having the same provider all the time. (Marguerite)

Respondents reported driving long distances to receive care from a known provider.

Just that we have a relationship, which is why we decided to keep our doctor in Ottawa, but just because we have that relationship we don't have to you know, meet somebody new each time, start over. (Vika)

In summary, the relationship with their provider that women are looking for develops through an exchange of information where the patient provides personal information and questions, and the known healthcare provider responds with information. This exchange requires good listening skills and a genuine interest in the people one cares for. Continuity with one provider is favoured and the use of locums can result in disjointed care. Francophone care providers are difficult to secure.

#### ***6.8.4 Characteristics of Quality Care***

All respondents were able to provide insight about what good care looks like, even if they did not report receiving such care. Good providers are friendly, empathetic, trustworthy, remember their patients, and take time to connect. Better listening skills are required as respondents are seeking care that feels personal and individualised.

Some women stated that their caregivers lack empathy and often behave in a paternalistic way, believing that they know what is best for their patients.

I didn't want to be on the pill, and the doctor had a very strong opinion about what I should or shouldn't be doing and using. Then again, it's not my body? You're telling me what I am supposed to be doing and I'll do it, was his attitude. (Carys)

Not all interviewees reported a lack of sensitivity, and it must be recognized that some providers make attempts to put the person at ease and provide an individualized approach by taking interest in the patient. Participants shared that 'good physicians' listen, are patient, don't judge and provide personalized care.

So I was a little bit scared when I went in, because it sounded like from all the reviews that she was super judgemental, ... it's the last thing I need right now. But she ended up being really nice. She actually sat down on a chair, which was nice. But yeah, so we talked a little bit and she actually answered all of my questions as well as she could I guess.... (Maya)

Women want their caregiver to be friendly and appreciate information about their care.

I went to do a colposcopy with a doctor at the hospital and I have seen her like once or twice before in the last couple of years. She remembered me, like as soon as I walked in the room she said 'hello again, how are your classes?' because she remembered what program I was in and everything, and she was like 'now you remember how this all goes' and she was always like saying 'I am sorry, you are going to feel a quick pinch and it might be a little cold here'. She was talking though the whole thing and it was really comfortable actually. (Dara)

Half of the women I interviewed reported being happy with the care provided at their family physician's office, although this did not mean that they received their reproductive healthcare from their family physician. Much of this care is being provided by nurses and nurse practitioners within physician offices. Women see these allied care providers as helping to carry the burden in a busy physician office.

They are starting to have a nurse practitioner available and I think if they could expand the nurse practitioner's role in that office there is opportunity to improve. (Kira)

Nurses, nurse practitioners and midwives were described as thorough, holistic, punctual, non-judgemental, friendly, and empathetic. They often act as the first point of contact in the clinical encounter, performing a ‘triage’ function for the physician.

I have noticed, in my experience that the nurses, in most cases, have been the most friendly. They seem to really care for you as an individual, but I’m not sure if that’s going above and beyond. They are caring and sympathetic as most health practitioners should be, in my opinion. (Raisa)

Women also reflected on whether providers are specifically trained to listen, as some cadres of providers, notably nurses, nurse practitioners and midwives appeared to the participants as being much better at communication, education and displaying empathy.

I always feel good like I’ve had all my questions answered, I don’t feel like I’ve been brushed off. I would almost compare her to the same level of care I got from my midwives where she doesn’t rush through the appointments or anything. (Marguerite)

In summary, good care was described by many interviewees and consisted of personalized care where friendly providers listen to concerns empathetically and without judgement and provide information and education. Some respondents felt that this style of care provision was innately tied to female sex or to the cadre of healthcare provider, such as nurses, nurse practitioners, and midwives.

#### ***6.8.5 Administrative Practices and Policies***

The environment within the clinic is largely dictated by the practices of the administrative staff and the policies that guide the delivery of care. Staff are the frontline of patient care and are a largely female workforce. The women I interviewed shared their frustrations as well as suggestions for improvements to the administrative practices.

Women report difficulties trying to book appointments and their perceptions that they are inconveniencing the staff.

She takes calls for 3 days a week for 2 hours a day. Women want to be able to book appointments easily and be seen roughly on time... and being open to listening to what the patient needs. She remembered me for the next times and was really rude, but now I think that she forgot who I am and is nice again. (Maya)

Only older women reported that the administrative staff are polite, helpful, and kind. All other age groups described staff that were rude, overworked, 'scary on the phone', not friendly, difficult to reach, and stressed. Perhaps staff are more respectful towards older patients or maybe increased age leads to modified perceptions or expectations of these encounters.

The administrative staff are not friendly when I call or visit. They want to know why I want to see the doctor so they can decide how urgent I need to get in. It is like triage but it is none of their business what I am coming in for. (Kira)

Women also shared concerns that the staff compromise their privacy. Administrative triage requires that women disclose their health concerns to staff.

It was always like that embarrassing moment when you are at the counter and they are like, what are you here for? Well I have a (?) bumps on my labia. You wouldn't necessarily want to say it out loud, especially in a waiting room, ....if it was just a place where it was only reproductive health, it would almost feel better like being at the counter and saying, just saying that like I try really hard not to be embarrassed.... (Maya)

Although the appropriate handling of confidential information by administrative staff in sparsely populated northern locations has been reported to be in need of improvement, many respondents acknowledge that these hard-working members of the team deserve some credit.

But generally I trust everyone that works in that organization so my physician trusts those administrators and would trust the administrator as well to keep that stuff confidential and not to be talking about it (Vera)

Women attribute some of the unwelcoming behaviour by administrative staff on overwork and are empathetic to the stresses of working in healthcare.

I had to stand at the counter and wait to be acknowledged for a couple of minutes. They hardly ever answer the phones because there's just too many clients, like way too many. I think they are just honestly overworked – they have so much to deal with. (Galen)

Respondents appreciate a welcoming environment and acknowledge the good job done in some offices.

To be honest, I feel that the receptionist at my family doctor does go above and beyond as far as being welcoming and friendly and just creating a nice environment in the office. She really just knows everybody by name and is chatty and I just feel like it's more pleasant because of her. (Opal)

As an administrative policy, many physicians employ nurses or nurse practitioners within their office, and many women reported accessing these providers, as they are most likely to perform recommended cervical cancer screening and offer education.

It's generally been the nurse practitioner – some of the questions I have had before have initially been answered by the nurse practitioner and then the doctors come in for a quick 2-3 minutes. (Mira)

Male physicians often enact a policy that a female employee must be present for physical exams. Although intended for the comfort and security of the patient, women report that this arrangement may make them feel more uncomfortable.

The last 2 times I have gone for a PAP I have actually gone to the health unit locally and it was good. It was friendly, the last time I went to my family doctor for a PAP, it has gotta be 4 years ago, and it was awkward. There is a rule that there has to be a female employee in the room, but it's a strange energy in there. I feel like I am the part of a job where they are going to take the garbage out. Do we have to do it? OK I'm just going to go to a clinic. (Carys)

In summary, it can be difficult to book appointments due to limited staff and hours. Staff can be rude, but it is acknowledged that they are overworked. Some administrative policies may encourage participation in recommended reproductive care by making nurses and NPs available.

Access to this largely female workforce may overcome the need for a ‘witness’ in the clinic room.

#### ***6.8.6 Results Summary***

Women’s descriptions/perceptions of their encounters accessing reproductive healthcare influenced their intentions to return for care, avoid care, or to choose alternate locations or arrangements to meet their needs. The elements of a woman’s reproductive healthcare experience that enable her to engage in recommended care includes a respectful relationship more fully with an acceptable provider, in a caring environment that values person-centred care and includes supportive administrative practices and staff. The appointment length needs to allow for time for active listening by the provider. Internet access helps women when limited information is provided by their caregivers and they need to turn to peers and websites to answer their questions. Physicians may view the patient’s use of the internet as a threat to their clinical autonomy or a resource to promote a care partnership (Hardey, 1999). Women prefer to be treated in a friendly manner by a caregiver who is a knowledgeable communicator and able to see the entire person. They expressed that women providers are naturally more gentle, better communicators, more empathetic, and less judgmental. They would like to grow a relationship with their primary healthcare provider and feel that continuity of care is vital to trust-building and confidence in provider skills.

What elements of a woman’s reproductive healthcare experience disable her from obtaining the services she desires or requires? Women realize that physicians are in high demand, resulting in time constraints, but this rushed care leaves women questioning the quality of the care they are receiving. Rushed care conducted without empathy can lead to unnecessarily painful experiences for women. Women feel silenced within their encounters, reporting that there

is no time to ask questions. Most of the women report feeling too embarrassed or uncomfortable to present for reproductive healthcare provided by a male clinician. They feel modest and report perceiving discomfort among the male providers tasked to provide reproductive healthcare. Administrative staff are perceived as "stressed to the max," rude, scary, and can cause women to forego seeking care. Women notice friendly and welcoming administrative staff, which likely makes presenting for care easier. There is little expectation of privacy in their care encounters, motivating women with adequate resources to seek care 'in the south.' Other compromises that seem inevitable due to their northern residency include a dearth of female providers, such as midwives, limited access to abortion, regular use of locums with compromised continuity of care, perceived lower quality due to limited exposure or practice, inconvenience, and limited choice.

In response to whether midwifery care is an acceptable alternative to current providers or options for reproductive healthcare, women were overwhelmingly in favour. Women would like more choices about where they access care. Midwives are perceived by women to be good communicators, experts in reproductive care, and dedicated to women's healthcare needs.

## **6.9 Discussion**

This investigation identified five conceptual constructs. Gender is one construct and is important as it is not only relevant to the sex of the healthcare provider, but also applies to the identity of the participants, the 'gendered' nature of reproductive healthcare, the gender of most administrative staff, and its perceived effects on the quality of care. The other four constructs include: the characteristics of good care, the relationship with the provider, the care environment, and administrative practices. The gender construct is related to the other four constructs in the following ways. Many interviewees stated a preference for a female reproductive healthcare

provider. Under 'characteristics of good care,' female providers were favoured for modesty reasons and assumed relatability for concordant reproductive organs. For 'the relationship with the provider,' female providers were repeatedly, but not exclusively, credited with providing person-centred care. Females were better communicators with good listening skills. For 'the care environment,' the female-dominated fields of nursing and midwifery were favoured for care provision. Concerning administrative practices, most staff are female, and many policies address gender specifically, such as requiring a female in the room when conducting intimate exams.

Similar factors influence reproductive healthcare consumers globally and include recognising the importance of a welcoming environment, good communication and relational care. An Australian study employed the constant comparative approach to analyse qualitative data from a larger survey about women's perceptions of care through pregnancy and postpartum (McKinnon, Prosser, & Miller, 2014). Four main themes emerged: quality of care, access to choices and involvement in decision-making; unmet information needs; and the care environment. Concerns regarding the quality of care included a lack of interpersonal skills, limiting two-way information sharing. Like the findings from my study, some women expressed satisfaction and gratitude for the excellent care they received, while others expressed extreme disappointment. Women reported feeling pressured, judged, and discriminated against by medical personnel and administrative staff. The Australian respondents blame the rushed and compromised care on inadequate human resources. Their care experiences were enhanced through continuity with the same provider, but assertiveness was required to obtain their preferences. They reported unmet information needs, particularly among women living rurally and remotely (McKinnon et al., 2014). As these concerns are in concordance with the findings

from the current study, they provide more evidence for the universality of barriers and enablers to quality reproductive healthcare.

Interviewees favoured repeated care encounters with a known provider over a prolonged period, termed continuity of care. The literature clarifies that patients would like to have their physical and emotional needs met by receiving individualized care from providers who respect and know about their health beliefs and involve family and friends, if requested (Neel, Dean, Negbenebor, & Ward, 2017). Sometimes termed relational continuity, it is the degree to which a series of discrete healthcare events are coherent, connected, and consistent with the patient's medical needs and personal context (Haggerty et al., 2003). The unit of measurement of continuity is the recipient of care or individual, as continuity is not an attribute of providers or organisations but refers to how individual patients experience integration of services and coordination (Haggerty et al., 2003). Research has consistently shown a strong relationship between relational continuity and patient satisfaction (Saultz & Albedaiwi, 2004, Dang, Westbrook, Njue, & Giordano, 2017). Relational continuity in care ensures that this information sharing results in a more informed provider who remains available for future care encounters.

Turning to locums to fill healthcare provider vacancies is more common in Northern Ontario (Mian & Strasser, 2017; Malko & Huckfeldt, 2017) and is one of the sacrifices respondents attribute to their northern residency. The loss of one's primary healthcare provider and the substitution with a temporary replacement reduces access to care, leading to compromised health outcomes (Sabety, Jena, and Barnett, 2020). In these situations, out-patient visits, prescriptions, and preventative care shift to specialty care, if available, along with an increase in urgent care or emergency room visits, driving up the cost of care. Northern Ontario lacks the specialists and the hospitals to absorb this shift. Increasing the number of primary

healthcare (PHC) providers could reduce reliance on care provided by locums, improving outcomes while limiting costs.

Many women in this study reported difficulty communicating with their providers due to time constraints, feeling judged, and a lack of listening skills. A meta-synthesis, conducted to examine the conditions contributing to Ontario women's inequitable access to care, found that judgemental encounters caused some women to lose trust, discontinue attendance or withhold information from providers (Angus et al., 2013). These are termed "barriers to care" and are defined as systemic features of care policies or delivery systems that block efforts to obtain care and health information (Angus et al., 2013). The authors suggested that providers can mediate these barriers by allowing time for questions and information sharing, becoming culturally responsive, and identifying institutional and provider biases (Angus et al., 2013). Numerous recent studies report that inadequate communication, such as not listening to concerns or answering questions and rushing the procedure, may increase women's emotional discomfort during the screening procedure (Majid et al., 2019). Not only the supply of providers in rural and northern locations must increase, but also the practices of those healthcare providers should improve to maximize attendance to preventative reproductive healthcare.

Concerning the care environment, women are aware that reproductive healthcare makes some providers uncomfortable. The Society of Obstetricians and Gynecologists (SOGC), in their "Female Sexual Health Consensus Guideline" (Lamont et al., 2012), state that a provider's reluctance to focus on sexual concerns may reflect personal discomfort, time management issues, poor remuneration, lack of training or fear of accusations of inappropriate behaviour. Following interviews conducted with midwives, gynecologists, and general practitioners in Sweden, researchers reported that lack of organisational support and poor communication skills, as well as

difficult emotions, complicate the sexual health encounter, which might restrain clinicians from raising sexual issues (Wendt, Markland, Lidell, Hildingh & Westerstahl, 2010). Researchers in Sheffield, England, conducted interviews with general practitioners and practice nurses and found that practitioners described sexuality issues as highly problematic due to their sensitivity and complexity, exacerbated by constraints in time and expertise (Gott, Galena, Hinchliff & Elford, 2004). A survey of primary care physicians in Belgium found that fewer than half of respondents provided any form of sexual health counseling (Verhoeven et al., 2003). They cited language and comprehension problems, ethnic differences, insufficient training, lack of time, presence of family members, and fear of embarrassing the patient as barriers to discussing sexually transmitted infections with their patients (Verhoeven et al., 2003). Although it appeared to participants that time constraints were to blame for a failure to provide information or answer questions, it becomes apparent in the literature that clinicians may be limiting the encounter based on their discomfort, lack of adequate remuneration, limited time, and lack of training.

How to engage in effective two-way communication is already part of the formal curriculum. However, physicians can also be encouraged to be more mindful and empathetic, which can transform their role from one characterised by authority to one with partnership, solidarity, and collaboration (Epstein & Street, 2011). A recent study sought to identify practical actions, behaviours, and communication strategies that busy clinicians can readily adopt, resulted in 18 suggested practices distributed across five domains (Zulman et al., 2020). Physicians are encouraged to familiarize themselves with their patient's life circumstances by asking, listening intently, and avoiding interrupting. Care providers should focus on what is most important to the patient and develop a shared set of priorities, as this is the core of patient-centred, humanistic care (Zulman et al., 2020). Previous research has shown that, on average, physicians interrupt

their patients within 11 seconds (Ospina et al., 2019). Listening attentively and avoiding interruptions allows patients to disclose more valuable medical information, resulting in increased satisfaction with care without substantially extending the length of the visit (Tallman et al., 2007). The advantage of making these minor adjustments to care provision is that they are inexpensive, easy to adopt and have the power to affect population health over time (Zulman et al., 2020).

Women describing good care describe care providers who listen, take time, are patient, and explain things, meeting the definition of patient-centred care. Essential elements of person-centred care (PCC) include considering the whole picture, respecting patient's choices, avoiding judgment, and providing individualised care. The provision of PCC is a dynamic process where the patient is the expert on their own life and body (Fontein-Kuipers, Koster, & Romijn, 2018). It requires input and interactivity by both the person and their provider, and the person's experiential knowledge is considered legitimate. Providing this care is a conscious act and deliberate choice. When this care is lacking, dehumanization and depersonalization of care can result, coinciding with a loss of quality of care (Fontein-Kuipers et al., 2018), as expressed by women in this study.

In addition, women reported issues around confidentiality, judgemental providers, and timely access, as doctors can act as gatekeepers, resulting in lower-quality care. Administrative practices around the protection of confidential information may benefit from broader patient education so that patients feel less vulnerable. Applying the principles of PCC could also result in culturally safe and competent personalised care (Gagliardi, Nyhof, Dunn, et al., 2019). Respondents reported difficulties accessing reproductive healthcare provided by Francophone providers. A recent brief made it clear that the availability of health services in French in Ontario

is limited (Ouapo et al., 2019). The training of more providers able to offer care in the French language is an important consideration when addressing health equity issues in Northern Ontario. As the only bilingual midwifery school in Canada was closed in April 2021, training future midwives to fill this gap will be difficult.

The preference for female providers to provide reproductive healthcare, which most participants clearly expressed, results from the widely held belief in 'embodied knowledge.' Social theories suggest that from infancy onward, humans build up in long-term memory a repertoire of reactions, movements, sensations, perceptions, and feelings. These embodiments are often culturally conditioned, becoming linked to ideas, images, and social situations, such as feeling shame or not seeing a naked body, to be internalized by individuals (Ignatow, 2007). Real expertise about cervical screening, breast exams, abortion access, and contraception may stem from embodied rather than textual knowledge. As a result, the patient's choice may be grounded in a gendered sense of trust (Lowe, 2005). A study by Lowe (2005) found that formal training was not sufficient to accredit male doctors with expert status and the preference for female providers for reproductive healthcare was evident in her results and is common in the literature.

Many recent studies support a preference for female providers for reproductive healthcare. A recent American study reported that 73.3% of gynecology patients would prefer a female provider (Hoke et al., 2019). Qualitative descriptions of this preference revealed that bedside manner, lived experience, and generally feeling more comfortable with a female provider were the stated reasons. There was no association between a patient's age, race, or education level and their preference for a female provider (Hoke et al., 2019). A cross-sectional study compared to breast and cervical screening participation rates among more than one million women aged 52 to 69 in Ontario, Canada. It revealed that women rostered to male physicians

were two times more likely to be overdue for cervical cancer screening than those rostered to female physicians (Tavasoli, Kane, Chiarelli, & Kupets, 2018). The authors also report that 70% of the patients who preferred a female examiner but had a male physician visited a separate provider for gynecologic care, introducing additional potential barriers, including the need to schedule multiple appointments. The same strategy was adopted by interview participants. These patients have a 10% lower cervical cancer screening rate (Tavasoli et al., 2018). This data builds on earlier findings that women in Ontario and Alberta have a strong preference for female care providers, suggesting that female practitioners are a necessity for isolated rural women (Sutherns & Bourgeault, 2008). Expanding the scope of practice of non-physician providers, primarily females, such as midwives, may result in a greater number of female reproductive healthcare providers serving rural, remote, and northern populations.

As stated in the introduction to this work, an essential goal of primary healthcare is achieving healthcare equity, care delivered without systematic variations related to the social, economic, demographic, or geographic characteristics of groups or individuals (Browne et al., 2012). Ensuring the delivery of PCC and respecting relational continuity could contribute to health equity in the North by counteracting some of the negative aspects. But any approach that seeks to remedy disadvantages rather than addressing the broader structural (i.e., social, political, economic) influences that shape the mal distribution of healthcare resources may narrow the scope of potential policy solutions to those that focus on an individual targeted approach. This approach may be less effective than action on the broader determinants that create social disadvantage (Graham, 2004). Achieving health equity requires a more upstream, structural approach that considers the social gradient and the social determinants when reconsidering processes that distribute resources across the population (Lucyk & McLaren, 2017). The creation

of a sustainable, well-resourced, reproductive healthcare workforce may enhance the capacity of the healthcare system to deliver quality care in rural, remote, and northern locations. Consumer-centred processes should guide healthcare reforms. A more community-driven or individual-level approach that focuses on social or behavioural factors operating within specific groups is required.

The results of this study lead to a recommendation to examine the roles of allied providers, such as nurses, nurse practitioners, and midwives. A recent systematic review found that the effectiveness of any intervention may be related to both the place where the intervention was delivered and the person who delivered it (Rodríguez-Gómez et al., 2020). Additionally, results show that nurse-led interventions improve participation in cancer screening (Davis et al., 2018). Studies highlight the crucial role of nurses in cancer prevention and early detection and identified potential activities performed by nurses during the cancer screening process, including the management of cases and the performance of diagnostic tests (Cooper, Tinmouth, & Rabeneck, 2014; Black, 2018). Along with nurses, a growing number of nurse practitioners are helping to offset practitioner shortages in rural areas and maybe the primary care provider for those living in medically underserved regions (Rodriguez-Gomez et al., 2020).

The results of this study and many recent investigations support the provision of reproductive healthcare by midwives. All providers could do a better job at providing PCC. At the same time, providers with more expertise in this type of care could be made available, expanding women's options for care. More providers may reduce the dependence on locums for reproductive healthcare, which would result in the increased continuity favoured by all of the people in this study. Expanded scope of practice alone will not help with provider shortages

overall, so enrollments in professional programs also need to be increased to meet the increased demand.

Some aspects of northern residency are not amenable to change, such as the distances required to travel for care and the often-inhospitable terrain and weather. However, an increase in providers, with the characteristics valued by the people seeking care, is possible through changes in health policy and increased enrolment in education programs. These changes may improve access to reproductive care, resulting in improved health for women living in Northern Ontario.

#### ***6.9.1 Study Limitations and Future Research***

I acknowledge that as a provider of reproductive healthcare, I may be biased about the exceptional care that I believe most midwives provide. The health policies that guide reproductive healthcare may require examination and revision, and I acknowledge that this study included my values and interests. All interviews were conducted in English, as the researcher's proficiency in French would not allow for a complete understanding. Native French speakers may have been more comfortable if interviewed in their first language, resulting in more robust responses. In terms of the self-selection bias, persons who are willing to share their experiences about a provider who does not meet their expectations may seek opportunities to provide feedback, which would bias the results against their providers. More diversity could have been realised in my participant pool through more targeted recruitment, although my pool of interviewees may have been more diverse than I realise but I failed to ask more extensive questions about gender identity and sexual orientation. A recent UK study indicated that transgender men and non-binary people assigned female at birth (TMNB) lack sufficient information about cervical screening and experience barriers to accessing screening services at

personal, interpersonal, and institutional levels (Berner et al., 2021). Collecting more detailed background information and intentionally interviewing women of differing abilities, LGBTQ++, immigrant women, and a more robust sample of Black women and women of colour may have allowed me to explore for variations in care experiences, although no broad conclusions would be possible about any of these distinct groups due to the nature of qualitative enquiry.

A similar study focusing on the experiences of Indigenous women in Northern Ontario might provide guidance. The development of culturally appropriate services will not be helpful for people who have been excluded from the definition of their own culture and excluded from the decision-making structures that determine how health resources are to be designed and distributed (Bourassa et al., 2004). No single, outside solution can serve the needs of the diverse Indigenous communities in Northern Ontario. Adequate resources and independence may allow Indigenous peoples to design and distribute their reproductive healthcare.

Future studies could invite participation, regardless of gender identity, to gather information about reproductive healthcare experiences from men, queer, trans+, gender fluid, and non-binary communities to recommend changes to improve quality and adherence to reproductive care for all.

## **6.10 Conclusion**

Women report mixed experiences concerning the reproductive healthcare they are accessing in Northern Ontario. Factors that enable access include the availability of person-centred care and relational continuity. Many interviewees had their reproductive healthcare provided by non-physician care providers such as midwives, nurses, and nurse practitioners, within and outside of their family physician's office. Most respondents perceived nurses, nurse practitioners, and midwives to provide more PCC. A larger role for these providers in providing

reproductive healthcare to women in Northern Ontario should be considered based on high satisfaction with their services and the need for more options. Cited barriers to care included rushed providers lacking interpersonal skills, perceived privacy compromises, and a limited number of female providers. Midwives may be an acceptable alternative to physicians, along with nurses and nurse practitioners.

Changes driven by strong health policy are required to engage women more fully in recommended reproductive healthcare. Expansion of the scope of practice of non-physician reproductive healthcare providers may improve consumer perceptions of service quality, leading to increased satisfaction with services, translating into behavioural intentions to engage more fully in recommended reproductive healthcare. Although northern geography will always present challenges that may not be subjectable to amelioration, other factors preventing women from accessing care are more amenable to change. As argued here, there is an obligation on the part of government to provide equitable access for all Canadians to healthcare services.

## **CHAPTER 7: DISCUSSION & CONCLUSIONS**

This research was motivated by my questioning whether there is equitable access to reproductive healthcare in Northern Ontario communities. This research sought to gather women's perspectives about their reproductive healthcare and determine whether women view midwifery care as an acceptable alternative to current providers or options. In returning to the research questions that guided this examination, I sought to understand:

1. How do women perceive their reproductive healthcare?
2. What elements of a woman's reproductive healthcare enable her to engage in recommended care more fully?
3. Which elements of a woman's reproductive healthcare act as a barrier to obtaining the services she desires or requires?
4. How do women's perspectives of their reproductive healthcare influence their use of reproductive healthcare services?
5. Do women view midwifery care as an acceptable alternative to current providers?

The answers to these research questions situate the needs of Northern Ontario reproductive healthcare consumers within the existing health system and recommend changes for the care to align with their needs more closely. Reducing barriers to maximize access to recommended services may require changes to current health policies. The chapter includes reflections on applying the HMHSQ tool for measuring reproductive healthcare service quality in a northern Canadian location and offers insights specific to gender, northern residency, and person-centred care (PCC). These elements emerged as crucial to our understanding of reproductive care access. This chapter concludes with recommendations for changes, conveyed in practical terms, to encourage expeditious application.

## **7.1 Women's Perceptions of Their Reproductive Healthcare (Question 1)**

We have gained insights into the research problem through a thorough analysis of the survey responses and a qualitative study of interview transcripts. From the survey, we can conclude that most consumers of reproductive healthcare in Northern Ontario rate this care as fair to good, with interpersonal relationships and administrative support rating lower. Most women favour female practitioners for their reproductive health care. Most women access reproductive health care through their family doctor's office, but a large percentage would prefer to visit a midwifery clinic for this care. The analysis of the interview transcripts yielded five conceptual constructs: the characteristics of good care, the relationship with the provider, the care environment, administrative practices, and gender. Gender was also part of the other four in the following ways. Under 'characteristics of good care,' female providers were favoured for modesty reasons and assumed relatability due to concordant reproductive organs. For 'the relationship with the provider,' female providers were repeatedly, but not exclusively, credited with providing PCC. The availability of PCC is an enabler for accessing recommended reproductive healthcare. A shortage of female healthcare providers is a barrier to accessing reproductive healthcare in the north. For 'the care environment,' the female-dominated fields of nursing and midwifery were favoured for care provision. Under 'administrative practices,' many gendered policies exist, including the need to have a female present in the room for clinical exams. Most administrative staff are female, with mostly male employers. They exist as the frontline barrier or enabler to accessing all reproductive healthcare services by booking appointments and answering phones and emails. Finally, reproductive healthcare for females is a gendered area of healthcare. Birth and avoidance through contraception, or access to abortion if

unwanted, impact females disproportionately more than males, with an acknowledged equal need between the sexes for STI screening/treatment and sexual health counseling.

Because my study employed QD data analysis techniques, we can comment on the who, what, and where of reproductive healthcare and gain insights from interviewees regarding their perceptions of care (Neergaard et al., 2009; Sullivan-Bolyai et al., 2005). Survey participants indicated where they were currently receiving reproductive healthcare and where they would choose to receive this care, if all options were available. They shared best and worst experiences in accessing care which allowed for a clearer picture of enablers and barriers to maintaining reproductive well-being.

## **7.2 Enablers and Barriers to Accessing Reproductive Healthcare (Questions 2 & 3)**

My study sought to examine the barriers and enablers to accessing reproductive healthcare in Northern Ontario. The barriers to accessing reproductive healthcare can include individual-level and healthcare system-level factors. Systemic barriers to healthcare access include healthcare policies and delivery systems that block people's efforts to obtain care and health information (Angus et al., 2013). Embarrassment is an individual factor, while a shortage of female providers or the over-reliance on locum providers are health system-mediated barriers. In Chapter 2 of this thesis, the literature review provided examples of health system-mediated barriers to accessing healthcare in northern environments, including population scarcity combined with harsh climatic conditions and limited health resources, resulting in restricted access to care, ultimately affecting outcomes (Angus et al., 2013). In rural and Northern Ontario, women have the lowest life expectancy in the province, perhaps connected to their limited access to healthcare practitioners and services (Liepert & George, 2008). Individual-level healthcare

system features can be sufficiently unsatisfactory to discourage participation, even when services are otherwise accessible, leading to preventable illness (Angus et al., 2013). Historically, researchers have paid less attention to the motivators for engaging in recommended reproductive healthcare. This study provides a careful analysis of individual-level and health system-mediated barriers and enablers to increase participation in reproductive healthcare.

### ***7.2.1 Enablers for Improving Access***

Access in healthcare refers to access to services, providers, or institutions, defined as the ease with which consumers can find and use services appropriate to their needs (Levesque, Harris, & Russell, 2013, Ringer, 2017). Historically, access to healthcare has depended on typical supply factors such as location, availability, cost, appropriateness, and demand factors created by the knowledge, attitudes, and abilities for self-care of health consumers (Levesque et al., 2013). A more comprehensive view would consider the structural features of the system, such as the availability of providers, along with individual features, such as the gender of the provider, which may be more responsive to targeted enablers.

General well-being and perceiving that acceptable reproductive healthcare is available is an enabler to accessing care. The survey results indicated that respondents report adequate care with good to excellent ratings for overall health and fair to good perceptions for availability and quality concerning their general healthcare. Concerning availability and in agreement with the literature about the relative scarcity of physicians in the north, fewer survey participants (85.5%) reported having a family doctor compared to the provincial average (90.6%) (Statistics Canada, 2019). The number of rural (84.0%) and urban (86.2%) participants with a family doctor was comparable. Earlier studies reported a shortage of French-speaking physicians available to provide care to northern Francophone residents (Gauthier et al., 2012), while in this study, more

Francophones (92%) had a family doctor than Anglophones (84%). However, the difference was not significant. I cannot comment on whether the participants were receiving healthcare services in French, so I am unable to conclude whether this remains a problem. Studies indicate that individuals with a dedicated healthcare provider have improved health-seeking behaviours and outcomes, greater use of preventative care, and fewer hospitalizations (Chor, Hebert, Hasselbacher, & Whitaker, 2016). Despite a relative shortage of primary care providers compared with their southern Ontario counterparts, consumers of reproductive healthcare in my study still rated their care above average.

Another enabler to access is liking one's caregiver. Many interviewees had their reproductive healthcare provided by non-physician healthcare providers, including midwives, nurses, and nurse practitioners, within and outside of their family physician's office. Respondents felt that nurses, nurse practitioners, and midwives excelled at providing quality care and would favour increased access. Cervical cancer screening is an essential element of reproductive healthcare and is part of the clinical practice of physicians, midwives, NPs, and some nurses. Recent government analysis of cancer screening rates across Ontario indicates that the highest percentage of women overdue for cervical screening reside in Northern Ontario (Cancer Care Ontario, 2020). My survey devoted additional questions, beyond the HMHSQ, to the frequency of screening and reasons for compliance, or lack of. Low adherence was not born out in this examination. Most participants were following provincial cervical cancer screening guidelines, with 86.6% of women indicating that their last pap test was within three years, compared with the Ontario provincial rate of 64.9% (CCO, 2020). In agreement with numerous other examinations into cervical cancer screening, survey respondents stated that liking one's

healthcare provider was the primary reason for complying with recommended cervical screening guidelines (Racey & Gesink, 2016).

Female healthcare providers are an enabler for women to access reproductive healthcare. Just over 1/3 of respondents indicated that it was not important if a female performed their cervical screening (35.3%), leaving nearly 2/3 responding in favour to preferring females. My study identified that a female provider who offer PCC could encourage continued high rates of cervical cancer screening. Participants in an Irish study favoured females and reported higher satisfaction ratings for screening performed by nurses (O'Connor et al., 2014). In agreement with the Irish study, my results show that the provision of quality reproductive health care was not confined to female practitioners (O'Connor et al., 2014). General practitioners of both sexes can contribute to higher cervical cancer screening uptake through their ongoing relationships or continuity of care, shown to limit the embarrassment perceived by their patients (O'Connor et al., 2014). In agreement with this Irish study, my study showed that access to a female provider may decrease embarrassment, but person-centred care with continuity of care can result in a trusting therapeutic relationship regardless of the gender of the provider. Motivators or enablers to accessing reproductive healthcare included care provision that is non-judgemental and empathetic and allows time for education. In agreement with the survey, most interviewees preferred female healthcare providers, mostly expressed as a more comfortable care arrangement.

Access to midwives for reproductive healthcare outside of pregnancy and postpartum is an enabler. Most women access cervical cancer screening at their physician's office (61.5%), but a significant percentage (29.4%) would like to access this screening at a midwifery clinic. Rural women without family physicians and women with lower family incomes particularly preferred

this option. Overall, the findings demonstrated interest among consumers in accessing cervical cancer screening in midwifery clinics. Their preference may reflect that they believe they are more likely to be cared for by a female midwife, thereby reducing their embarrassment. It may also reflect a shortage of family physicians, especially among low-income persons. An example of a health systems- level, consumer-led improvement recommended by multiple interview participants would be the addition of midwives as abortion care providers. The concomitant access to contraceptives may reduce the requirement for abortion services in the future and increase the ease with which consumers can access cervical cancer screening and other reproductive healthcare services, appropriate to their needs.

Finally, interviewees conveyed the importance of welcoming and flexible administrative practices and staff. The satisfaction of the front-end service delivery and back-end processes are essential aspects of customer satisfaction (Regan, 2011). Interviewees in my study rated the quality of the administrative support below average and conveyed the importance of welcoming and flexible administrative practices and staff. Hall, Roter, and Katz (1988) found that patient satisfaction correlated to the staff's skill level and reported that patients sought positive non-verbal behavior elements of social conversation such as courtesy and consideration and clearness of communicated information. A more recent review of PCC in eight countries, including Canada, reported that scheduling flexibility allowed patients to plan their life around care, and inflexibility of scheduling and limited appointment times led to patients feeling devalued (Gagliardi et al., 2019). Several studies identified the need for humanization, meaning feeling seen and heard as a person and receiving individualized communication (Gagliardi et al., 2019). Interpersonal relationships were also rated lower, and in agreement, the above studies demonstrated the need for courtesy and flexibility among all care team members.

The stated goal of this research was to increase participation in recommended reproductive healthcare practices, which requires a focus on enablers to improve access. Enablers to accessing reproductive healthcare include practitioners responsive to women's vulnerabilities and promote respect for autonomy, trust, communication, rapport, and confidentiality, to create an inclusive, positive, and morally respectful environment (Burrows, Goldberg, Searle, & Aston, 2018). These are individual-level features that must be paired with health system-level changes for system improvement. System-level factors can be addressed through robust health policy. Examples include access to midwives or nurses and person-centred approaches to care that allow time for information sharing, with confidentiality assurance. The feminisation of medicine may make more women feel comfortable accessing care from their family doctor's office. Despite provider type, motivators, or enablers to accessing reproductive healthcare include care provision that is non-judgemental and empathetic and allows time for education. An effective stigma reduction strategy appropriate for our health system is task-shifting, which involves distributing healthcare responsibilities to alternate providers, and service integration, allowing health consumers to meet multiple needs efficiently (Nyblade et al., 2019). Examining the policies that inform how care is delivered should incorporate both system and individual-level enablers to increase reproductive healthcare access.

### ***7.2.2 Eliminating Barriers to Access***

Improving access to care involves an appreciation for the factors that enable health consumers to adhere to recommended healthcare practices. Equally important is an understanding of the barriers encountered by people seeking care. Complex challenges to access span system and individual levels and are related to culture, language, history, discrimination, and racism and must be considered when discussing strategies for increasing access (Ringer,

2017). Relations of power within reproductive healthcare settings are ever-present, though rarely investigated, and can lead to interpersonal tensions, feelings of embarrassment, silence, and judgement (Ollivier, Aston, & Price, 2018). Interview participants expressed extreme disappointment due to feeling pressured, judged, and discriminated against by medical personnel and administrative staff. Various terms have been used to describe women's poor treatment from reproductive health care providers, including dehumanisation, obstetric violence, disrespect, and abuse (Sen, Bhavya, & Iler, 2018). In these cases, disrespect is the violation of a woman's dignity as a person based on her economic status, gender, caste, race, ethnicity, marital status, disability, and sexual orientation (Sen et al., 2018). Health care workers often display it in biased normative judgements and the resulting acts of omission or commission (Sen et al., 2018). Abuse refers to the actions that increase the risk of harm to the woman and are often learned and reproduced by the practices of institutional medicine (Sen et al., 2018). The providers do not intend to cause harm and feel justified due to resource constraints (Sen et al., 2018). The critical drivers of disrespect and abuse intersect social and economic inequality and institutional structures that frame obstetric and gynecological care (Sen et al., 2018). Studies into sexual health and reproductive health care must recognise the power inherent in patient-provider interactions and the inequities that underpin the different experiences of marginalised versus more empowered women (Sen et al., 2018). In agreement with the literature, the most common reason cited for not complying with cervical cancer screening was "too embarrassed or modest" to engage in this type of personal care (Oscarsson, Wijma, & Benzein, 2008, Racey & Gesink, 2016). Many participants in my study shared care experiences in which they felt judged by their providers. Stigma refers to the othering and marginalization of populations deemed different from the norm and is characterized by labeling and stereotyping, leading to status loss and discrimination,

which is the endpoint of the stigmatization process (Bombak, McPhail, & Ward, 2016, Nyblade et al., 2019). Stigma in healthcare is particularly egregious as it negatively affects people at their most vulnerable. Providers exhibit it as a refusal of care, provision of sub-standard care, physical and verbal abuse, or more subtle forms such as making some people wait longer for care or to be cared for by more junior providers (Nyblade et al., 2019). Adverse health outcomes to consumers result from the avoidance of medical care, psychosocial stress, and poor mental health (Bombak, McPhail, & Ward, 2016). Addressing individual level enablers of care requires addressing the historical discrimination and systemic racism within reproductive healthcare that is preventing some women from accessing care.

Interview participants reported rushed and compromised care, and some viewed this as a result of inadequate human resources. Health human resource associated barriers include not having a family physician to encourage compliance or a female to decrease embarrassment. In Northern Ontario, the shortage of family physicians, especially female physicians, is a barrier to the provision of reproductive healthcare. Nurses and midwives could fill this void, but this would require an expansion in practitioners' numbers, efficient use of the existing workforce, and expansion to their respective scopes of practice. This is termed discipline substitution (WHO, 2012). Midwives are a viable and acceptable option to provide this care by past and current consumers and people who have never been clients of midwives. Welcoming additional providers into the arena of reproductive healthcare would require a paradigm shift in delivering this care. Not only would the practitioner landscape change, but the approach to care would change. Using abortion as an example, women presenting for abortion are more likely not to have a regular physician or a clinic where they routinely receive care. This leaves unaddressed post-abortion care needs and ongoing unmet needs for contraception (Chor et al., 2016). Several

participants in my study described non-existent abortion services, or dated abortion practices, or compromised privacy due to smaller populations. The participants in my study highlighted the need for choice in providers and locations and stressed that privacy may be elusive in their small communities. Consumer-led improvements to the abortion care process may include the addition of midwives, allowing underserved groups of women to better integrate into the healthcare system and establish relationships with regular care providers, enabling them to engage in vital preventative healthcare such as cervical cancer screening (Chor et al., 2016). A limited pool of providers is a barrier to timely access to care and could be remedied or improved through discipline substitution.

In my study, a lack of interpersonal skills limited two-way information sharing, and was cited as a barrier to quality care. In meeting the information needs of patients, clinicians have a duty of care not only to patients' bodily and mental health but also to the adequacy of their knowledge (Begley et al., 2019). Education should be offered freely and disclose the provider's personal beliefs and biases that may impede the decision-making (Begley et al., 2019). The participants in my study reported limited opportunities for discussions with physicians. Even if they arrived with prepared questions, there did not appear to be adequate time or interest in engaging in information sharing or education. Participants stated that assertiveness was required to ask questions or relay their preferences. This resulted in participants seeking health information of questionable quality elsewhere. A shift to PCC with its hallmark shared decision-making represents a new way of engaging with patients. In line with PCC principles, expertise can be defined holistically to include lay knowledge from patients and their support people (Hardey, 1999). PCC may suffer the same growing pains as most innovations in care with slow adoption due to resistance and the need for champions to lead the reluctant.

We understand that low SES can act as a barrier to accessing care. From the literature we understand that lower-income women and women of colour face reproductive health disparities, including an unmet need for contraception and increases in unintended pregnancies (Chor et al., 2016). This failure to meet their contraceptive needs results in more abortions as disparities multiply. My study sought to uncover the effects of sociodemographic variables on perceptions of care by collecting information about SES and education. The participants in my study shared some vulnerabilities because they were all women and resided in Northern Ontario. The effects of the wider social determinants on their experiences accessing reproductive care may depend on past encounters and the care environment, as well as their education, income levels, and values. A study by Malat (2001) found that lower socioeconomic status results in lower expectations of the healthcare encounter based on being treated with less respect in one's daily life. Gender concordance with the provider may decrease social distance and may improve communication, rapport, and the overall perceived quality of the encounter (Malat, 2001). In my study, lower SES women were less likely to favour physicians for their reproductive healthcare. Distrust in clinicians among lower socio-economic status people arises when providers show signs of stigmatization/discrimination towards their poverty (Majid et al., 2019). Lower-income patients surveyed in the US provided explicit negative examples such as clinicians avoiding eye contact, speaking condescendingly, showing physical signs of disgust when touching patients, brushing off concerns and symptoms, and ignoring patient's input (Grob, Darien, & Meyers, 2019). In my study, women reporting lower family incomes were more likely to favour midwifery care for their reproductive needs, perhaps finding the midwife to be more relatable due to a perceived reduced social distance compared with physicians. It should come as no surprise that lower SES

as a social determinant of health, affects perceptions, and that catering to this population requires an appreciation for individual vulnerabilities.

A lack of time or interest in providing education or answering questions is a barrier to care. Interview participants reported no time for questions, assumptions by physicians that they know the best course of care, and a reluctance to ask their opinions or educate. Even if they arrived with prepared questions, there did not appear to be adequate time or interest in engaging in information sharing or education. The participants reported unmet information needs and stated that assertiveness was required to ask questions or relay their preferences. This lack of education resulted in participants seeking health information of questionable quality elsewhere. For women to make informed choices, access to accurate, timely, women-sensitive health information is essential (Boscoe et al., 2004). The internet has provided access to lots of information, but it is not necessarily the knowledge needed nor universally accessible (Boscoe et al., 2004). In 1999 a British health researcher expressed concern about 'deprofessionalisation', defined as a power shift where internet users would decide the material available, not professionals or experts (Hardey, 1999). Deprofessionalisation is associated with the demystification of medical expertise and increasing skepticism towards medical professionals (Hardey, 1999). This had led to widely available health information online, with benefits including the ability to search for answers in the familiar and private safety of one's home where difficult or embarrassing questions are shared anonymously (Hardey, 1999). It protects from information overload as the health consumer controls the encounter and represents a challenge to previously hierarchical models of information provision (Hardey, 1999). But this reliance on internet-sourced health information in lieu of medical advice has drawbacks due to the greater reliance on digital tools, which has the potential to increase disparities between those who have

skills and access to digital tools and those who do not and thereby multiplying existing health disparities (Sieck et al. 2021). Some health researchers refer to digital literacies and internet connectivity as "super social determinants of health" because they impact all other social determinants of health such as applications for education, employment, housing, and other assistance programs, which are increasingly, and sometimes exclusively, accessible online (Sieck et al., 2021).

An informed choice not to engage in recommended care may result from encountering barriers. In considering the agency of health consumers, we acknowledge that there exists an inherent tension between ensuring informed choice and maximizing adherence to recommended care (Waller, Jackowska, Marlow, & Wardle, 2011). Non-attendance was a choice made by some participants in my study and is an active decision not to follow reproductive health advice. Persons adopting this approach may be termed 'disinclined abstainers,' as they weighed the benefits and the risks and make an informed choice not to seek care (Waller et al., 2011). Women interviewed in Sweden reported that decisions not to attend cervical cancer screening including avoiding a situation where they feel vulnerable, a distaste for exposing their genitals from a position of submission, and a lack of faith in the health system, ranging from a slightly negative view to total distrust (Oscarsson et al., 2008). In Ireland, although most women believed that 'having the smear test' was important, it was seen as a women's personal choice to attend or not (O'Connor, Murphy, Martin, et al., 2014). It may be challenging for care providers to accept and even promote a women's choice not to attend cervical cancer screening, as reasons include a complex combination of intentionally and unintentionally weighed advantages and disadvantages (Oscarsson et al., 2008). Other individuals may prefer a more medical model of care because they feel reassured by familiar paternalistic approaches and do not wish to be decision-makers.

This preference is valid if the element of choice is involved (Lines, Lepore, & Weiner, 2015). To support patient autonomy and relational care, providers are encouraged to engage the person in discussions about their choices because there is a chance that emotions, misconceptions, or poor advice may influence the decision. Providers can also strive to meet the stated needs of their patients and adjust how they deliver care to minimise feelings of exposure and vulnerability. However, the person's decision must stand after such engagement. The principle of autonomy dictates that providers aid decision-making by engaging in discussions that contribute to a mutual understanding and then accept both action and inaction. This is termed agency and is vital for realising full human rights. Despite accepting body autonomy as a principle, eliminating discriminatory care is essential towards ensuring equitable access. Quality reproductive healthcare should be accessible, acceptable, and appropriate.

In summary, barriers to accessing reproductive health care include feeling judged, pressured or discriminated against by care providers and staff. Persons of low SES may be more vulnerable to discrimination in health care. A limited pool of care providers, particularly females, and little choice of alternatives to physicians is a barrier to care. It is important that providers make time to engage in two-way information sharing to encourage attendance and limit the influence of questionable information obtained on the internet. The provision of PCC can help to overcome many barriers to attendance.

### **7.3 Performance of the Satisfaction Measurement Tool**

The data collection instrument used in my study, the Hierarchical Model of Health Service Quality (HMHSQ) tool, was developed to monitor the quality of service delivered to health consumers with a goal of improvement. The constructs were validated to ensure they measured the factors applicable to patient satisfaction (Dagger et al., 2007, Larson et al., 2019).

Although developed in the context of general practice and oncology clinics, this instrument can be used in any healthcare service context, providing health planners with valuable insights into the dimensions that reflect customers' health service quality perceptions (Dagger et al., 2007). Problematically, women have been largely invisible in satisfaction research and instruments were not developed with gender in mind, with little to no analysis broken down by gender (Weisman et al., 2000). It is not clear to which extent existing patient satisfaction questionnaires are equally valid for different groups of patients, such as men and women (Foss & Hofoss, 2004). The tool adopted for this inquiry, the Hierarchical Model of Health Service Quality or HMHSQ, is no exception. Aside from the primary goal of examining satisfaction with reproductive healthcare in a northern setting, my study allowed for the application and refinement of the chosen measurement tool. The tool appeared to accurately capture reproductive health consumers' concerns regarding the relationships with their providers and the desire for more robust administrative support, as these were the main findings from interviews with the same consumers. Qualitative methods following a quantitative exploration, with the population of interest, were conducted to be appropriate for more in-depth exploration and content validation (Larson et al., 2019). The ability to triangulate the conclusions was due to applying a mixed-methods approach, which was a strength of the study methodology from the design phase.

The five conceptual constructs, shared elements with the HMHSQ. The characteristics of quality care and the relationship with the provider could be grouped under the HMHSQ domain 'Interpersonal' and were the most significant areas for dissatisfaction with care. The importance of the care environment and administrative practices mapped directly onto HMHSQ domains. The final domain, 'Technical,' did not stand out as lacking. Survey participants rated their access to care as fair to good, and interviewees mostly trusted their healthcare providers' clinical skills.

Gender was noted as an overarching construct, while the HMHSQ failed to capture the importance of the gender of the provider to the provision of healthcare. Gender congruence, or a desire for female providers for women's reproductive healthcare, was clear in my study, although not captured under the 'interpersonal' domain, or under the sub-domains of 'relationship' and 'interaction,' contributing to perceived service quality in the HMHSQ. In general medicine or oncology, the preference for female providers for female patients may not be as pronounced as in obstetrics, gynecology, or reproductive healthcare overall. Women and men experience healthcare differently and evaluate their experiences based on different factors (Weisman et al., 2000). The quality of communication may be a more important determinant of women's satisfaction with primary care, with 65% of women vs. 55% of men citing communication problems as the main issue when choosing to change doctors (Weisman et al., 2000). A study of gender differences in satisfaction with care found that the direction of effect for most independent variables was similar for women, but the effect sizes differed (Kolodinsky, 1998). From this observation, we can hypothesize that the results of my study are valid despite the use of a tool that did not consider the gender of the patient or the provider and had not been trialed in a reproductive healthcare setting, but effect sizes may be questionable. There is a need to validate patient experience instruments for different groups of patients, particularly divided by gender (Foss & Hofoss, 2004).

Perceptions of quality can guide improvement efforts, which is vital because of the subsequent impact of service quality improvements on customer satisfaction and behavioral intentions and broader outcomes such as an improved quality of life experienced by these consumers (Dagger & Sweeney, 2006). Quality improvement should address the sub-dimensions, thereby improving ratings for the dimensions and the global rating (Dagger et al.,

2007). In this case, meeting health consumers' preferences for person-centred care and improved interactions with administrative staff could increase cervical screening rates, improve contraceptive uptake, and limit the transmission of STIs, improving the quality of life for women in Northern Ontario.

## **7.4 Perspectives on Care and Influence on Reproductive Healthcare Choices (Question 4)**

To answer the fourth research question, I had to combine the accounts of care from the study participants with my reflections on the main factors affecting their care. As this study sought to fill a void in information about women's reproductive healthcare experiences living in a northern setting the first area for more in-depth exploration is the influence of northern residency. My study found that gender was a significant construct as it applied to the gender of the participants (women), the preferred gender of their providers (matching), and the gendered nature of reproductive healthcare for females. These three areas where gender influences care will be discussed in greater length followed by reflections on the provision of person-centred care. Study participant's accounts of their care are rife with examples of non-existent PCC compromising their experiences, along with the application of PCC overcoming provider gender preferences and limited northern resources. Ultimately, the care experiences relayed by the study participants point strongly to the importance of the 'how' of care provision, versus the 'who'. Person-centred care is the competency that women are seeking in their reproductive care encounters, maybe more than a particular provider type or gender.

#### **7.4.1 Northern**

The relative scarcity of healthcare resources in Northern Ontario is due to a mismatch between available health services and the needs or expectations of distinct sub-populations, in this case, women. Northern residents may feel both privileged to have access to a primary care physician and state that they want better access to quality healthcare (Timmermans et al., 2011). Interestingly, a Canadian scoping review into PCC in rural areas reported that residents were less likely to have unmet healthcare needs as rurality increased, suggesting a potential difference in expectations between rural and urban residents (Murphy, Burge, & Wong, 2019). Lower expectations may explain the high ratings for quality of healthcare regardless of rural or urban residency found in my study and supports the gap theory of satisfaction, referring to the gap between client expectations and actual experiences of care.

My study results agree with other studies that show that fewer people who reside in Northern Ontario have a regular family physician compared with the rest of the province. About 8% of physicians practice in rural areas where about 19% live (CMA, 2019). Younger male physicians are more likely to practice in northern and rural areas, while female physicians are frequently found in the south (Wenghofer, Timony, & Pong, 2011). Reduced access to female GPs is related to poorer health outcomes and reduced health service utilization among women (Mazumdar, & McRae, 2019). In the northern areas of Ontario, although the proportion of female physicians was lower than in the south, there was a slight increase in the proportion of female physicians as rurality increased (Wenghofer, Timony, & Pong, 2011). Nationally, the workforce's overall proportion of female physicians has grown from 11.1% in 1978 to 39.9% in 2015 and 42.8% in 2019 (CIHI, 2020). This trend is likely to be sustained as two-thirds (64%) of family physicians under age 35 are female (CMA, 2019). More females choosing this career path

is a positive sign, as many health consumers seek female practitioners to provide their reproductive healthcare. Research has shown that recruiting, retaining, and promoting the success of female physicians in rural communities is crucial to improving rural health (Stutzman et al., 2020). Retaining female physicians will require strong support networks, professional mentors, and patient connections to thrive in rural and remote practice environments (Stutzman et al., 2020).

The scarcity of healthcare providers in the north can cause women to consider non-physician options for reproductive care. In northern environments, women's decisions about care-seeking are influenced by the accessibility, cost, perceived quality of the care, and other's opinions of the care (Leipert & Reutter, 2005). The scarcity of physicians means that seeking an alternative physician is not an option. However, women could circumvent their usual caregivers while seeking more appropriate and accessible providers, often public health nurses (Leipert & Reutter, 2005). An exploration into how women in Northern British Columbia maintain their health in their isolated settings concluded that health resources are limited in number and variety, but also in the manner that they are provided (Leipert & Reutter, 2005). Women described examples of being objectified and dismissed by their providers, especially physicians (Leipert & Reutter, 2005). In agreement with the BC study, women in my study described public health nurses as approachable, and women appreciated the time, education, and respect that these nurses accorded them. Some participants chose to access care at the Public Health Office despite having a regular family physician. Many other participants who were happy receiving care within their family physician's office reported that the nurses employed by the physician to provide reproductive healthcare made this location preferable to them.

Financing is available for locum programs to address physician shortages in Northern Ontario (Mian & Strasser, 2017). These measures can compromise the continuity of care, resulting in a breakdown of the physician-patient relationship and loss of trust, but are essential to maintain the existing physician pool (Danish, Blais, & Champagne, 2019). Some women in my study preferred leaving the north to obtain care in the urban south, as did some women in British Columbia (Leipert & Reutter, 2005). Women in the BC study stated that leaving for care was a temporary strategy to decrease exposure to vulnerabilities and supplement resources while benefiting from better quality care (Leipert & Reutter, 2005). A group of Ontario researchers recently conducted a systematic review and qualitative meta-synthesis to elaborate on women's issues accessing cervical cancer screening in rural and remote areas of high-income countries (Majid et al., 2019). Like the participants in my study, the authors state that satisfaction with care depends on whether women have a comfortable rapport with their providers (Majid et al., 2019). In common with my study, the included Canadian studies reported fear and mistrust of northern healthcare providers arising from underlying perceptions that providers in rural and remote areas are poorly qualified and questionably competent, amplifying the distrust (Majid et al., 2019). Cited barriers to care were familiar and included: providers with a discriminatory, demeaning, or disdainful attitude; absence of continuity of care, partially due to locums; and perceptions of limited privacy due to the intimate nature of their communities (Majid et al., 2019).

A lack of privacy and anonymity with one's healthcare provider is another barrier introduced through rural and remote residency and contributes to embarrassment and discomfort (Racey & Gesink, 2016). Small communities frequently suffer from less clarity between people's professional and social relationships with their healthcare providers, offering no true privacy (Racey & Gesink, 2016). Socially constructed norms of gender privacy contribute to the

discomfort and embarrassment experienced by many women, and rurality may worsen as there is less choice of a provider's gender and a lack of social distance (Majid et al., 2019). In my study, many participants favoured traveling to southern Ontario to access quality care more anonymously, despite the limits on continuity of care.

In summary, accessing reproductive healthcare in Northern Ontario is generally hampered by a shortage of family physicians and female providers. Despite these health human resource constraints, participants rated their care as fair to good. This relatively high rating may be a product of tempering expectations as the compromises for residing in more remote areas are well known and accepted by many. Locum healthcare providers are more common in the north and are required to meet the needs overall. Building a trusting relationship with one provider is more complicated under these circumstances. Faith in confidentiality within the healthcare encounter is questioned by northerners, with many feeling that it is not possible due to the small, close-knit communities. Some participants responded by traveling out of the region for care. In contrast, others accept the limitations of their northern residency but may avoid meeting their reproductive healthcare needs under the current climate of limited choice and questionable quality.

#### ***7.4.2 Gendered Work, Gendered Care, and the Gender of Practitioners***

Gender is only one social category among many that interacts with healthcare delivery. As my study aimed to be sensitive to diversity, a solely gender-based analysis would fail to capture the range of circumstances contributing to women's health disparities (Angus et al., 2013). The participants reported encounters with health services that intensified their social marginalization and negatively influenced their intentions to return for care. Expressing agency, women may not seek reproductive healthcare if they experience discrimination from their

providers (rurality, gender, race, class, language). Reducing bias in healthcare is an important goal, and non-physician providers can be guilty of providing discriminatory care. Regardless, increased access to alternative providers perceived by the woman as having the capacity to relate to their situations may improve adherence to recommended care (Majid et al., 2019). Female providers for female health consumers are favoured by most women, perhaps primarily due to their relatability.

Historically, male-dominated professions excluded women from professional status and channeled them into supporting roles with limited scopes of practice or autonomy (Adams & Bourgeault, 2004). This resulted in a shortage of female health care providers that has persisted for more than a century. A preference for female providers of women's reproductive healthcare has been demonstrated in my study and has been a critical finding in quantitative and qualitative studies. Female health professionals, nurses, midwives, or doctors, are assumed to be contraceptive users, conferring real expertise based on embodied knowledge (Lowe, 2005). In the current age of gender fluidity, a critique of this essentialist approach includes visually identifying female practitioners, which is crude to determine phenotypic congruence with a socially constructed taxonomy (Acquaviva and Mintz, 2010). For women from religious-cultural backgrounds in which separation and seclusion of the genders is a societal norm, a preference for female providers is even more robust, related to privacy and concerns about modesty (Aubrey et al., 2017). A study of immigrant women in Alberta found that some women report accepting a male provider in recognition of the structure of the Canadian healthcare system and its limited ability to meet their preference for female providers (Aubrey et al., 2017). Women made concessions for social acceptability and acute situations, but for many, care by a male provider can lead to psychological stress, delays, or avoidance in seeking care (Aubrey et al., 2017).

The discomfort of reproductive care may be shared between health consumers and their providers, as there is evidence that male providers feel uncomfortable providing reproductive healthcare and are aware of the preference for female providers (Aubrey et al., 2017). Participants in my study reported being acutely aware of their provider's discomfort. The act of prioritising the wellbeing of women subverts the patriarchal origins of modern medicine, defined as destabilising or damaging established beliefs (Hawke, 2021). Prioritising the consumers of care preferences may mean being explicit about the importance of female providers and acknowledging the potential for harm if we cannot meet these needs, despite the destabilising effect that this may have on our notions of gender equity.

#### ***7.4.3 Person-Centred Care***

Since the early 20th century, scientific advances in biomedicine have privileged 'cure' over 'care,' and it has become apparent that we need synthesised, humane, and personalised caring and curing practices (Goldenberg, 2014). There are critical calls for humane medicine, which would prioritise empathy, understanding, and compassion within all health care transactions (Goldenberg, 2014). Individual agency and responsibility are essential components in the process of accessing reproductive healthcare services. Providers can help women to engage in recommended care by being culturally responsive, establishing communication, and addressing institutional and provider biases, often grouped under the banner of "person-centred care" (Angus et al., 2013). PCC prioritizes essential outcomes to the patient, such as communication, over technical and process measures (Lines, Lepore, & Weiner, 2015). PCC can also be understood for what it is not: not paternalistic, not disease-centered, and not technology-driven, and considers the person's desired level of participation in shared decision-making (Majid, Kandasamy, Farrah, et al., 2019). Shared decision-making is critical to PCC. It depends

on the acceptance of the premise that individual self-determination is a goal and that healthcare professionals should support their clients or patients to achieve that goal (Begley, Daly, Panda, & Begley, 2019). Self-determination can exist despite the power asymmetry when there is equality in discourse, facilitated by the provider who has the superior position (Begley et al., 2019). PCC starts with the health care provider initiating conversations to invite discussion and sharing, leading to preserving personhood, respect, and agency (Ollivier et al., 2018).

In reviewing the results of my study, I needed to consider the issues preventing clinicians from engaging in person-centred care. A British study set out to understand what health professionals know about PCC. Although unable to name the core concepts, they summed it up as building a relationship, which includes transferring information bi-directionally, and actively engaging (Adams et al., 2018). Irish care providers cited barriers to the provision of this care, which include a lack of resources or time; concerns about litigation; financial incentives favouring increased intervention; the constraining effects of guidelines and policies; clinicians age, male gender, limited confidence, and skills; and a tendency to lean towards the provider's convenience (Ollivier et al., 2018, Begley et al., 2019). A meta-analysis of 26 studies concluded that female primary care providers engage in more patient-centred communication and spend more time with their patients than male colleagues (Roter, Hall, and Aoki, 2002).

Accommodating requests for female providers can be viewed as providing culturally sensitive PCC, respecting patients' values, preferences, and expressed needs (Aubrey et al., 2017). Despite some studies that appear to indicate that PCC is gendered, the provision of PCC is not the domain of female providers. Any healthcare worker willing to take the time for trust-building and information sharing, regardless of gender, can offer PCC, as reported by several

interviewees. Repeated visits with one provider can contribute to the establishment of a person-centred, continuity of care relationship.

Patients are increasingly cared for by various providers, raising concerns about fragmented care and its contribution to lower quality care and poorer outcomes (Haggerty et al., 2003). Continuity of care refers specifically to relational continuity of the ongoing therapeutic relationship between a patient and their provider, which is less common in rural areas (Kristjansson et al., 2019). As a component of person-centred care, the research consistently shows a strong relationship between continuity of care and patient satisfaction and improved uptake of preventative care, improved health outcomes, and cost-effectiveness (Kristjansson et al., 2013). An investigation into factors associated with continuity of care in Ontario concluded that rural areas report lower continuity and more locums (Murphy, Burge, & Wong, 2019). Subsequent research confirmed that more physicians in rural areas employ nurses as members of the practice staff, reducing continuity with one provider (Kristjansson et al., 2013, Murphy et al., 2019). Despite the potential for fragmented care, participants in my study favored nurses' care within their physician's offices. They did not report concerns about continuity or PCC for this substitution. A review of PCC and continuity of care in rural areas concluded that increasing access and comprehensiveness in a rural setting comes at the cost of continuity as non-physician healthcare providers can improve access to care (Murphy et al., 2019). However, as expressed in my study, rural women may be willing to make this trade-off if it entails receiving their reproductive healthcare from midwives. The same review recommended that future research examine the roles of alternate clinicians in the provision of rural and remote PCC, which is the purpose of the current study. Quality care can be delivered under conditions resembling continuity of care in rural and remote areas through flexibility.

A consistent core group of staff and providers can ensure that care is connected and coherent (Haggerty et al., 2003). For patients and their support people in rural and remote settings, the experience of continuity is the perception that providers know their history, agree on a management plan, and that a known provider will be available in the future (Haggerty et al., 2003). This relationship of friendliness and mutual trust can contribute to decision-making that relies on a full exchange of information in a non-urgent, non-authoritarian, cooperative setting (CMO, 2015). Using cervical cancer screening as an example, an enabler of attendance is a positive or meaningful relationship with a healthcare provider (Racey & Gesink, 2016). A caring relationship and joint responsibility for screening, where the patient takes responsibility for care-seeking, and the provider creates a safe space for sharing, improves screening rates and uptake of other reproductive healthcare services (Racey & Gesink, 2016). Health professions curricula should continue to confront systemic inequities perpetuated by generations of oppression to train providers in anti-racist cultural competence, enabling them to develop an understanding of patients' values and concerns, leading to equitable decision-making that honours autonomy and beneficence (Neel et al., 2017). Health care providers should use gender-neutral language, be sensitive to cultural and historical issues, and explain to patients what to expect before, during, and after examinations (Gorfinkel, Perlow, & Macdonald, 2021). Midwives are well situated to provide care that prioritizes spending time to develop relationships of trust and respect and engaging in the sharing of expertise, information, and experiences.

## **7.5 Midwives as Acceptable Reproductive Healthcare Providers (Question 5)**

There is a uniqueness about midwifery care that resulted in a significant percentage of women residing in Northern Ontario stating that this is their preferred provider for reproductive healthcare, even among women who had never received care from midwives. Midwives grant

authority to other ways of knowing, including feelings, past experiences, insights into lifestyle, and moral or religious motivators, supporting a relational approach to support autonomy (MacDonald, 2018). In evaluating caseload midwifery practice in the UK, midwives favored their relationships with women, characterised as 'professional friends,' focusing on support and care provision, appropriate to the individual (McCourt & Stevens, 2006). Factors such as flexibility, choice, and patient control have previously been essential facilitators for cervical cancer screening (Racey & Gesink, 2016) and were significant findings in my study, all of which are the stated goals of midwifery practice.

Participants in my study showed an understanding and appreciation for the role of midwives in our healthcare system. While only 6.5% of survey respondents currently access cervical cancer screening at a midwife's office, nearly a third of them (29.8 %) would choose a midwife if available. Many were agreeable to midwives providing reproductive healthcare outside of pregnancy, even those who had never been cared for by midwives. Rural women, with lower incomes, and no family physician were most likely to make this choice. Some interviewees expressed that the great thing about midwives is the relationship you build with them and offered that their comfort level would be higher with a midwife. Those with experience under midwifery care liked that the appointment times weren't rushed. For participants seeking PCC, the interviewees described personalized care and praised the way that midwives care for the women and their families, meeting the definition of inclusive patient-directed care. With respect to continuity of care, interviewees suggested that the existing relationship with your midwife through regular screenings, would extend seamlessly into care when its time to have a baby. One interviewee stated that if you already known them and you are not just meeting them when you are first pregnant, it would be nice to have that history with them heading into pregnancy.

Finally, one interviewee shared that she believes that midwives are specialists, specialists in reproductive healthcare. Rather than going to see someone who's a generalist, she stated that it is more comfortable to see someone who specializes in this area.

Feminism is the paradigm that allows midwifery content to align with the midwifery context, as feminism recognises power imbalances inherent in the inflexible systems, resulting in limitations on proper choice (Hawke, 2021). Shared decision-making, PCC, and informed choice describe the partnership model of midwifery care (MacDonald, 2018). Midwifery's commitment to informed choice as a principle of care, both in the sense of a consumer's right to choose a caregiver and make decisions about the care, was a challenge to the status quo medical monopoly but appeared to meet consumer demands for transparency (MacDonald, 2018). Informed choice foregrounded the midwifery professionalisation movement to provide coherence for the campaign and make it legible to a hostile medical profession and skeptical public (MacDonald, 2018). Informed choice lies in contrast to informed consent, circumscribed by how medicine is often portrayed, with short appointments, doctor-patient hierarchy, and limited continuity of care (MacDonald, 2018). Women report generally agreeing with physicians through a subliminal avoidance of antagonism (Hawke, 2021). The midwifery movement encouraged women to combine their biomedical information with their own experiences to increase their knowledge and sense of empowerment in their care (MacDonald, 2018).

The Task Force on the Implementation of Midwifery (1987) recommended that Ontario enact a Midwives Act in which the midwife's scope of practice is defined consistently with the international definition where the role involves antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and childcare (ICM, 1972). In 1991, midwifery became a profession in Ontario, and "registered midwife" became a

protected title (MOH, 1991). Only individuals registered with the College of Midwives CMO are eligible to practice midwifery in Ontario legally. The only exceptions are Aboriginal Midwives (AM), who are exempt as stated in the Midwifery Act (1991) (Six Nations Health Services, 2012). The Association of Ontario Midwives (AOM) lists midwives' contributions to well-woman gynecological care, including cervical cancer screening, STI screening, sexual complaint screening, contraception counseling/family planning, preconception counseling, and breast examination (AOM, 2001).

Despite strong international, national, provincial, and local support for a consistent definition, the 1991 *Midwifery Act* (1991) adopted a more limited scope for Ontario midwives. The *Midwifery Act* (1991) outlines the scope of midwifery practice as follows: "the practice of midwifery is the assessment and monitoring of women during pregnancy, labour and the postpartum period and of their newborn babies, the provision of care during normal pregnancy, labour and the postpartum period and the conducting of spontaneous normal vaginal deliveries." A change to this scope of practice, for example, mirroring the international definition of the midwife, could be advocated for by the College of Midwives of Ontario (CMO), subject to prior review by the Ministry of Health and Long-Term Care (MOHLTC) and approval of the Lieutenant Governor in Council. An expansion of scope would allow the midwives currently residing in Northern Ontario to expand the services available to their communities. Scope of practice expansion would simultaneously increase the need for midwives in the north, contributing to the profession's growth.

In 2008, the College of Midwives of Ontario proposed legislative changes to the Ontario midwifery scope of practice intending to reflect current and emerging maternity care best practices, providing more flexibility for members, allowing responsiveness to the community,

and supporting midwives' participation in interprofessional care (CMO, 2008). Although claiming to represent the voices of consumers, no consultation informed the request for expansion of scope. The CMO postulated that these changes would enable midwives to contribute to the health human resource shortage, support efficient use of healthcare resources, and allow timely, seamless, efficient, and cost-effective access to primary care (CMO, 2008). The CMO (2008) asserts that there are communities in Ontario facing severe health human resource shortages. An extended scope of practice for midwives would alleviate some of the existing gaps in service to women and infants and relieve the pressure on strained local health service delivery systems. In response, the *Regulated Health Professions Statute Law Amendment Act* (2009) allowed amendments to the *Midwifery Act* (1991) in December 2009. Still, the scope of practice review did not result in midwives expanding their scope to include reproductive healthcare outside of pregnancy and postpartum. Absent from these discussions were the voices of the people who are consumers of reproductive healthcare. This research collected women's voices in Northern Ontario to inform future reviews of Ontario midwives' scope of practice and hopefully work towards timely, accessible reproductive care.

Midwifery as a profession is still experiencing scrutiny as its potential to inform feminist theory has not been fully realised. It has historically struggled with its definition of expertise and knowledge (Adams & Bourgeault, 2004). The system of professions (Abbotts, 1988) is a complex, dynamic, and interdependent structural network of a group of professionals within a given domain of work, claiming knowledge, skill, and expertise, defined as jurisdictions (Bourgeault, 2006). There was early suspicion among advocates and adversaries directed towards the emergence of a 'new' profession during contentious times, deemed a 'pilot project' or health experiment, while simultaneously providing an opportunity for the government to

demonstrate to physicians that they can be replaced in the birthing rooms of Ontario (Rushing, 1993). The basic tenets of midwifery, including individualised, continuous, and non-authoritarian care provision (Sharpe, 1998), seemed antithetical to the healthcare system's often authoritarian, fragmented, and routinized care delivery model (Van Wagner, 2004). Professions develop through interrelations with other disciplines when a jurisdiction becomes vacant.

Vacancies occur in response to external system disturbances, such as technological or organisational change, or because an earlier tenant has abandoned the work (Bourgeault, 2006). Midwives filled a vacancy in the reproductive healthcare field by replacing family physicians as they left obstetrics and being the only care provider supporting homebirth. Despite their designation as primary care providers, midwives remain subordinated, under the watchful gaze of obstetricians (Bourgealt, 2006). The history of midwifery can be seen as a struggle over occupational territory (Hastie, 2006). This new profession had to grapple with the inevitable fall-out of professionalisation and regulation and the exclusionary nature of both. In response, midwives expressed concerns that involvement in regulation could create pressure to conform to medical standards and create hierarchical models of training and practice that could undermine women's choices (Van Wagner, 2004). Van Wagner, a practicing Ontario midwife, worried that pressure could lead midwives away from their roots as advocates and partners with women towards increasing the use of technology (Van Wagner, 2004). She lamented that midwives could be confined to physician assistants rather than using their skills to promote birth as a healthy process and a significant event in a woman's life (Van Wagner, 2004). Midwifery needs to develop a knowledge base of reproductive care that can withstand the dominance of physicians and create model profession more compatible with modern feminism (Adams & Bourgeault, 2004).

Policymakers know that healthcare organizations are built on human capital and emphasize that a skilled, knowledgeable, and committed workforce is required for quality experiences and optimal health outcomes (Macfarlane, Greenhalgh, Humphrey, et al., 2011). Midwifery is just such a workforce. The rebirth of midwifery in Ontario drew upon science and feminist ideologies, including cementing women's control over their reproductive lives and aspirations of female empowerment for legitimacy (Adams & Bourgeault, 2004). The integration of midwifery into the Ontario healthcare system is a case study of a successful, organized, predominantly female, and professionally based effort directed at the state. As such, it demands a broader consideration of the dynamics of the relationships between women, both as consumers and care providers, other professions, and the state (Bourgeault, 2006). Although potentially exclusionary and elitist, regulation and professionalisation offered many advantages to midwives and reproductive healthcare consumers. Midwifery would need to learn how to navigate its role within feminist ideologies while realising the benefits of its professional status and seeking political power for survival.

Despite the opportunity for midwives to play a more prominent role in providing reproductive healthcare, those who wish to practice in rural or remote communities face many difficulties. These include challenges in recruiting and retaining associate midwives and skilled second attendants for adequate back-up and support, maintaining sufficient caseload when birth rates fluctuate, managing clients across large catchment areas, driving long distances, accessing locum coverage, and negotiating hospital privileges at small rural hospitals. There is also insufficient funding to cover the additional costs of running a rural or remote midwifery practice (AOM, 2015). There are a limited number of retention initiatives for midwives in rural and remote areas but no recruitment initiatives. Unlike both nurses and physicians, there is no tuition

support program for midwives working in rural and remote communities, nor are there funds available to assist midwives with moving expenses and the higher cost of living in rural, remote, and northern locations (AOM, 2015). Health providers in rural and remote communities may benefit most from the new inter-professional health teams because there are limited human resources. Collaboration will benefit consumers as some providers may have more expertise than others in certain areas (Connecting Care Act, 2019). Historically, several barriers to effective inter-professional care existed in rural and remote communities. These included a lack of awareness about the skills and qualifications of other health professionals, fears over liability and risk, and unstable funding to support inter-professional work (Iglesias, Grzybowski, Klein, Gagné, & Lalonde, 1998). Team-based care has expanded considerably over the last 15 years in Ontario. A recent analysis of provincial data showed that physicians, particularly females, serving higher needs populations (rural, low income) are more attracted to team-based practice (Haj-Ali, et al., 2020). If continued, this trend could help alleviate the shortage of female providers in the north, but the funding and frameworks for interdisciplinary practice need to remain stable. Considering incentives and removing barriers will be required before midwives can be effective team members, able to provide full reproductive healthcare.

The delivery of care involving midwives could potentially take a multitude of forms. Some argue that inter-professional teams are best positioned to deliver rural primary healthcare, which helps overcome barriers to care due to recruitment and retention and geographical isolation (McPherson & McGibbon, 2010, Haj-Ali, 2020). Canada has embraced this idea through several iterations of provincial health acts as the best response to address increasingly complex healthcare needs within a framework of social accountability, with hopes of better access, improved quality, increased satisfaction, and the efficient use of resources (McPherson &

McGibbon, 2010, Haj-Ali, 2020). Other approaches prioritize task-shifting or discipline substitution as a strategy to address problems associated with the shortage and mal-distribution of healthcare providers, allowing providers to develop competency in areas of clinical care otherwise reserved for physicians (WHO, 2012). In a study of strategies to optimize the delivery of contraceptives, outcomes for intra-uterine device (IUD) insertion and tubal ligations were comparable between midwives and physicians (Polus et al., 2015). Change depends on an adequate pool of qualified midwives able to work in clinics that embrace new roles within a policy context that allows for negotiation of local goals, rather than imposing a standard set of requirements (Macfarlane, Greenhalgh, Humphrey, et al., 2011). So as not to get left behind in emerging health planning, midwives need an institutional voice in primary care conversations, where representation from physicians and nurses is common (Mattison, Lavis, Hutton, Dion, & Wilson, 2020). Midwives cannot achieve change without the support of physicians. A partnership where physicians are committed to improving access, quality, and efficiency is possible (Lewis, 2013). Identifying critical junctures when conditions are ripe for institutional change may allow midwives to move past the constraints imposed by policy legacies (Mattison et al., 2020).

Midwifery is poised to play a more significant role in providing reproductive healthcare in Northern Ontario, as evidenced by consumer support for expanding the scope of practice demonstrated in this study. My study is an example of engaging the public as a stakeholder, considered key before considering regulatory initiatives (Leslie & Nelson, 2017). Efforts towards change would also benefit from collaboration with other reproductive healthcare providers, which may be enabled through the regional health teams recently created by the current government (Connecting Care Act, 2019). The integration will require an increased awareness by

other team members about midwives' skills and abilities and transparent discussions about any liability implications of sharing care. Adequate resources will be necessary for the education of health care providers and towards the midwifery workforce's growth to fulfill this critical mandate. With its emphasis on PCC, midwifery practice could manifest feminism in action (Hawke, 2021). The most subversive act of midwifery may lie in providing PCC in reproductive health care with its tenets of amplifying the consumer's voice, practicing informed choice through shared decision-making, and honouring bodily autonomy (Hawke, 2021).

## **7.6 Study Limitations and Future Research**

As the primary researcher, I was careful to disclose my identity, acknowledging that power dynamics can influence data collection and analysis. There is an inherent potential for abuse in reconstructing accounts of others' lives, minimised through researcher accountability. Reproductive research continues to culturally privilege the image of the white, western, nuclear family, thereby constructing those outside this image as 'other' (Reiger & Liamputpong, 2010). In my study, 86% of survey respondents identified as white, and I am a white researcher. The same question about racial identity was not asked of the interviewees. The results of this study may be limited by my white, culturally privileged lens. I checked transcripts with informants and immersed myself in the same experiences by accessing reproductive healthcare personally in Northern Ontario, which aided my reflexivity by requiring me to interrogate my emotions, embodiments, identities, and allegiances (Rice, 2009). I accept that my research provides only a glimpse into the lived experiences of accessing reproductive healthcare in Northern Ontario. While the participants' experiences are valuable in and of themselves, in line with feminist standpoint, I do not hold these accounts as universal truths and accept the possibility of bias on all of our parts. I seek to look at the gendered system of care and make suggestions to improve

healthcare structure, choosing to focus my critiques on the material conditions of care-seeking while avoiding conclusions on the conditions of the participant's lives. This study claims no universal truth.

This study sought the perspectives of anglophone and francophone residents of Northern Ontario by offering the survey in French and English. I piloted the survey with fourteen women, three of whom spoke French as a first language. I now understand that ensuring a robust translation would have required a back-translation of the French version back to English to ensure readability and confirm the clarity of the questions in French (Mujiyanto, 2016). This last step was not done and exists as a limitation to my study. I cannot assure the reader that some misinterpretation of survey questions didn't happen among francophone respondents. Due to my limited ability to communicate in French, all interviews were conducted in English.

To redesign the methodology for this study, I would recommend enquiring from whom participants are receiving reproductive health care rather than where they are receiving this care. It was not until I began interviews that I realised that many women have access to care within their family doctor's office, provided by non-physicians. Due to this revelation, I cannot comment on what percentage of the greater than 60% of women currently accessing this care at their family doctor's office are receiving it from their family doctor. Also, I did not ask about the language used by their reproductive care providers resulting in a knowledge gap about whether francophone women were receiving care in French.

Within the orthodox paradigm of our current healthcare system, we can become overwhelmed with the enormity of tackling quality and access issues, but further examination of reproductive health care access is warranted. This fatigue can cause us to limit our examinations to the micro-system, remaining occupied with client interactions and administrative practices.

This myopic approach ignores the structures beyond the individual, such as health system or organisational factors that impede access to care. Professional jurisdictions, occupational and status hierarchies, and gender implications for providers, clients, and care areas are among these high-level barriers. Underlying these barriers are meanings, beliefs, and moral norms that constitute cultures, representing the context of care delivery. The social structuring of activities and practice, the interactional characteristics of care, social boundaries, organisational and professional cultures, power dynamics of care delivery, and the regulatory, political, and institutional contexts of care are still in need of further examination (Waring, Allen, Braithwaite & Sandall 2016). Asymmetries of knowledge continue to shape the social interactions within reproductive healthcare-seeking. However, influence over quality control by health consumers introduces a semblance of power within the social organisation of healthcare. The reproductive health care experiences of men, the disabled, LGBTQ+, and non-binary individuals still needs examining.

## 7.7 Reforming Reproductive Healthcare

Updating the current system for the provision of reproductive healthcare would require significant changes (i.e., a paradigm shift) to the existing healthcare system. Thomas Kuhn defines a paradigm as a package of claims about the world, methods for gathering and analyzing data, and scientific thought and action (Kuhn, 2012). Revolutions occur when one paradigm replaces another (Kuhn, 2012). Revolutionary periods involve a breakdown of order and questioning the game's rules (Kuhn, 2012). This period is followed by rebuilding that can create fundamentally new conceptual structures (Godfrey-Smith, 2006). Applying Kuhn's thinking around revolutions as a prerequisite for a paradigm shift, I seek to use the author's insights to the provision of reproductive healthcare in Ontario

A growing sense of dissatisfaction inaugurates revolutions, exposing that an existing paradigm has ceased to function adequately. The 'reproductive revolution' may commence when consumers of care demand change. The ongoing austerity measures applied to healthcare spending in the preceding decades, aggravated by expenses associated with Covid-19, may represent a crisis. Significant changes may be necessary for sustainability. Healthcare practitioners may divide into competing camps or parties, with physicians more likely to seek to defend the old institutions that served them well. Through virtue of their shared training and experience, the professional group populating the old paradigm believes that they are the sole possessors of the requisite knowledge for providing reproductive healthcare. The transfer of allegiance from one paradigm to another is a conversion experience that cannot be forced, and resistance is inevitable and legitimate (Gorham, 2012). Hesitancy towards the introduction of midwives in Ontario may serve as an example. Conversions will occur continually until the last holdouts have ceased practicing. All current practitioners now operate under a different paradigm than 100 years ago (Gorham, 2012), perhaps aided by the feminization of medicine. The most prevalent claim advanced by the proponents of the new paradigm is that they can solve the problems that led the old paradigm to a crisis. The recommended discipline substitution translates into less-expensive care providers offering the same care previously provided by physicians while remaining acceptable to consumers. Ideally, this change will result in increased adherence to recommended screenings and treatments. Solutions need to be tested through research, exploring the alternatives, and improving delivery (Gorham, 2012). The new paradigm suggests that new cadres of practitioners can provide reproductive healthcare, representing a shifting of associated tasks previously performed by physicians to other providers.

When challenging the medical model paradigm, the frame for analysis is our healthcare system, which structures the patient-professional interaction, connecting the patient's lived experiences with the medical system, the state of knowledge, and the social statuses of all concerned (Lorber & Moore, 2002). A biomedical representation of reproductive health gives physicians a monopoly over the therapeutic aspects and undermines experiential means of knowing or situated knowledge (Riska, 2003). This control will always carry gender, class, and racial/ethnic assumptions and agendas (Riska, 2003). Most reform efforts have focused on improving access and reducing costs rather than expanding coverage. However, even in these areas, Canada appears to be under-achieving, ranking in the bottom third among prosperous countries on safety, quality, access, and efficiency (Lewis, 2013). As an example, spending on healthcare doubled between 1998 and 2010. However, neither improved access nor expansion of services resulted, suggesting that more deeply rooted organisational factors and practice cultures are significant obstacles to improvement (Lewis, 2013). Improving access to rural and northern health services has been a goal of successive governments over many decades, evidenced by the creation of the Northern Ontario School of Medicine and the current Health Force Ontario, which added non-physician providers to the strategy (Whaley, 2020). In the future, any attempts at reforming reproductive healthcare delivery must be accompanied by robust health policy, stable funding, and accountability for quality by providers. For tackling persistent challenges, Canada needs to develop a vision and action plan for sexual health care in rural and northern areas. This will require a sustained and coordinated approach to well-being that aligns sexual health and policy with local leadership and accountability for health outcomes (National Academies of Sciences, Engineering, and Medicine 2021). The new millennium brought a new policy environment, emerging from the lessons learned from the past (Hutchison, Levesque,

Strumpf, & Coyle, 2011). Policy legacies, along with professional and public values, can limit the possibilities for radical reform as there is no single "right" model and no single best funding or payment method. Change can be difficult and expensive, and significant investments are required for system transformation and infrastructure (Hutchison et al., 2011). Despite these challenges, our goals, and objectives for healthcare in Canada should mirror those presented by the Institute of Medicine (2001) in their report titled *Crossing the Quality Chasm: A New Health System for the 21st Century* (Institute of Medicine, 2001). They include:

- Improved access to services
- Expansion of team-based approaches
- Improved quality/appropriateness (focus on prevention)
- Emphasis on patient engagement/self-management and self-care
- Community/public participation in decision-making and responsiveness to needs
- Greater health equity

The health reform suggestions from my study focus on the 'where,' how,' and 'who' of reproductive healthcare. The health system must adapt to support the sexual health needs of the population that effectively meets their social, spiritual, psychological, and physical needs (Ollivier et al., 2018). Additional training of health care providers needs to include knowledge and sensitisation about gender, caste, and other forms of socioeconomic inequality that result in poor care and communication skills to bridge the distance (Sen et al., 2018). There are fewer formal rules for applying the non-technical aspects of medicine. PCC may require a more complex skill set than ranking studies according to an evidence hierarchy (Goldenberg, 2014). The necessary skills include introspection, compassion, understanding, and interpersonal abilities, along with sound clinical judgement (Goldenberg, 2014). Teaching empathetic and

caring behaviours seems relegated to the more informal clinical teaching sites, where superiors act as role models (Sen et al., 2018). In practice, trainees are more likely to observe provider distancing and rationing of care due to resource shortages (Sen et al., 2018). The participants in my study clearly stated a preference for person-centred care (PCC). PCC acts as an enabler by building familiarity and trust, perhaps leading to a fondness for one's caregiver. A good relationship with the care provider was the number one reason for adherence to recommended preventative reproductive care. That same trust and familiarity reduces the main barrier to reproductive healthcare, embarrassment. Residents of Northern Ontario consider midwives an acceptable option for their reproductive healthcare. The extension of the midwife's scope beyond providing care in pregnancy and birth towards full reproductive healthcare would be an innovation in healthcare in Ontario.

According to a multi-level model of diffusion of innovations in healthcare organizations, human resource management starts with the individual and their capability, capacity, and motivation, to deliver the innovation (Macfarlane, et al., 2011). Applied to my study's findings, it leads us to question whether midwives are capable and motivated to deliver reproductive healthcare outside of pregnancy and postpartum and whether there is capacity within the profession to expand their scope of practice. In considering midwives' abilities, one must consider their limited numbers and their knowledge base or requirements for additional training. There are over one thousand midwives of Ontario Midwives (AOM) as of May 2021 (AOM, 2021). Midwives attended 18% of Ontario's 142 444 births in 2019 (AOM, 2021). Midwives are thinly distributed across the province, particularly in Northern Ontario, with limited resources to provide care within the current scope of practice. For recruitment and retention, pay increases and benefits comparable to other health professions are needed. Midwives need choice in

payment models, employee status, and work schedule, as part-time or full-time options could improve work-life balance and assist in retaining midwives in the profession. (Zeytinoglu et al., 2020). In rural and remote communities, midwives may be well-positioned to expand their scope to include well-woman care (AOM, 2015). Concerning the knowledge capacity of midwives to provide reproductive healthcare, they would need some additional training and funding for these services. The College of Midwives of Ontario has already begun modifying midwives' active practice requirements to allow greater flexibility to work in alternative ways to support community needs (AOM, 2015). Towards health workforce optimization, the scope of practice for any provider must remain flexible enough to serve the efficient and effective use of human health resources (Leslie et al., 2021). Regulatory frameworks need to be more nimble for innovations and modernisation in our healthcare system that is responsive to community needs (Leslie et al., 2021).

Scopes of practice limitations applied unevenly are an example of a policy legacy with implications to access. A recent environmental scan found that Quebec and Ontario are the only provinces where midwives cannot prescribe contraception (Currie, Marquez, & Darling, 2020). In New Zealand, Australia, the USA, Sweden, Norway, Netherlands, Finland, and France, midwives with similar education to Canada can prescribe oral contraceptives and insert IUDs (Currie et al., 2020). The authors conclude that cost savings and increased access to contraception could be realised if contraceptive prescribing and administration were included in the scope of practice of all Canadian midwives (Currie et al., 2020). Concerning access to abortion, the International Confederation of Midwives (ICM) position statement on midwives' provision of abortion-related services states that a woman who seeks or requires abortion-related services is entitled to be provided with such services by a midwife (Fullerton, Butler, Aman,

Reid, & Dowler, 2018). There is a wide range of investigative and implementation science research examining the safety, efficacy, and acceptability of midwives' involvement in abortion-related care, demonstrating the feasibility and utility of midwives (Fullerton et al., 2018). Considering the scarcity of abortion providers in Canada, midwives could expand access to abortion care (Patten, 2009). They are well-suited to provide first-trimester medical abortions, which offers women privacy, accessibility, and control over the process (Patten, 2009). A survey of over two-thirds of midwives practicing in Ontario in 2015 found support for expanding the scope of practice to include medical abortion. Still, interest waned as more surgical techniques were considered (Handa & Rosenberg, 2016). Midwives identified several barriers to providing abortion services which included unknown compensation, poor hospital integration, and opposition from clients (Handa & Rosenberg, 2016). As a leader in midwifery nationally, Ontario emerged as the first province to regulate the profession and has the largest and most established workforce. Women in positions of power may instigate change as physicians, health administrators, and politicians because the issues are more extensive than a practitioner pool, and individual health cannot exist without social justice (Boscoe et al., 2014). Health care providers need to collaborate with other stakeholders to advocate for systemic changes to remove health affecting inequities such as poverty and racism (Boscoe et al., 2014). While cognisant of gains achieved with creating new, more woman-centred services, woman-centred research still struggles for funding. There are no funds dedicated to community-based, consumer-controlled services for women (Boscoe et al., 2014). With investment in education to grow the profession, midwifery could provide the human capital to optimize reproductive health outcomes and justify a seat at the health policy table.

Regulatory initiatives, such as expanding midwives' scope of practice, must align with the public interest and should not be mistaken for enhancing the profession (Leslie & Nelson, 2017). Optimizing the ability of midwives to contribute to positive health outcomes could be the objective that meets the requirement for public benefit (Wilkie & Tzountzouris, 2017). Unfortunately, health system transformation initiatives in Ontario have restricted midwifery's integration through policy legacies related to payment mechanisms and limits on roles and scope of practice (Mattison et al., 2020). A broad coalition of consumers fought for midwifery. If midwives remain in short supply, the women most likely to benefit, including rural and northern women, have the least access (Boscoe et al., 2004). Recent healthcare reforms in Ontario have focused on health teams within community-based settings, where midwives have demonstrated excellent health outcomes and high levels of client satisfaction (Hutton, Reitsma, & Kaufman, 2009, O'Brien et al., 2011, Hutton et al., 2018, Elderhorst, Ahmed, Hutton, & Darling, 2019). As an example of policy legacies, questions remain about why midwives were excluded from the Patients First primary care reform, especially given their focus on person-centred care and commitment to community-based interdisciplinary practice (Patients First Act, 2016). Midwives were not integrated because the focus of the reform was confined to service provision by doctors and nurses only, likely due to a lack of visibility of midwives in the policy arena (Mattison Lavis, Hutton, et al., 2020). Midwifery payment mechanisms also act as a barrier to reform. The current payment systems privilege physician-provided, hospital-based services, which exist as a policy legacy, with the unintended consequence of constraining the policy options available today (Mattison et al., 2020). The public healthcare system remains true to its roots by compensating 91% of hospital care and 99% of physician care while not always absorbing the costs of non-physician professionals (Lewis, 2013). The government's inclination to expand the

scope of publicly financed services waxes and wanes based on the ideology of the day and the province's fiscal circumstances (Lewis, 2013). As the roll-out of the Ford government's restructured system is new, it remains to be seen if more recent changes can meet their stated objectives.

Returning to the model of diffusion of innovations in healthcare organizations, human resource management also needs to appreciate the interpersonal, organisational, and external levels for successful implementation (Macfarlane et al., 2011). At the interpersonal level, opinion leaders and change agents are helpful promoters. However, at the organisational level, changes to the healthcare system are often constrained by less immutable factors such as health policies, legislation, the prevailing economic climate, and political leanings (Macfarlane et al., 2011). Examples include the ambitious *Rural and Northern Healthcare Framework*, funded by the MOHLTC in 2011 to identify rural and northern health priorities and create a vision for the future of healthcare. The goal was to provide appropriate access and achieve equitable outcomes for rural, remote, and northern Ontarians (MOHLTC, 2011). In agreement with the *People's Health Care Act* (2019), the *Rural and Northern Healthcare Framework* depended on several guiding principles, including community engagement, flexible local planning, and delivery, integration, and innovation; being connected and coordinated; evidence-based, and sustainable (People's Health Care Act, 2019, MOHLTC, 2011). The *Rural and Northern Healthcare Framework* also proposed that further enhancing scopes of practice for health providers working in rural and remote communities would increase interprofessional care and improve access to health services (MOHLTC, 2011). Current health policy led to the creation of health teams, resulting in more patient-centred, seamless care (People's Health Care Act, 2019). One modern healthcare delivery initiative specific to reproductive healthcare and considered radical in the UK

involves developing a generic qualification in sexual health. It is open to physicians, nurses, and midwives and does not seek to replace other traditional qualifications (Macfarlane, Greenhalgh, Humphrey, et al., 2011). This initiative provides further support for the introduction of non-physician providers. Health consumers informing the delivery of care may be more flexible about who provides their care if it is delivered in a PCC way.

From the current study, we know that midwives are appropriate primary healthcare providers for reproductive healthcare in Northern Ontario, in line with recommendations from the *Rural and Northern Healthcare Framework* of 2011 and in keeping with current initiatives as mandated in the *People's Health Care Act* (2019). Access, diversity, and inclusion are explicit goals of the modern social health movement. Midwives pursue these goals by reaching out to marginalised communities, holding places for immigrant women, encouraging diversity in their ranks, recognising the need for cultural competency as practitioners, and advocating for systemic changes (MacDonald, 2016). Despite knowing for nearly a decade about the required changes to improve care delivery, the necessary adjustments for policies that guide midwifery practice have not been evident.

It remains to be seen whether the interdisciplinary health teams that resulted from the *Government for the People Act* (2019) will achieve their stated purpose of putting the patient at the centre of an efficient and effective healthcare system. Organisational culture plays a role, and success may depend on the decentralisation of power, enabling physicians, midwives, and nurses to work similarly (Sen et al., 2018). Although midwives are appropriate reproductive healthcare providers, they are joined on that list by nurses, nurse practitioners, and physicians with PCC skills. Health planners need to broaden the scope of practice to apply to specific health services, such as reproductive healthcare, instead of select healthcare professions (Blythe & Baumann,

2006). Reform will not be possible without sustained financial and organisational support from the provincial government. This approach aligns with the UK idea of the generalist reproductive healthcare specialist that crosses disciplines. These changes also require a context-driven rather than discipline-specific approach, with best-practice consisting of the expansion of health networks, maximization of the contributions of all health professions, and the collection of statistical data to inform future health planning (Blythe & Baumann, 2006). Study participants have been clear about their preferences for the delivery of reproductive healthcare. It remains for health planners to appreciate the barriers and enablers faced by reproductive healthcare consumers and respond with policy changes to enable equitable access to quality care.

Special mention about changes to Indigenous healthcare delivery is warranted as a roadmap exists for community consultation regarding healthcare delivery sensitive to institutional and structural racism. The historical abuses that may make it difficult for first persons to relate to providers in authority positions can potentially lead to the avoidance of healthcare-seeking and health disparities (Ringer, 2017). The Truth and Reconciliation Commission (TRC) of Canada provided a starting point for recognising the profound health inequities facing Indigenous peoples resulting from the legacy of colonialism, leading to present-day racism and persistent health disparities (McNally & Martin, 2017). There must be greater recognition and a deeper understanding through the direct involvement of Indigenous peoples in care planning, recognising unique social determinants of health for Indigenous peoples associated with colonization and racism (Ringer, 2017). Indigenous women face significant geographic and social barriers to accessing culturally safe care, particularly in remote and northern communities (AOM, 2015). The government of Ontario should work with Indigenous leadership to support culturally safe care and self-determination in Indigenous communities,

which should include enhanced funding and support for recruiting, training, and funding Indigenous midwives and other Indigenous health professionals (AOM, 2015, McNally & Martin, 2017).

The COVID-19 pandemic has affected the provision of reproductive healthcare. While medical care was available for services considered essential, sexual, and reproductive health care services and procedures were disrupted in significant ways (Balkus, 2020). Access to sexual and reproductive health prevention services, procedures, and medications have been delayed, altered, and drastically reduced due to compliance with quarantine measures and the focus on addressing COVID-19 (Riley, Sully, Ahmed, & Biddlecom, 2020). There are substantial reductions in screening for breast cancer, cervical cancer, human papilloma virus and other asymptomatic sexually transmitted infections (STIs) (EHRN, 2020). The supply chain for several pharmaceuticals that support sexual and reproductive health, including treatment for STIs, HIV treatment and prevention, hormone therapy, contraception, and medical abortions, may be disrupted because of COVID-19 (Ahmed, Dawson, Donovan, et al., 2020). Individuals with limited access to a reliable internet connection, have unstable housing, or who live in residences where it is difficult to find a private space for an open conversation with a medical provider, may continue to have reduced access to care (Broom, 2020). It is critical that we recognize how adjustments to services and medications might increase disparities to access. Changes to local and national policies may be required to minimize the impact of revised sexual and reproductive health care practices to support access, particularly for populations in rural, remote, and northern settings.

In February 2021 Laurentian University declared insolvency and began restructuring under the *Companies' Creditors Arrangement Act* (CCAA), which is a federal law allowing

insolvent corporations that owe their creditors more than \$5 million to restructure their business and financial affairs (Government of Canada, 2016). Part of the restructuring included closing the School of Midwifery on April 30, 2021. The School of Midwifery at Laurentian University graduated 30 new midwives annually and was the only bilingual midwifery school in Canada. As only 90 midwives graduated annually from the previous three Midwifery Education Programs, this represents a one third reduction in new practitioners. These reductions will limit the number of new midwives practicing in Northern Ontario, particularly francophone midwives. Although midwives may embrace providing reproductive health care outside of pregnancy, the school closure will limit the ability of midwives to fill this service provider gap in northern settings.

## **7.8 Conclusions**

Throughout the history of modern healthcare, assurances of quality and safety have been the responsibility of the healthcare professionals with their claims of expertise and demands for autonomy and self-regulation (Waring, et al., 2016). Fundamental advances in knowledge and practice were prohibited by the broader politics of professional power, especially if it questioned the legitimacy of the emerging medical profession (Waring, et al., 2016). More recently, there has been recognition that improving quality and safety needs to address broader care systems, requiring that sociologically informed work could offer complementary and critical insights into these issues (Waring, et al., 2016). There is an emerging consensus that developing the theoretical, methodological, and empirical foundations necessary to advance the study of quality care with an inclusive and multidisciplinary approach is required, leading to the evolution of policy, practice, and research (Waring, et al., 2016). My study adds a brick to this foundation as it addresses service quality and gender as conceived and completed by a practitioner-researcher.

My study sought to examine the experiences of women in accessing reproductive healthcare in Northern Ontario. Good news: most rate themselves as healthy and able to access healthcare services. Participants also rated their reproductive healthcare from fair to good. However, distinct areas for improvement were identified, including increased access to female providers, less locum coverage, thereby favouring continuity of care as part of the package of relational care, termed person-centred care. These were the enablers that could encourage increased uptake of recommended care. Barriers to reproductive health care access were also explored and include less choice of providers and limited physicians, especially females. Judgemental care, non-supportive administrative practices and staff, and limited time for questions or information sharing also hampered access to care. Non-physician reproductive healthcare providers cannot provide needed care due to regulations and dated health policies. Midwives are an acceptable reproductive healthcare provider for women in Northern Ontario, as a primarily female cadre with expertise in PCC provision. Midwives will not be able to play a more significant part in improving access to person-centred reproductive healthcare until they are seated with government and health planners to remind everyone about the ability of midwives to meet many stated objectives towards modernizing Ontario's healthcare system. A paradigm shift may need to occur. Health leaders need to acknowledge midwives' expertise and be willing to champion the cause of a more significant role for midwives. An expansion of the scope of practice to include reproductive healthcare outside of pregnancy may result in more accessible reproductive healthcare in Northern Ontario. But Canada has moved so slowly on the journey to expand and improve Medicare that it stands accused of "paradigm freeze"—stuck in a system just good enough to prevent any significant change or improvement from ever occurring (Caron & Martin, 2020). A rich body of literature exists on how to fix wait times in Canada.

Strengthening primary care and home care so that most care occurs with a provider who knows you well and is easily accessible is key to eliminating waits for specialists (Caron & Martin, 2020). Midwives are primary care providers able to provide community-based PCC. Maximizing their ability to meet their communities' essential reproductive healthcare needs could reduce wait times and increase the time physicians can spend with other patients.

The receipt of healthcare services results from several complex processes that need to be understood to ensure equitable access. The design and delivery of care exist within a sociopolitical context that must also be appreciated, as disparities in access are intensified by gender. The factors affecting women's access to health resources, such as lower education, lower income, and geographic isolation, are compounded and intensified in rural, remote, and northern areas. These factors influence health-seeking behaviours by constraining choices and reducing access to healthcare. As feminist research, my study privileged women's knowledge and acknowledged the importance of agency and context in women's lives. My study took an approach that explicitly recognised the social determinants of health for women who live in rural and remote areas of the province. Selecting women as the study population recognises gender as a discreet and essential determinant of health worthy of scrutiny. Through a combination of quantitative and qualitative methods, my study drew on women's experiences to create a clear picture of what it means for women to access reproductive healthcare in Northern Ontario. My investigation uncovered their challenges as members of specific social and geographic communities in this rural and remote area to explore options for alleviating inequities in health outcomes related to the intersections between gender and geography. Conveying this information to decision-makers and healthcare planners is necessary to improve how people access care. This research attempted to be responsive to women's needs in context to guide reproductive healthcare

planning and policy development. Policies should be responsive to women who reside far away from southern metropolitan areas, as health policy created in the south of the province may not resonate with residents of northern communities.

My study sought to investigate how these determinants interact to compound their influence on reproductive healthcare access. It is essential to understand the individual within their social, economic, and cultural contexts and apply methods that prioritize the accounts and interpretations to their reproductive healthcare encounters. One must appreciate that people's ways of thinking and acting are embedded in their broader context and cannot be understood independently. Hostile and invalidating interactions in the healthcare system happen throughout the province. However, the difference for people residing in the north or rural and remote areas, accessing an acceptable care provider may not be possible, causing women to avoid care. Lack of choice threatens confidentiality disproportionately in smaller communities due to few to no options for care. We know that equal access to the full spectrum of reproductive healthcare prevents morbidity and mortality and supports the advancement of women in society (Espey et al., 2019). Limited access serves to keep women residing in northern areas less healthy and hinders their advancement in society.

My study reinforces our understanding of the value of interpersonal aspects of care and the importance of involving health consumers in their care, leading to increased satisfaction with care, ideally translating into increased adherence to recommended care. Improved outcomes are assumed, as interventions that enhance patient participation in decision-making improve health due to shared decision-making (Carlson, 2000). Should the findings of my study initiate changes to the delivery of reproductive healthcare in Northern Ontario, health consumers may feel that they contributed to changing established ways of working, customary practices, and dominant

forms of power and authority. Expanded scope of practice for midwives will likely be met with resistance by those with vested interests. Overcoming this final barrier will require political acuity due to the enduring nature of Ontario's institutional and professional power in healthcare. The idea of midwives contributing to improved access to person-centred reproductive healthcare in Northern Ontario holds interest among healthcare consumers. It awaits only institutional policy support to be realised, subject to the motivation of health planners to meet the needs of women in remote locations.

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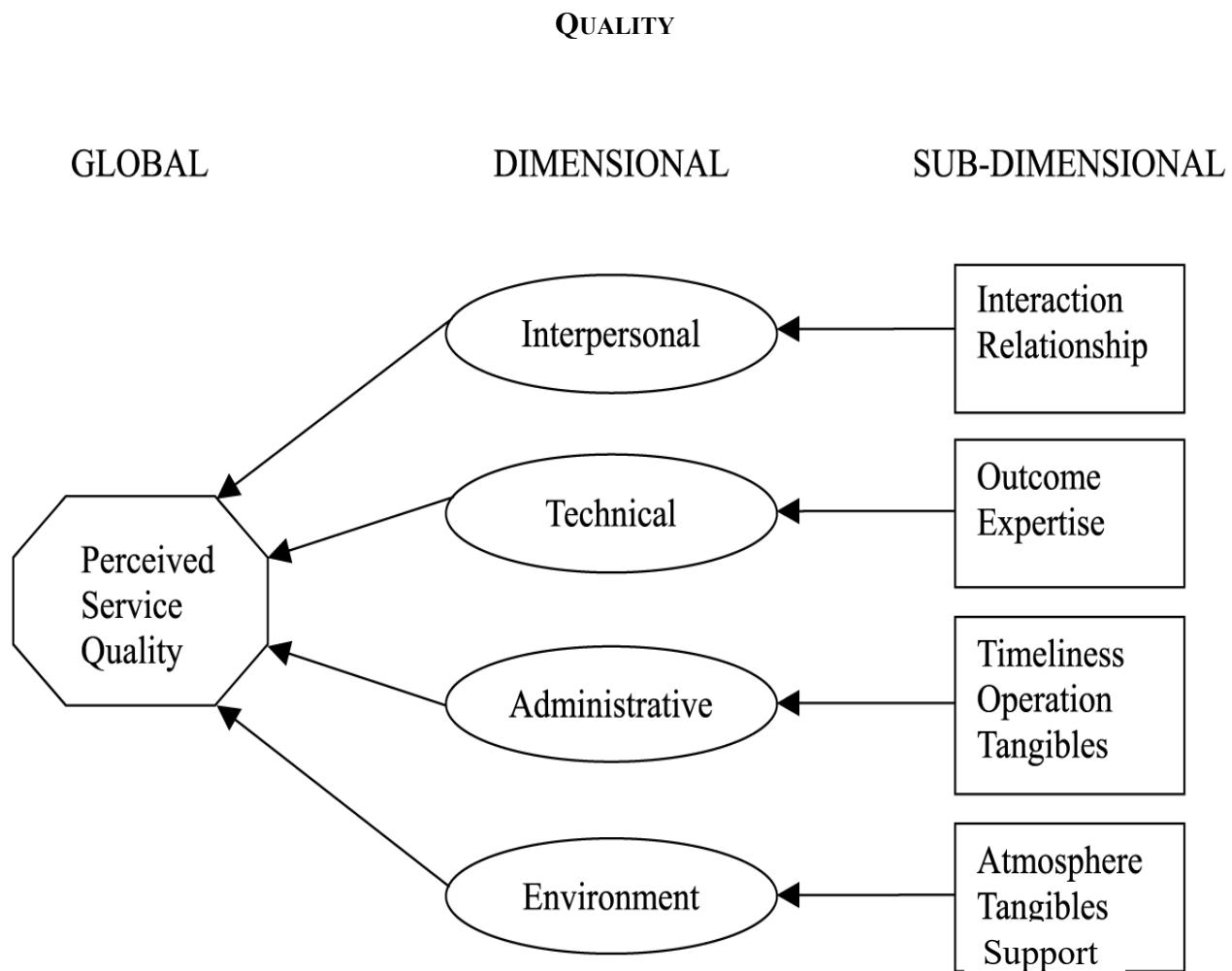
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<https://doi.org/10.1001/jama.2019.19003>

## **APPENDIX A: CONCEPTUAL FRAMEWORK HIERARCHICAL MODEL OF HEALTH SERVICE**



**Source:** Dagger *et al.* (2007)

Dagger, T.S., Sweeney, J.C. & Johnson, L.W. (2007) A hierarchical model of health service quality: scale development and investigation of an integrated model. *Journal of Service Research*, 10(2), 123-142.

## **APPENDIX B: TRUSTWORTHINESS PROTOCOL**

I have chosen to conduct a multiple methods study, which combines both a quantitative and qualitative approaches. Potentially problematic, is that quantitative and qualitative paradigms have differing philosophic premises and purposes that must be understood and maintained for credible research outcomes. The two are not incompatible, but comparing the two approaches in terms of trustworthiness of findings, requires a unique lens for each approach (McBrien, 2008). According to Schwandt, Lincoln and Guba (2007), trustworthiness involves establishing credibility, transferability, dependability, and confirmability. These headings are included in the table below under the heading of criterion (criteria) for trustworthiness. Credibility refers to ensuring confidence in the truth of the findings, corresponding with internal validity in quantitative research (Malterud, 2001). This can be otherwise understood to mean the extent to which what is observed is a true representation of the variable under investigation (McBrien, 2008). Transferability attempts to show that the findings have applicability in other contexts which equates with generalizability or external validity. That being said, findings are not meant to be valid for large groups of the population, making random sampling a less than ideal approach for qualitative inquiry (Malterud, 2001). Dependability shows that the findings are consistent and could be repeated (reproducibility). Confirmability refers to the degree of neutrality or the extent to which the findings are shaped by the respondents and not researcher's biases, motivations, or interests, considered equivalent to objectivity (Schwandt, Lincoln and Guba, 2007).

Criterion	Activities/Technique	Actual Activity	Evidence of Activity	Dates Planned & Completed
credibility	<p>Research conducted using qualitative methodology with established guidelines (qualitative description).</p> <p>Member checks on transcripts.</p> <p>Reflective journal kept throughout project with reflections recorded after each interview.</p>	<p>Carefully following guidelines for analysis.</p> <p>Transcripts were sent to participants to allow them to edit for accuracy. They were asked “Does the interview transcript reflect your words during the interview?”</p> <p>Biases, beliefs and assumptions recorded at outset and continually throughout research process.</p>	<p>Steps are referenced.</p> <p>Email trail exists of exchange of documents. All interviews were recorded and saved.</p> <p>Reflexive diary available for audit.</p>	<p>Continuous referral since 2013.</p> <p>Transcripts were sent to participants within 1 week of their interview and returned within 1 week to researcher for revisions if necessary.</p> <p>Diary began within 1<sup>st</sup> month of studies and maintained to date.</p>
transferability	<p>Confirming key demographic details to provide context for investigation.</p> <p>Purposive sampling.</p>	<p>Compared demographics of interview respondents with general population in Northern Ontario to ensure similar.</p> <p>Interview participants were grouped based on age group,</p>	<p>Demographic info is provided for both the population and interview participants.</p> <p>Approach journaled. Tally provided in summary.</p>	<p>General populations stats obtained before start of project.</p> <p>Participant stats provided through interview request form.</p> <p>Approach confirmed prior to data collection.</p>

	<p>Audit trail - Anonymized raw data available to academic committee.</p> <p>Researcher's reflective diary.</p>	<p>language, rural or urban residence and experience with midwives.</p> <p>Interviews, transcripts, themes and summaries provided to committee.</p> <p>Biases, beliefs and assumptions recorded at outset and continually throughout research process.</p>	<p>Confirmed receipt of materials.</p> <p>Reflexive diary available for audit.</p>	<p>Will remain available through defense.</p> <p>Diary began within 1<sup>st</sup> month of studies and maintained to date.</p>
dependability	Development of an audit trail.	The following documents are available for audit: raw data, analysis materials, process notes, and instrument development info.	My academic committee has access.	Data, analysis & synthesis documents were submitted to my committee in August 2017.
	Research conducted using qualitative methodology with established guidelines (qualitative descriptive approach and grounded theory for analysis).	Carefully following Charmaz “Constructed Grounded Theory” guidelines for analysis.	Steps are referenced.	Continuous referral since 2013.

<b>Criterion</b>	<b>Activities/Technique</b>	<b>Actual Activity</b>	<b>Evidence of Activity</b>	<b>Dates Planned &amp; Completed</b>
confirmability	Reflective diary contains noted personal feelings, insights, and methodological decisions.	Regular entries were made throughout the research process which allowed me to record methodological decisions and reasons, study logistics, and reflections pertaining to my own values and interests.	Diary exists and is available for review.	Throughout the research process, my academic committee have been aware of my journal and free to review.
	Member checking	Interview participants were asked to clarify language. An example would be if they used the word “holistic”. They were asked what “holistic” meant to them.	Transcripts clearly show these lines of inquiry.	While interview in progress, more indepth explorations were made of word choices and meanings.
	Triangulation	Triangulation of sources; qualitative results compared with quantitative results for consistency.	Comparison chart produced.	Completed following qualitative analysis.
	Development of an audit trail in reflective diary.	Regular entries were made throughout the research process which allowed me to record methodological decisions	Journal available for examination	Notes made throughout process.

### Member Checks

Member checks are one of the most robust mechanisms of assuring credibility as it involves seeking the participant's views on the honesty and consistency of the findings (McBrien, 2008). Through this process, interview participants were asked to confirm that the transcript produced by me was a true and fair account of their experiences. Several participants provided additional insights which were added to the end of the transcripts.

### Peer Debriefing

Enlisting the assistance of experienced colleagues can enhance validity and safeguard against researcher bias (McBrien, 2008). I consider my academic committee to serve this role as they are alerted to inappropriate subjectivity and guard against attempts to fit interpretations that cannot be substantiated by the data. I also acknowledge that my advisors did not have the same involvement with the data, compared with me as the principal researcher. My in-depth familiarity with the data and the subject's world will undoubtedly affect my subsequent interpretations. I ask my committee to assess the persuasiveness and coherence of my work, as well as challenge the robustness of the merging themes (Angen, 2000).

### Audit Trail

Schwandt, Guba and Lincoln (2007) suggest that auditability is important to developing a defensible position. I have been careful to detail the decisions that I made along the entire length of the project in order to establish a clear audit trail. My notes account for my methodological decisions, interpretations and investigator biases, which allows for insight into my research judgements. The ability to follow the decision trail relating to theoretical, methodological and analytical choices is an important indicator of trustworthiness (McBrien, 2008). I used these notes to set the agenda, debrief, share ideas and discuss issues arising during our committee meetings.

### Reflexivity

A researcher's background and position will affect what they choose to investigate, the approach taken, the methods deemed most appropriate, and the framing and communication of conclusions (Malterud, 2001). In order to remain objective and produce confirmable research, I recognised that knowledge is partial and situated, and attempted to account for the effects of my position. Bias can be accounted for but not eliminated through such an approach. I rely on my committee to evaluate the extent to which I identify and explicate my involvement and its potential and actual affect on the findings. I have maintained a reflective journal throughout the study in order to promote critical thinking and to record information about my decisions, insights and progress.

### Triangulation

Triangulation has been defined as the combination of two or more theories, data sources, methods, or investigators in one study of a single phenomenon, leading to confirmability and completeness (McBrien, 2008). Because I am conducting a multiple methods study, I am able to compare the results of the quantitative portion with the qualitative findings. I am aware that they operate on different paradigms and that there is a danger that one will dominate. Also, combining methodologies leads to a high degree of complexity as my two methods come with distinct frameworks.

### Negative Case Analysis

Negative case analysis calls for the analysis of cases in which the outcome that had been predicted by the theory did not occur, which must lead to an expansion of the theory's range of explanation (Emigh, 1997). Through negative case analysis I was able to identify outliers. I found that some women liked their GP and felt that there was genuine compassion and mutual respect. These examples do not cause me to change my hypothesis or expand on my theories.

They are in line with the elements that the participants have reported matter to them. It is a minority of participants who are receiving this sought after care.

## **APPENDIX C: INTERVIEW GUIDE**

### **Introduction**

Purpose of study. What interview is going to cover. Issues around confidentiality. Methods of recording.

### **Opening Questions**

What has your experience been in accessing healthcare for yourself?

- Timely access?
- Quality?
- Concerns?

What would be your ideal healthcare setting and conditions? Distance from home? Physical environment (clean, comfortable, clear directions, ample parking)? Does the sex of your provider matter to you? Does it matter whether you see the same provider on subsequent visits? Are the administrative staff friendly when you call or visit? Is this important to you? Are you able to make same day appointments? Does your care provider allow for walk-in appointments? Do you have to wait long to be seen? Are you seen on time?

### **Main Body of Interview**

What has your experience been in getting Pap tests?

- Timely access?
- Quality?
- Concerns?

What has your experience been in accessing family planning information / birth control?

- Timely access?
- Quality?
- Concerns?

What has your experience been in getting sexually transmitted infection screening?

- Timely access?
- Quality?
- Concerns?

Have you ever needed to access abortion counselling or services? What has your experience been in accessing these services?

- Timely access?
- Quality?
- Concerns?

Tell me about your best gynecological experience. Why?

Tell me about your worst gynecological experience. Why?

Do you feel comfortable discussing your sexuality or sexual health concerns with your current caregiver?

Do you feel that your cultural or linguistic background affects your experiences with your reproductive healthcare?

What are your opinions of midwives in general?

What is your knowledge of midwives in Ontario?

- Competent?
- Trustworthy?

Would you feel comfortable discussing your sexual health concerns with your local midwife? In the survey you were asked to rank your choice of location/caregiver for your reproductive healthcare. What was your first choice and why? Did you list your local midwifery clinic as one of your three choices? Why or why not?

Would you feel comfortable receiving preconception counselling, STI screening, family planning / birth control counselling, abortion counselling and /or Pap testing at your local midwifery clinic?

### **Finishing the Interview**

Do you have any suggestions for the overall organization of reproductive healthcare?

Any additional information that you would like to share that may be relevant?

Thank you for participating in this research. Your input is very valuable for improving on our current reproductive healthcare through the collection of information from the consumers of this care.

## APPENDIX D: ETHICS CERTIFICATE



### APPROVAL FOR CONDUCTING RESEARCH INVOLVING HUMAN SUBJECTS

Research Ethics Board – Laurentian University

This letter confirms that the research project identified below has successfully passed the ethics review by the Laurentian University Research Ethics Board (REB). Your ethics approval date, other milestone dates, and any special conditions for your project are indicated below.

TYPE OF APPROVAL / New / Modifications to project / Time extention
<b>Name of Principal Investigator and school/department</b> Lisa Morgan, School of Rural and Northern Health Susan James, supervisor, Midwifery Program
<b>Title of Project</b> The Perceptions of Women in Northern Ontario About Their Reproductive Health Care
<b>REB file number</b> 2014-01-09
<b>Date of original approval of project</b> May 9, 2014
<b>Date of approval of project modifications or extension (if applicable)</b>
<b>Final/Interim report due on:</b> <i>(You may request an extension at that time using this weblink)</i> May 9, 2015
<b>Conditions placed on project</b>

During the course of your research, no deviations from, or changes to, the protocol, recruitment or consent forms may be initiated without prior written approval from the REB. If you wish to modify your research project, please refer to the Research Ethics website to complete the appropriate REB form.

All projects must submit a report to REB at least once per year. If involvement with human participants continues for longer than one year (e.g. you have not completed the objectives of the study and have not yet terminated contact with the participants, except for feedback of final results to participants), you must request an extension using the appropriate REB form.

In all cases, please ensure that your research complies with Tri-Council Policy Statement (TCPS). Also please quote your REB file number on all future correspondence with the REB office.

Congratulations, and best of luck in conducting your research.

A handwritten signature in blue ink that reads "Rosanna Langer".

Rosanna Langer, Acting chair  
Laurentian University Research Ethics Board

## **APPENDIX E: CONSENT TO PARTICIPATE IN RESEARCH**

You are being invited to participate in a research project. My name is Lisa Morgan and I am the primary researcher.

### **Title**

The Perceptions of Women in Northern Ontario about Their Current Reproductive Healthcare

### **Project Summary**

I will be surveying and interviewing women in Northern Ontario about their perceptions about their reproductive healthcare (paps, sexually transmitted infection diagnosis and treatment, birth control counselling, pregnancy care and abortion services) and about their preferences for caregivers in order to make recommendations for improving this care. It is accepted that perceptions of good quality leads to satisfaction with care which leads to more women presenting to their local clinics for the recommended healthcare.

### **Researcher**

I am a full-time student in the Interdisciplinary Health PhD offered by the School of Rural and Northern Health at Laurentian University. My academic advisors are Dr. Elizabeth Wenghofer and Dr. Rachel Ellaway. I am also a lecturer in the Midwifery Education Program at Laurentian University and a practicing midwife in Cambridge Ontario. Currently, my project has no outside funders or sponsors.

### **Nature of Participation**

The survey should take 10-15 minutes to complete. The survey can be completed on-line or on paper and returned by post. Only those who indicate at the end of the survey that they are willing to be interviewed will be asked to provide contact information along with demographic information in order to choose a representative sample to interview. Also, participants who would like a copy of the summary of the research findings will be asked to provide either an email address or address where the summary can be sent. Only women 18 years and older can participate. Women who agree to be interviewed will be contacted by me to arrange for a time, date and location for the interview. The interview will last from 30-60 minutes. All women interviewed will be sent a summary of our interview and my analysis to comment on accuracy and make any changes or corrections they wish.

### **Incentives**

One dollar (\$1) for each completed survey will be donated to the Canadian Women's Health Network on behalf of the study participants. The Canadian Women's Health Network (CWHN) was created in 1993 as a voluntary national organization to improve the health and lives of girls and women in Canada and the world by collecting, producing, distributing and sharing knowledge, ideas, education, information, resources, strategies and inspirations. At the beginning of each interview the participant will be given a \$10 Tim Horton's card. The card is a gift and does not require that the interview be completed. The participant can refuse to answer any questions and stop the interview at any time and keep the gift card.

### **Risks or Discomforts**

There is the potential for participants to experience stress during the completion of the survey due to the sensitive nature of the topic. If a participant feels uncomfortable, she has the right to discontinue participation temporarily or permanently. By consenting, participants have not waived any rights to legal recourse in the event of research-related harm. If you do experience stress as a result of the survey or interview, I recommend that you discuss this with your local healthcare provider or seek advice by calling the Ontario Mental Health Helpline at 1-866-531-2600.

### **Voluntary Nature of Participation**

Participation in this study is voluntary. You are free to withdraw your consent at any time. At any point during the survey or interview, you may refuse to answer a question or stop participating entirely. If you choose to withdraw, your survey will be destroyed and not reported.

### **Confidentiality**

The data collected will be coded and password protected. During analysis, data, including surveys and interview transcripts, will be stored in a locked cabinet, in a locked room, in a locked building. Only I will see the raw data. My academic advisor and committee members may view the data once coded and anonymity is assured. All audio recordings will be destroyed following successful defense of my thesis. Coded data (anonymous) will be kept indefinitely which may allow for secondary analysis or future research. Every effort will be made to protect participant's confidentiality.

### **Conflicts of Interest**

There are no real, potential or perceived conflicts of interest on the part of the researcher or her institution. The research findings will not be commercialized.

### **Dissemination of Research Findings**

The participants will not be identified on any research findings. A summary will be made available to all participants via the study website, email or mail. The summary will be distributed to local media such as newspapers and radio for dissemination. The findings will be presented at conferences and published in peer-reviewed journals.

### **Questions about the Study**

If you have questions about the research, please contact Lisa Morgan, Principal Investigator (705) 675-1151 ext. 3969, or toll free at 1-800-461-4030 x 3969    [lmorgan@laurentian.ca](mailto:lmorgan@laurentian.ca)

If you have questions regarding possible ethical issues in the research, please contact:

Ethics Officer at Laurentian University.      1-800-461-4030      [ethics@laurentian.ca](mailto:ethics@laurentian.ca)

Participants will be considered to have consented to the use of the data they provide once the “Submit” button has been pushed (web-based) or the postal survey has been received.

## **APPENDIX F: ENGLISH SURVEY**

### **Survey of Northern Ontario Women's Perceptions About Their Reproductive Health Care**

The survey should take 10-20 minutes to complete. Only those who indicate at the end of the survey that they are willing to be interviewed will be asked to provide contact information. Participants who would like a copy of the summary of the research findings will be asked to provide either an email address or a street address where the summary can be sent. **At any point during the survey, you may refuse to answer a question or stop entirely.** If you choose to withdraw, your survey will be destroyed and not reported. You must be at least 18 years of age to participate. If you do experience stress as a result of the survey or interview, I recommend that you discuss this with your local healthcare provider or seek advice by calling the Ontario Mental Health Helpline at 1-866-531-2600.

How did you find out about this survey?

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Public health office | <input type="checkbox"/> Radio                        | <input type="checkbox"/> Newspaper     |
| <input type="checkbox"/> Midwifery clinic     | <input type="checkbox"/> Friends                      | <input type="checkbox"/> Family        |
| <input type="checkbox"/> Doctor's office      | <input type="checkbox"/> Poster                       | <input type="checkbox"/> Health center |
| <input type="checkbox"/> Speaker at a talk    | <input type="checkbox"/> Other. Please specify: _____ |  |

What are the first 3 digits of your postal code? (e.g. P0B) \_\_\_\_\_

People often identify themselves with a particular racial group. To which do you belong?

Mark or check the one that best describes you.

- |  |
|--|
| <input type="checkbox"/> Aboriginal or Native (e.g. Innu, Inuit, Metis, First Nations)     |
| <input type="checkbox"/> South Asian (e.g. East Indian, Pakistani, Punjabi, Sri Lankan)    |
| <input type="checkbox"/> Southeast Asian (e.g. Cambodian, Indonesian, Laotian, Vietnamese) |
| <input type="checkbox"/> Middle Eastern (e.g. Armenian, Egyptian, Iranian, Lebanese)       |
| <input type="checkbox"/> Asian (e.g. Chinese, Korean, Japanese)                            |
| <input type="checkbox"/> Black (e.g. African, Caribbean)                                   |
| <input type="checkbox"/> Latin American (e.g. Mexican, South American, Central American)   |
| <input type="checkbox"/> White   |
| <input type="checkbox"/> Filipino  |
| <input type="checkbox"/> Other. Please specify: _____                                      |

Mixed Race (please list all groups that apply):  
\_\_\_\_\_

Are you culturally/linguistically francophone?

Yes \_\_\_\_\_ No \_\_\_\_\_

What is your highest level of education completed?

- Primary school
- High school
- College or University
- Masters level degree
- PhD

What is your annual family income?

- 0 - \$24,999
- \$25,000 - \$49,999
- \$50,000 - \$99,999
- \$100,000 - \$199,999
- Above \$200,000

Please circle the most appropriate response.

	Poor	Fair	Good	Excellent
How would you rate your health?	1	2	3	4
How would you rate the availability of health care services in your community?	1	2	3	4
How would you rate the quality of the health care services that are available in your community?	1	2	3	5

Do you have a family doctor?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, would you recommend your doctor to your friends?

Yes \_\_\_\_\_ No \_\_\_\_\_ Maybe \_\_\_\_\_

The following questions refer to reproductive health care (Paps, birth control, pregnancy care, sexually transmitted infection screening and treatment, abortion counselling) you receive from your health caregiver. This may be your family doctor, midwife, nurse or a nurse practitioner. If you do not have a regular caregiver, answer the following questions based on your most recent experience with reproductive health care at a walk-in clinic, health center, or any other health facility.

Please circle the most appropriate response.

	Strongly Disagree	Agree			Strongly Agree		
	1	2	3	4	5	6	7
I believe the clinic is well-managed.							
The clinic's operating hours meet my needs.							
The staff and I talk about the things that are happening in our lives, and not just about my medical condition.							
I leave the clinic feeling encouraged about my care.							
The clinic works well with other health providers (e.g. specialists).							
The clinic smells pleasant.							
The atmosphere at the clinic is pleasing.							
I feel good about the interaction I have with the staff at the clinic.							

	Strongly Disagree	Agree			Strongly Agree		
	1	2	3	4	5	6	7
I believe having care at the clinic has been worthwhile.							
The quality of the service provided at the clinic has been impressive.	1	2	3	4	5	6	7
The physical environment at the clinic is of a high standard.	1	2	3	4	5	6	7
I have said positive things about the clinic to my family and friends.	1	2	3	4	5	6	7
My care has produced the best possible outcome.	1	2	3	4	5	6	7
The clinic frequently runs support groups and programs for patients.	1	2	3	4	5	6	7
Coming to the clinic has increased my chances of improving my health.	1	2	3	4	5	6	7
Overall I am satisfied with the clinic and the service it provides.	1	2	3	4	5	6	7
I believe that my future health will be good as a result of attending the clinic.	1	2	3	4	5	6	7
Generally appointments are on time.	1	2	3	4	5	6	7
I like the “feel” of the atmosphere at the clinic.	1	2	3	4	5	6	7
I would highly recommend the clinic to other patients.	1	2	3	4	5	6	7
Next time I need care, I will come to this clinic again.	1	2	3	4	5	6	7
The overall quality of the service provided by the clinic is excellent.	1	2	3	4	5	6	7
I intend to continue having care and any follow-up care I need at this clinic.	1	2	3	4	5	6	7

	Strongly Disagree	Agree			Strongly Agree		
	1	2	3	4	5	6	7
I believe that the outcomes of my care will be the best they can be.							
I feel hopeful as a result of having care at the clinic.	1	2	3	4	5	6	7
I believe the staff at the clinic are highly skilled at their jobs.	1	2	3	4	5	6	7
The staff at the clinic are concerned about my well-being.	1	2	3	4	5	6	7
I feel the staff at the clinic understand my needs.	1	2	3	4	5	6	7
The administration at the clinic are at a high standard.	1	2	3	4	5	6	7
The clinic keeps waiting time to a minimum.	1	2	3	4	5	6	7
I like the interior decoration (e.g. style of furniture) at the clinic.	1	2	3	4	5	6	7
The furniture at the clinic is comfortable.	1	2	3	4	5	6	7
The quality of care I receive at the clinic is excellent.	1	2	3	4	5	6	7
The staff at the clinic explain things in a way that I can understand.	1	2	3	4	5	6	7
I always get personalized attention from the staff at the clinic.	1	2	3	4	5	6	7
The staff at the clinic always listen to what I have to say.	1	2	3	4	5	6	7
I have built a close relationship with some of the staff at the clinic.	1	2	3	4	5	6	7
The administration system at the	1	2	3	4	5	6	7

	Strongly Disagree	Agree			Strongly Agree			
clinic is excellent.		1	2	3	4	5	6	7
I believe the physical environment at the clinic is excellent.								
You can rely on the staff at the clinic to be well-trained and qualified.	1	2	3	4	5	6	7	
I am impressed by the care provided at the clinic.	1	2	3	4	5	6	7	
My feelings toward the clinic are very positive.	1	2	3	4	5	6	7	
The staff at the clinic carry out their tasks competently.	1	2	3	4	5	6	7	
The staff and I sometimes kid around, laugh or joke with each other like close friends.	1	2	3	4	5	6	7	
The clinic staff treat me like an individual and not just a number.	1	2	3	4	5	6	7	
The colour scheme at the clinic is attractive.	1	2	3	4	5	6	7	
I feel good about the quality of care given to me at the clinic.	1	2	3	4	5	6	7	
I believe the staff at the clinic care about me.	1	2	3	4	5	6	7	
The registration procedures at the clinic are efficient.	1	2	3	4	5	6	7	
I feel satisfied that the results of my care are the best that can be achieved.	1	2	3	4	5	6	7	
I feel good about coming to this clinic for care.	1	2	3	4	5	6	7	
I believe that the clinic offers a service	1	2	3	4	5	6	7	

	Strongly Disagree	Agree			Strongly Agree		
	1	2	3	4	5	6	7
<b>that is superior in every way.</b>							
The temperature in the clinic is pleasant.	1	2	3	4	5	6	7
The clinic records and documentation are error free.	1	2	3	4	5	6	7
The interaction I have with the staff at the clinic is excellent.	1	2	3	4	5	6	7
The lighting at the clinic is appropriate for this setting.	1	2	3	4	5	6	7
The clinic provides patients with an excellent range of services.	1	2	3	4	5	6	7
I intend to follow the medical advice given to me at the clinic.	1	2	3	4	5	6	7
The clinic looks attractive.	1	2	3	4	5	6	7
I am impressed with the quality of the clinic's physical environment.	1	2	3	4	5	6	7
I like the layout of the clinic.	1	2	3	4	5	6	7
The design of the clinic is patient friendly.	1	2	3	4	5	6	7
The staff at the clinic are willing to answer my questions.	1	2	3	4	5	6	7
I have no desire to change clinics.	1	2	3	4	5	6	7
The service provided by the clinic is of a high standard.	1	2	3	4	5	6	7
I have confidence in the clinic's administration system.	1	2	3	4	5	6	7
The interaction I have with the staff at the clinic is of a high standard.	1	2	3	4	5	6	7

	Strongly Disagree	Agree			Strongly Agree		
	1	2	3	4	5	6	7
The discharge procedures at the clinic are efficient.							
The clinic provides patients with services beyond medical treatment.	1	2	3	4	5	6	7
I find it easy to discuss things with the staff at the clinic.	1	2	3	4	5	6	7
I am glad I get care at this clinic rather than somewhere else.	1	2	3	4	5	6	7
The clinic has an appealing atmosphere.	1	2	3	4	5	6	7
The care provided by the clinic is of a high standard.	1	2	3	4	5	6	7

Is it important to you to have a female perform your gynecological exams (e.g. Pap testing)?

Yes \_\_\_\_\_ No \_\_\_\_\_ Maybe\_\_\_\_\_

When was the last time you had a Pap test? (Check mark the most accurate response.)

\_\_\_\_\_ Never \_\_\_\_\_ < 1 year \_\_\_\_\_ 1-3 years \_\_\_\_\_ 3-5 years \_\_\_\_\_ > 5 years

If you have had a Pap test within the last 3 years, you are following recommended screening guidelines. How have you been encouraged to have your pap?

- |                           |   |
|---------------------------|---|
| _____ Female caregiver    | _____ Convenient hours                          |
| _____ Convenient location | _____ I know that it is important for my health |
| _____ Caregiver offered   | _____ I was worried about something             |
| _____ I like my caregiver | _____ Other: _____                              |

If you have not had a Pap test in the last 3 years, you may not be following recommended screening guidelines. Why have you not had a pap?

- No caregiver available       Hours do not suit work/life
- To embarrassed/modest       Too uncomfortable
- I do not know what this is       I do not want bad news
- I do not believe that it is necessary
- I did not know that I needed one
- Other: \_\_\_\_\_

Where did your most recent gynecological care take place? (Choose one only)

**Pap Screening**

- Doctor's office  
 Walk-in clinic  
 Nurse practitioner clinic  
 Community health centre  
 Sexual health centre  
 Public health office  
 Midwifery clinic  
 Other (please state where)  
\_\_\_\_\_

**Birth Control**

- Doctor's office  
 Walk-in clinic  
 Nurse practitioner clinic  
 Community health centre  
 Sexual health centre  
 Public health office  
 Midwifery clinic  
 Other (please state where)  
\_\_\_\_\_

- I have never had a Pap Smear  
 I have no access to Pap screening  
 Not applicable

- I have never discussed birth control  
 I have no access to info  
 Not applicable

**Sexually Transmitted Infection (STI)**

- Doctor's office
- Walk-in clinic
- Nurse practitioner clinic
- Community health centre
- Sexual health centre
- Public health office
- Midwifery clinic
- Other (please state where)  
\_\_\_\_\_

**Abortion Counseling / Abortion Care Screening**

- Doctor's office
- Walk-in clinic
- Nurse practitioner clinic
- Community health centre
- Sexual health centre
- Public health office
- Midwifery clinic
- Other (please state where)  
\_\_\_\_\_

- Have never had STI screening
- I have no access to STI screening
- Not applicable

- Never discussed abortion
- I have no access to counselling
- Not applicable

If you are not familiar with the term “midwife”, here is the definition from the Canadian Association of Midwives: “Registered midwives are health professionals who provide primary care to women and their babies during pregnancy, labour, birth and the postpartum period.” Midwives’ services are similar to a family doctor who attends births and is covered by the Ministry of Health.

To the best of your knowledge, is there a midwifery clinic in your community?

Yes \_\_\_\_\_ No \_\_\_\_\_ Not sure \_\_\_\_\_

What is your experience with midwives? (Choose one only)

I am a former client of a midwife

- I am a current client of a midwife  
 I have never been cared for by midwives

If you are a current or former client of a midwife, would you recommend your midwife to a friend?

- Yes       No       Maybe

If you are a current or former client of a midwifery practice, would you recommend the practice to a friend?

- Yes       No       Maybe

If you have never been cared for by midwives, indicate your awareness of midwives.  
(Choose one only)

- I do not know anything about midwives  
 I am aware of what midwives do  
 Other. Please explain \_\_\_\_\_

If you could access Pap smears, birth control, STI screening and abortion counselling at all of the following locations in your community, please choose where you would most like to receive this care.

**Pap Screening**

- Doctor's office  
 Walk-in clinic  
 Nurse practitioner clinic  
 Community health centre  
 Sexual health centre  
 Public health office

**Birth Control**

- Doctor's office  
 Walk-in clinic  
 Nurse practitioner clinic  
 Community health centre  
 Sexual health centre  
 Public health office

Midwifery clinic  
 Other (please state where)

Midwifery clinic  
 Other (please state where)

I will never have a Pap Smear  
 Not applicable

I will never need birth control  
 Not applicable

### **Sexually Transmitted Infection (STI) Screening**

Doctor's office  
 Walk-in clinic  
 Nurse practitioner clinic  
 Community health centre  
 Sexual health centre  
 Public health office  
 Midwifery clinic  
 Other (please state where)

### **Abortion Counseling / Abortion Care**

Doctor's office  
 Walk-in clinic  
 Nurse practitioner clinic  
 Community health centre  
 Sexual health centre  
 Public health office  
 Midwifery clinic  
 Other (please state where)

I will never need STI screening  
 Not applicable

I will never need to discuss abortion  
 Not applicable

Thank you for helping with this important women's health research. \$1 will be donated to the Canadian Women's Health Network for each submitted survey.

**The Canadian Women's Health Network (CWHN) was created in 1993 as a voluntary national organization to improve the health and lives of girls and women in Canada and the world by collecting, producing, distributing and sharing knowledge, ideas, education, information, resources, strategies and inspirations.**

## APPENDIX G: FRENCH SURVEY

### Sondage auprès des femmes du nord de l'Ontario sur les perceptions de leurs soins de santé reproductive

Le sondage devrait prendre de 10 à 20 minutes de votre temps. Seulement celles qui, à la fin du sondage, indiquent qu'elles sont prêtes à être interviewées seront invitées à fournir leurs coordonnées. De même, les participantes qui aimeraient obtenir le résumé des résultats seront invitées à fournir une adresse de courriel ou une adresse à laquelle envoyer le résumé. En tout point pendant le sondage, **vous pouvez refuser de répondre à une question** ou arrêter entièrement d'y participer. Si vous décidez de vous retirer, votre sondage sera détruit et exclu des résultats. Vous devez avoir au moins 18 ans pour participer. Si vous vous sentez stressée à cause du sondage ou de l'entrevue, je vous recommande d'en discuter avec votre dispensateur de soins local ou de demander conseil à la Ligne d'aide sur la santé mentale, au 1 866 531-2600.

Comment avez-vous entendu parler de ce sondage ?

- Service de santé publique     Radio     Journal  
 Clinique de sages-femmes     Amies     Famille  
 Bureau du médecin     Affiche     Centre de santé  
 Conférencier à présentation de santé  
 Autre, précisez : \_\_\_\_\_

Quels sont les trois premiers caractères de votre code postal ? (P0B ex.) \_\_\_\_\_

Les personnes s'identifient souvent à un groupe racial. Auquel appartenez-vous ?

Cochez celui qui vous décrit le mieux.

- Autochtone (p. ex., innu, inuit, métis, Première nation)
- Sud-asiatique (p. ex., indien d'Asie, pakistanaise, pendjabi, sri-lankais)
- Asiatique du Sud-Est (p. ex., cambodgien, indonésien, laotien, vietnamien)
- Moyen-oriental (p. ex., arménien, égyptien, iranien, libanais)
- Asiatique (p. ex., chinois, coréen, japonais)
- Noir (p. ex., africain, antillais)
- Latino-américain (p. ex., mexicain, sud-américain, centre-américain)
- Blanc
- Philippin
- Autre. Précisez : \_\_\_\_\_
- Race mixte (précisez tous les groupes applicables) :  
\_\_\_\_\_

Êtes-vous francophone sur le plan culturel et linguistique ?

Oui \_\_\_\_\_ Non \_\_\_\_\_

Quel est votre plus haut niveau de scolarité ?

Primaire

- Secondaire  
 Collège ou université  
 Maîtrise  
 Doctorat

Quel est votre revenu familial annuel ?

- 0 à 24 999 \$  
 25 000 \$ à 49 999 \$  
 50 000 \$ à 99 999 \$  
 100 000 \$ à 200 000 \$  
 Plus de 200 000 \$

Circlez celui qui vous décrit le mieux.

	Mauvaise	Moyenne			Bonne	Excellente	
	1	2	3	4	5	6	7
En général, diriez-vous que vous êtes en (excellente, très bonne, bonne, moyenne ou mauvaise) santé ?							
Dans l'ensemble, comment classeriez-vous l'accès aux services de santé dans votre collectivité ?	1	2	3	4	5	6	7
Dans l'ensemble, comment classeriez-vous la qualité des services de santé offerts dans votre collectivité ?	1	2	3	4	5	6	7

Avez-vous un médecin de famille ?

Oui \_\_\_\_\_ Non \_\_\_\_\_

Dans l'affirmative, recommanderiez-vous votre médecin à vos amis ?

Oui \_\_\_\_\_ Non \_\_\_\_\_ Peut-être \_\_\_\_\_

Les questions suivantes portent sur la santé reproductive (test de Pap, contraception, suivi de grossesse, dépistage et traitement des infections transmises sexuellement, conseils en matière d'avortement). Il peut s'agir de votre médecin de famille, votre sage-femme, votre infirmière ou votre infirmière praticienne. Si vous n'avez pas de dispensateur de soins régulier, répondez aux questions suivantes en fonction de votre expérience la plus récente en soins reproductifs dans une clinique sans rendez-vous, un centre de santé ou un autre établissement de santé.

Circlez celui qui vous décrit le mieux.

	En total des-accord		In-certain		Tout à fait d'accord
Je trouve que la clinique est bien gérée.	1	2	3	4	5
Les heures d'ouverture de la clinique répondent à mes besoins.	1	2	3	4	5
Le personnel et moi parlons des choses qui se produisent dans nos vies, et pas seulement de mon état de santé.	1	2	3	4	5
Quand je quitte la clinique, je me sens encouragée au sujet de mes soins.	1	2	3	4	5
La clinique a une odeur agréable.	1	2	3	4	5
La clinique collabore bien avec d'autres dispensateurs de soins (p.ex., spécialistes).	1	2	3	4	5
L'atmosphère à la clinique est agréable.	1	2	3	4	5
Je me sens bien au sujet des interactions que j'ai avec le personnel de la clinique.	1	2	3	4	5
Je pense que les soins que j'ai reçus à la clinique en valaient la peine.	1	2	3	4	5
La clinique m'offre des services d'une qualité impressionnante.	1	2	3	4	5

	En total des- accord		In- certain		Tout à fait d'ac- cord		
Le milieu physique à la clinique respecte des normes élevées.	1	2	3	4	5	6	7
Le milieu physique à la clinique respecte des normes élevées.	1	2	3	4	5	6	7
J'ai dit des choses positives au sujet de la clinique à ma famille et mes amis.	1	2	3	4	5	6	7
Je trouve que mes soins ont donné les résultats les plus satisfaisants possible.	1	2	3	4	5	6	7
La clinique organise souvent des groupes et programmes d'entraide pour les patientes.	1	2	3	4	5	6	7
La fréquentation de la clinique accroît mes chances d'améliorer ma santé.	1	2	3	4	5	6	7
Dans l'ensemble, je suis satisfaite de la clinique et des services qui y sont offerts.	1	2	3	4	5	6	7
Je pense que j'aurai un avenir en bonne santé parce que j'ai fréquenté la clinique.	1	2	3	4	5	6	7
En général, les rendez-vous à la clinique sont à l'heure.	1	2	3	4	5	6	7
J'aime l'ambiance de la clinique.	1	2	3	4	5	6	7
Je recommanderais fortement la clinique à d'autres patients.	1	2	3	4	5	6	7
La prochaine fois que j'aurai besoin de soins, je reviendrais à cette clinique.	1	2	3	4	5	6	7
La qualité globale des services offerts à cette clinique est excellente.	1	2	3	4	5	6	7
J'ai l'intention de continuer de me faire soigner et de me faire suivre à cette clinique.	1	2	3	4	5	6	7
Je pense que les résultats de mes soins seront les meilleurs résultats possible.	1	2	3	4	5	6	7
J'ai de l'espoir grâce aux soins que je reçois à la clinique.	1	2	3	4	5	6	7
Je pense que le personnel de la clinique sont très compétents dans leurs travail.	1	2	3	4	5	6	7

	En total des- accord		In- certain		Tout à fait d'ac cord		
Le personnel de la clinique se préoccupe de mon bien-être.	1	2	3	4	5	6	7
J'ai l'impression que le personnel de la clinique comprend mes besoins.	1	2	3	4	5	6	7
L'administration de la clinique ont des normes élevées.	1	2	3	4	5	6	7
La clinique maintient le temps d'attente au minimum.	1	2	3	4	5	6	7
J'aime la décoration intérieure (p. ex., style de meubles) de la clinique.	1	2	3	4	5	6	7
Les meubles sont confortables à la clinique.	1	2	3	4	5	6	7
Je reçois des soins d'excellente qualité à la clinique.	1	2	3	4	5	6	7
Les explications que me donne le personnel de la clinique sont faciles à comprendre.	1	2	3	4	5	6	7
Je reçois toujours de l'attention personnalisée du personnel de la clinique.	1	2	3	4	5	6	7
Le personnel de la clinique écoute toujours ce que j'ai à dire.	1	2	3	4	5	6	7
J'ai developpe des liens positif avec certains membres du personnel de la clinique.	1	2	3	4	5	6	7
La clinique a un excellent système d'administration.	1	2	3	4	5	6	7
Je trouve excellent l'environnement physique de la clinique.	1	2	3	4	5	6	7
Je que me fier que le personnel de la clinique sont bien formé et compétent.	1	2	3	4	5	6	7
Je suis impressionnée par les soins fournis à la clinique.	1	2	3	4	5	6	7
J'ai des sentiments très positifs envers la clinique.	1	2	3	4	5	6	7
Le personnel de la clinique effectue leurs tâches avec compétence.	1	2	3	4	5	6	7

	En total des-accord		In-certain		Tout à fait d'accord		
Il arrive que le personnel et moi faisions des blagues, rions ou nous amusons les uns avec les autres comme si nous étions des amis proches.	1	2	3	4	5	6	7
Le personnel de la clinique me traite comme une personne, pas comme un numéro.	1	2	3	4	5	6	7
La palette de couleurs utilisée à la clinique est attrayante.	1	2	3	4	5	6	7
Je me sens bien quant à la qualité des soins offerts à la clinique.	1	2	3	4	5	6	7
Je pense que le personnel de la clinique se préoccupe de moi.	1	2	3	4	5	6	7
Le processus d'inscription à la clinique est efficace.	1	2	3	4	5	6	7
Je crois obtenir les meilleurs résultats possibles de mes soins.	1	2	3	4	5	6	7
Je me sens bien de venir à cette clinique pour me faire soigner.	1	2	3	4	5	6	7
Je pense que la clinique offre un service supérieur à tous égards.	1	2	3	4	5	6	7
La température est agréable à la clinique.	1	2	3	4	5	6	7
Les dossiers et la documentation de la clinique ne contiennent pas d'erreurs.	1	2	3	4	5	6	7
J'ai d'excellentes interactions avec le personnel de la clinique.	1	2	3	4	5	6	7
L'éclairage de la clinique est adapté aux lieux.	1	2	3	4	5	6	7
La clinique fournit aux patientes une excellente gamme de services.	1	2	3	4	5	6	7
J'ai l'intention de respecter les conseils médicaux qui m'ont été donnés à la clinique.	1	2	3	4	5	6	7
La clinique est attrayante.	1	2	3	4	5	6	7
Je suis impressionnée par la qualité de l'environnement physique de la clinique.	1	2	3	4	5	6	7

	En total des-accord		In-certain		Tout à fait d'accord		
J'aime la disposition de la clinique.	1	2	3	4	5	6	7
La conception de la clinique est adaptée aux patientes.	1	2	3	4	5	6	7
Le personnel de la clinique sont prêt à répondre à mes questions.	1	2	3	4	5	6	7
Je n'ai pas envie de changer de clinique.	1	2	3	4	5	6	7
La clinique offre un service de haute qualité.	1	2	3	4	5	6	7
Je fais confiance au système d'administration de la clinique.	1	2	3	4	5	6	7
J'ai des interactions de qualité avec le personnel de la clinique.	1	2	3	4	5	6	7
Le processus de congé de la clinique est efficace.	1	2	3	4	5	6	7
La clinique offre aux patientes des services qui dépassent les simples traitements médicaux.	1	2	3	4	5	6	7
Je trouve facile de discuter avec le personnel de la clinique.	1	2	3	4	5	6	7
Je suis heureuse d'être soignée à cette clinique plutôt qu'ailleurs.	1	2	3	4	5	6	7
La clinique a une atmosphère attrayante.	1	2	3	4	5	6	7
La clinique offre des soins de haute qualité.	1	2	3	4	5	6	7

Est-il important pour vous qu'une femme effectue vos examens gynécologiques (p. ex., test Pap) ?

Oui \_\_\_\_\_ Non \_\_\_\_\_ Peut-être \_\_\_\_\_

Quand avez-vous subi votre dernier test de Pap? Cochez celui qui vous décrit le mieux.

\_\_\_\_\_ Jamais      \_\_\_\_\_ Plus d'un an      \_\_\_\_\_ De 1 à 3 ans

\_\_\_\_\_ De 3 à 5 ans      \_\_\_\_\_ Plus de 5 ans

Si vous avez eu un test de Pap au cours des trois dernières années, vous respectez les recommandations de dépistage. S'il vous plaît partagez pourquoi vous avez choisi à l'écran.

Où est-ce que vos plus récents soins gynécologiques ont eu lieu? (Cochez une seule réponse)

Femme au foyer

Heures d'ouverture pratiques

Emplacement ideal

Je sais que c'est important pour ma santé

Mon fournisseur de soins offre un test de Pap

J'étais inquiet au sujet de quelque chose et demandé un pap

J'aime mon fournisseur de soins

Autre, pourquoi? \_\_\_\_\_

Si elle a été de plus de 3 ans depuis votre dernier test de Pap, vous ne pouvez pas être la suite de dépistage recommandée. Pourquoi avez-vous choisi de ne pas subir un test de Pap?

Aucun soignant disponible

Heures ne conviennent pas travail/vie

Trop gêné ou modeste

Trop mal à l'aise

Je ne sais pas ce que c'est

Je ne crois pas qu'il est nécessaire

Je ne veux pas de mauvaises nouvelles

Je ne savais pas que j'avais besoin d'une

Autre, pourquoi? \_\_\_\_\_

Où est-que vos plus récents soins de santé reproductive ont eu lieu? (Cochez une seule réponse)

**Test de Pap**

Bureau du médecin

Clinique sans rendez-vous

Clinique d'infirmières praticiennes

Centre de soins communautaires

Centre de santé sexuelle

Service de santé publique

Clinique de sages-femmes

Autre (précisez où)

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Je n'ai jamais subi de test Pap

Je n'ai pas accès au test Pap

Non applicable

**Contraception**

Bureau du médecin

Clinique sans rendez-vous

Clinique d'infirmières praticiennes

Centre de soins communautaires

Centre de santé sexuelle

Service de santé publique

Clinique de sages-femmes

Autre (précisez où)

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Je n'ai jamais recu de contraception

Je n'ai pas accès à l'information

Non applicable

**Dépistage des infections transmises sexuellement (ITS)**

- Bureau du médecin
- Clinique sans rendez-vous
- Clinique d'infirmières praticiennes
- Centre de soins communautaires
  
- Centre de santé sexuelle
  
- Service de santé publique
  
- Clinique de sages-femmes
  
- Autre (précisez où)

**Conseils ou soins en matière d'avortement**

- Bureau du médecin
- Clinique sans rendez-vous
- Clinique d'infirmières praticiennes
- Centre de soins communautaires
  
- Centre de santé sexuelle
  
- Service de santé publique
  
- Clinique de sages-femmes
  
- Autre (précisez où)

Si vous ne connaissez pas le terme « sage-femme », en voici la définition de l'Association canadienne des sages-femmes : « La sage-femme est une professionnelle registre de la santé qui offre des soins de santé primaires aux femmes et à leur bébé pendant la grossesse, l'accouchement et la période postnatale. » Les services des sages-femmes sont similaires à

ceux d'un médecin de famille qui assiste à des accouchements et ils sont assurés par le ministère de la Santé.

En autant que vous le sachiez, y a-t-il une clinique de sages-femmes dans votre collectivité ?

Oui \_\_\_\_\_ Non \_\_\_\_\_ Incertaine \_\_\_\_\_

Quelle est votre expérience des sages-femmes ? (Cochez une seule réponse)

\_\_\_\_\_ Je suis l'ancienne cliente d'une sage-femme.

\_\_\_\_\_ Je suis actuellement une cliente d'une sage-femme.

\_\_\_\_\_ Je n'ai jamais été soignée par une sage-femme

Si vous êtes un client actuel ou ancien, recommanderiez-vous votre sage-femme à un ami?

\_\_\_\_\_ Oui      \_\_\_\_\_ Non      \_\_\_\_\_ Peut-être

Si vous êtes un client actuel ou ancien, recommanderiez-vous la pratique de sage-femme à un ami?

\_\_\_\_\_ Oui      \_\_\_\_\_ Non      \_\_\_\_\_ Peut-être

Si vous n'avez jamais été soignée par une sage-femme, dites-nous si vous connaissez les sages-femmes. (Cochez une seule réponse.)

\_\_\_\_\_ Je ne sais rien des sages-femmes.

\_\_\_\_\_ Je sais ce que font les sages-femmes.

\_\_\_\_\_ Autre, précisez : \_\_\_\_\_

Si vous pouviez avoir accès aux tests Pap et à la contraception à tous les emplacements suivants dans votre collectivité, sélectionnez ceux où vous aimeriez le plus les recevoir.

**Test de Pap**

- Bureau du médecin  
 Clinique sans rendez-vous  
 Clinique d'infirmières praticiennes  
 Centre de soins communautaires  
 Centre de santé sexuelle  
 Service de santé publique  
 Clinique de sages-femmes  
 Autre (précisez où)
- 
- Je ne serai jamais besoin de test de Pap  
 Non applicable

**Dépistage des infections transmises sexuellement (ITS)**

- Bureau du médecin  
 Clinique sans rendez-vous  
 Clinique d'infirmières praticiennes

**Contraception**

- Bureau du médecin  
 Clinique sans rendez-vous  
 Clinique d'infirmières praticiennes  
 Centre de soins communautaires  
 Centre de santé sexuelle  
 Service de santé publique  
 Clinique de sages-femmes  
 Autre (précisez où)
- 
- Je n'aurai pas besoin de contraception  
 Non applicable

**Conseils ou soins en matière d'avortement**

- Bureau du médecin  
 Clinique sans rendez-vous  
 Clinique d'infirmières praticiennes

- |   |   |
|---|---|
| <p><input type="checkbox"/> Centre de soins communautaires</p> <p><input type="checkbox"/> Centre de santé sexuelle</p> <p><input type="checkbox"/> Service de santé publique</p> <p><input type="checkbox"/> Clinique de sages-femmes</p> <p><input type="checkbox"/> Autre (précisez où)</p> <hr/> <p><input type="checkbox"/> Je ne serai jamais besoin</p> <p><input type="checkbox"/> Non applicable</p> | <p><input type="checkbox"/> Centre de soins communautaires</p> <p><input type="checkbox"/> Centre de santé sexuelle</p> <p><input type="checkbox"/> Service de santé publique</p> <p><input type="checkbox"/> Clinique de sages-femmes</p> <p><input type="checkbox"/> Autre (précisez où)</p> <hr/> <p><input type="checkbox"/> Je ne serai jamais besoin<br/>Aux de dépistage d'ITS<br/>conseils en matière<br/>d'avortement</p> <p><input type="checkbox"/> Non applicable</p> |
|---|---|

Nous vous remercions d'avoir contribué à cette importante recherche sur la santé des femmes. Pour chaque sondage rempli, 1 \$ sera versé au Réseau canadien pour la santé des femmes.

**Le Réseau canadien pour la santé des femmes (RCSF) est un organisme national de bénévoles créé en 1993** pour améliorer la santé et la vie des filles et des femmes du Canada et du monde par la collecte, la production, la distribution et le partage de connaissances, d'idées, de formation, d'information, de ressources, de stratégies et d'inspirations.

## APPENDIX H: QUESTIONS MATCHED TO DIMENSIONS AND SUB-DIMENSIONS

<b>Dimension / Sub-Dimension</b>	<b>Survey Questions</b>
Dimension – Interpersonal Quality	#21 The quality of the service provided at the clinic is impressive. #68 The clinic provides patients with an excellent range of support services. #80 The clinic provides patients with services beyond medical treatment.
Sub-Dimension – Interaction	#40 The administration at the clinic is of a high standard. #41 The clinic keeps waiting time to a minimum. #47 The staff at the clinic always listen to what I have to say. #48 I have built a close relationship with some of the staff at the clinic. #49 The administration system at the clinic is excellent. #58 I feel good about the quality of the care given to me at the clinic. #61 I feel satisfied that the results of my treatment are the best that can be achieved. #76 The service provided by the clinic is of a high standard.
Sub-Dimension – Relationship	#16 The clinic works well with other service providers. #50 I believe the physical environment at the clinic is excellent. #57 The color scheme at the clinic is attractive.
Dimension – Technical Quality	#46 I always get personalised attention from the staff at the clinic. AN I find it easy to discuss things with the staff at the clinic. #54 The staff at the clinic carry out their tasks competently. #84 The care provided by the clinic is of a high standard.
Sub-Dimension – Outcome	#17 The clinic smells pleasant. #22 The physical environment at the clinic is of a high standard. #28 I believe my future health will improve as a result of attending the clinic. #30 I like the “feel” of the atmosphere at the clinic. #37 I believe the staff at the clinic are highly skilled at their jobs.
Sub-Dimension – Expertise	#39 I feel the staff at the clinic understand my needs. #53 My feelings towards the clinic are very positive. #56 The clinic’s staff treat me as an individual and not just a number. #60 The registration procedures at the clinic are efficient.
Dimension – Environment Quality	#24 The extent to which my treatment has produced the best possible outcome is satisfying. #52 I am impressed by the care provided at the clinic. #73 The design of the clinic is patient friendly.
Sub-Dimension – Atmosphere	#19 I feel good about the interaction I have with the staff at the clinic. #20 I believe having treatment at the clinic has been worthwhile. #32 If I had to start treatment again I would want to come to this clinic. #66 The interaction I have with the staff at the clinic is excellent. #83 The clinic has an appealing atmosphere.
Sub-Dimension – Tangibles	#44 The quality of the care I receive at the clinic is excellent. #45 The staff at the clinic explain things in a way that I can understand. #59 I believe the staff at the clinic care about me. #69 I intend to follow the medical advice given to me at the clinic. #72 I like the layout of the clinic. #74 The staff at the clinic are willing to answer my questions. #75 I have no desire to change clinics.
Dimension – Administrative Quality	#42 I like the interior decoration (e.g., style of furniture) at the clinic. #51 You can rely on the staff at the clinic to be well trained and qualified. #79 The discharge procedures at the clinic are efficient.
Sub-Dimension – Timeliness	#31 I would highly recommend the clinic to other patients. #43 The furniture at the clinic is comfortable.

<b>Dimension / Sub-Dimension</b>	<b>Survey Questions</b>
Sub-Dimension – Operation, question	#14 The staff and I talk about the things that are happening in our lives, and not just about my medical condition. #15 I leave the clinic feeling encouraged about my treatment. #18 The atmosphere at the clinic is pleasing. #62 I feel good about coming to this clinic for my treatment. #67 The lighting at the clinic is appropriate for this setting. #81 I find it easy to discuss things with the staff at the clinic.
Sub-Dimension – Support, question	#27 Overall I am satisfied with the clinic and the service it provides. #70 The clinic looks attractive. #82 I am glad I have my treatment at this clinic rather than somewhere else.

## APPENDIX I: HIERARCHICAL MODEL OF HEALTH SERVICE QUALITY

### MODEL QUESTIONS AND MEAN SCORES

Health service quality: Respondents rated the clinic's performance on each scale item using a 7-point scale (1 = *strongly disagree*, 7 = *strongly agree*).

<b>Survey Question</b>	<b>N</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>mean</b>
#12 I believe the clinic is well-managed.	176	2.8	6.3	8.0	25.6	14.8	19.3	23.3	4.9
#13 The clinic's opening hours meet my needs.	176	6.7	10.8	12.5	26.7	13.6	14.2	15.3	4.3
#14 The staff and I talk about the things that are happening in our lives, and not just about my medical condition.	176	18.2	13.1	7.4	21.0	12.5	13.1	14.8	4.0
#15 I leave the clinic feeling encouraged about my treatment.	175	7.4	7.4	18.9	17.1	14.9	17.7	16.6	4.4
#16 The clinic works well with other service providers.	175	4.0	3.4	16.0	26.3	13.7	18.3	18.3	4.7
#17 The clinic smells pleasant.	176	3.4	2.3	8.0	37.5	8.0	23.9	17.0	4.8
#18 The atmosphere at the clinic is pleasing.	175	5.7	8.0	12.6	22.3	12.6	18.3	20.6	4.6
#19 I feel good about the interaction I have with the staff at the clinic.	175	2.9	5.7	22.9	17.1	9.7	22.3	19.4	4.7
#20 I believe having treatment at the clinic has been worthwhile.	175	1.7	4.0	14.3	26.9	6.3	24.0	22.9	5.0
#21 The quality of the service provided at the clinic is impressive.	176	5.1	10.2	21.0	16.5	11.9	19.3	15.9	4.4
#22 The physical environment at the clinic is of a high standard.	175	2.9	6.9	10.9	26.3	14.3	18.9	20.0	4.8
#23 I have said positive things about the clinic to my family and friends.	175	7.4	11.4	12.0	21.1	7.4	16.6	24.0	4.6
#24 The extent to which my treatment has produced the best possible outcome is satisfying.	174	3.4	12.1	16.7	24.7	8.6	15.5	19.0	4.5
#25 The clinic frequently runs support groups and programs for patients.	169	24.3	21.3	11.2	20.7	5.3	10.7	6.5	3.2
#26 Coming to the clinic has increased my chances of improving my health.	172	5.2	8.1	15.1	34.9	8.7	15.1	12.8	4.3
#27 Overall I am satisfied with the clinic and the service it provides.	175	4.0	9.7	12.6	31.4	3.4	20.6	18.3	4.6
#28 I believe my future health will improve as a result of attending the clinic.	174	5.2	9.8	15.5	27.6	10.3	17.8	13.8	4.4
#29 Generally, appointments at the clinic run on time.	175	11.4	10.3	13.1	22.9	10.3	15.4	16.6	4.2
#30 I like the "feel" of the atmosphere at the clinic.	175	8.0	12.0	17.7	20.0	11.4	13.7	17.1	4.2
#31 I would highly recommend the clinic to other patients.	174	7.5	7.5	20.7	18.4	8.0	16.1	21.8	4.5
#32 If I had to start treatment again I would want to come to this clinic.	174	3.4	4.6	6.9	32.8	4.6	16.7	31.0	5.0

<b>Survey Question</b>	<b>N</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>mean</b>
#33 The overall quality of the service provided by the clinic is excellent.	173	5.2	9.2	19.1	17.9	8.1	18.5	22.0	4.6
#34 I intend to continue having treatment, or any follow-up care I need, at this clinic.	172	4.1	7.6	8.7	28.5	4.7	16.9	29.7	4.9
#35 I believe the results of my treatment will be the best they can be.	173	4.0	9.8	16.2	22.0	6.9	21.4	19.7	4.6
#36 I feel hopeful as a result of having treatment at the clinic.	171	5.3	9.4	18.1	20.5	5.8	20.5	20.5	4.6
#37 I believe the staff at the clinic are highly skilled at their jobs.	172	2.3	5.2	12.2	26.7	9.9	21.5	22.1	4.9
#38 The staff at the clinic are concerned about my well-being.	173	4.6	9.2	15.0	17.9	11.0	22.5	19.7	4.7
#39 I feel the staff at the clinic understand my needs.	173	6.4	9.2	20.8	15.6	10.4	19.7	17.9	4.5
#40 The administration at the clinic is of a high standard.	171	8.2	5.8	17.5	22.8	11.1	18.1	16.4	4.4
#41 The clinic keeps waiting time to a minimum.	172	12.2	7.0	17.4	17.4	9.3	16.9	19.8	4.3
#42 I like the interior decoration (e.g., style of furniture) at the clinic.	173	9.2	15.0	17.3	23.1	9.8	11.6	13.9	4.0
#43 The furniture at the clinic is comfortable.	172	9.9	15.7	16.9	23.3	11.0	11.6	11.6	3.9
#44 The quality of the care I receive at the clinic is excellent.	172	5.2	6.4	19.2	22.1	9.3	16.3	21.5	4.6
#45 The staff at the clinic explain things in a way that I can understand.	172	2.3	4.7	9.3	31.4	8.7	17.4	26.2	5.0
#46 I always get personalised attention from the staff at the clinic. AN I find it easy to discuss things with the staff at the clinic.	174	8.0	9.8	16.7	15.5	8.6	17.8	23.6	4.6
#47 The staff at the clinic always listen to what I have to say.	170	4.7	10.0	14.7	21.8	12.4	14.7	21.8	4.6
#48 I have built a close relationship with some of the staff at the clinic.	170	24.1	13.5	12.9	12.4	7.6	14.1	15.3	3.7
#49 The administration system at the clinic is excellent.	169	10.7	8.9	17.2	23.1	12.4	15.4	12.4	4.1
#50 I believe the physical environment at the clinic is excellent.	171	5.8	12.3	19.9	22.2	8.2	15.2	16.4	4.3
#51 You can rely on the staff at the clinic to be well trained and qualified.	169	4.7	7.1	11.2	27.2	11.8	17.8	20.1	4.7
#52 I am impressed by the care provided at the clinic.	168	7.1	9.5	20.2	20.2	9.5	16.7	16.7	4.3
#53 My feelings towards the clinic are very positive.	169	10.1	8.3	18.3	19.5	9.5	14.8	19.5	4.3
#54 The staff at the clinic carry out their tasks competently.	167	6.6	7.8	12.6	25.7	11.4	15.6	20.4	4.6
#55 The staff and I sometimes kid around, laugh, or joke with each other like close friends.	169	28.4	10.1	11.8	15.4	10.1	10.7	13.6	3.6
#56 The clinic's staff treat me as an individual and not just a number.	169	14.8	11.8	9.5	21.3	7.1	17.8	17.8	4.2
#57 The color scheme at the clinic is attractive.	172	15.1	10.5	17.4	23.8	8.7	11.6	12.8	3.9

<b>Survey Question</b>	<b>N</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>mean</b>
#58 I feel good about the quality of the care given to me at the clinic.	172	5.8	9.9	10.5	26.7	8.1	20.3	18.6	4.6
#59 I believe the staff at the clinic care about me.	171	8.2	9.4	17.0	18.7	12.3	16.4	18.1	4.4
#60 The registration procedures at the clinic are efficient.	170	4.1	10.0	10.6	26.5	9.4	17.6	21.8	4.7
#61 I feel satisfied that the results of my treatment are the best that can be achieved.	172	6.4	10.5	19.8	19.2	9.3	18.6	16.3	4.4
#62 I feel good about coming to this clinic for my treatment.	171	8.2	8.2	14.0	22.2	7.0	17.5	22.8	4.6
#63 I believe the clinic offers service that is superior in every way.	171	11.7	16.4	18.7	14.6	11.7	12.3	14.6	3.9
#64 The temperature at the clinic is pleasant.	170	5.3	3.5	10.6	37.1	10.0	14.1	19.4	4.6
#65 The clinic's records and documentation are error free (e.g., billing).	170	5.3	5.3	17.1	32.9	10.6	14.7	14.1	4.4
#66 The interaction I have with the staff at the clinic is excellent.	171	7.0	12.9	12.9	21.1	9.9	15.8	20.5	4.4
#67 The lighting at the clinic is appropriate for this setting.	171	1.2	4.7	8.8	43.3	5.8	15.8	20.5	4.8
#68 The clinic provides patients with an excellent range of support services.	171	9.9	8.8	17.5	24.6	12.3	14.0	12.9	4.1
#69 I intend to follow the medical advice given to me at the clinic.	171	0.6	6.4	11.1	34.5	8.8	18.1	20.5	4.8
#70 The clinic looks attractive.	171	9.4	11.7	16.4	24.6	7.0	18.1	12.9	4.1
#71 I am impressed with the quality of the clinic's physical environment.	170	5.3	17.1	17.6	22.4	8.2	14.7	14.7	4.1
#72 I like the layout of the clinic.	172	5.2	12.2	13.4	30.8	10.5	12.2	15.7	4.3
#73 The design of the clinic is patient friendly.	173	4.6	12.1	14.5	31.2	9.8	12.7	15.0	4.3
#74 The staff at the clinic are willing to answer my questions.	172	3.5	8.7	11.0	29.7	11.6	14.0	21.5	4.7
#75 I have no desire to change clinics.	173	15.0	6.9	7.5	23.1	3.5	11.6	32.4	4.6
#76 The service provided by the clinic is of a high standard.	172	5.8	5.2	19.8	19.8	8.7	19.8	20.9	4.6
#77 I have confidence in the clinic's administration system.	173	9.8	5.8	12.1	26.6	12.7	13.9	19.1	4.4
#78 The interaction I have with the staff at the clinic is of a high standard.	173	5.8	10.4	12.1	26.0	9.8	15.6	20.2	4.5
#79 The discharge procedures at the clinic are efficient.	169	4.1	8.3	11.2	35.5	9.5	14.2	17.2	4.5
#80 The clinic provides patients with services beyond medical treatment.	171	11.1	17.0	17.5	15.8	9.4	12.3	17.0	4.0
#81 I find it easy to discuss things with the staff at the clinic.	172	8.7	10.5	15.7	17.4	9.9	16.9	20.9	4.4
#82 I am glad I have my treatment at this clinic rather than somewhere else.	173	14.5	6.4	15.0	17.3	6.9	9.8	30.1	4.5
#83 The clinic has an appealing atmosphere.	172	9.9	11.0	16.3	20.9	9.9	15.1	16.9	4.2
#84 The care provided by the clinic is of a high standard.	171	6.4	4.7	19.9	20.5	10.5	15.2	22.8	4.6

## APPENDIX J: RECRUITMENT MATERIALS



What Lies Beneath Mural. A Myths & Mirrors Community Arts Project. Sudbury, ON.

Are you interested in improving healthcare for women?

**Fill out my survey!**

Log on to [www.reproductivehealthcare.ca](http://www.reproductivehealthcare.ca)

Email [lmorgan@laurentian.ca](mailto:lmorgan@laurentian.ca)

Call 705-675-1151 x 3969 Toll free 1-800-461-4030 x 3969

## Press Release

Laurentian University researcher wants to hear from women

A researcher from Laurentian University's School of Rural and Northern Health wants to hear about women's experiences with their reproductive healthcare. According to PhD student Lisa Morgan, the evidence is clear that health services in rural, remote and northern communities can suffer from lack of access along with other factors that can compromise availability. Previous studies have examined women attitudes around pap screening and have concluded that improvements need to be made to the current system in order to encourage more women to comply with recommended screening. This is the first study of its kind to look beyond the pap and examine access and perceptions of quality around STI screening, contraception, care in pregnancy and access to sexual health education and counselling. "Through the exploration of women's opinions about their care we can uncover how women perceive the quality of their care, their satisfaction with their care, and ultimately, their intentions to seek recommended care in the future". With rising rates of STI's and the need to curb unplanned pregnancies, women's ability to obtain diagnosis and treatment becomes crucial to public health. It is only through asking women about the elements of their care that make it both easier or more difficult for them to obtain the care they need can we make changes to our current system to meet the needs of the women in Northern Ontario. For more information, visit [www.reproductivehealthcare.ca](http://www.reproductivehealthcare.ca).



I am a midwife and PhD student at the School of Rural and Northern Health at Laurentian University. I am interested in hearing about the experiences of women in Northern Ontario with their reproductive healthcare, specifically around issues of availability, accessibility, acceptability and perceptions of quality. Women in Northern Ontario, as evidenced by the letter " P " at the beginning of their postal codes, are invited to complete my online survey. The survey is available in French and English and can be found on my website, [www.reproductivehealthcare.ca](http://www.reproductivehealthcare.ca). Click the tab with the consent form (French or English) and the link to the survey will appear at the bottom of the consent form . There are 100 questions and it will take 10-15 minutes to complete. Women who are willing to be interviewed, to give depth to the responses, are invited to complete the "Volunteer to be Interviewed " form available on the top menu. An executive summary is available through the same process. Through the analysis of women's responses, I hope to be able to make recommendations to improve the reproductive healthcare of women in Northern Ontario.

As an incentive for participation, I will donate \$1 for each submitted survey to the Canadian Women's Health Network.

Thanks for your help.

Lisa Morgan



Je suis une sage-femme et étudiante au doctorat à l'École de santé rurale et du Nord de l'Université Laurentienne. J'étudie l'expérience des femmes du Nord de l'Ontario avec leurs soins de santé reproductive, spécifiquement la disponibilité, l'accessibilité, l'acceptabilité et la perception de la qualité. Les femmes du nord de l'Ontario, mise en évidence par la lettre "P" au début de leurs codes postaux, sont invitées à remplir mon questionnaire en ligne. Le sondage est disponible en français et en anglais et peut être consulté sur mon site [www.reproductivehealthcare.ca](http://www.reproductivehealthcare.ca). Cliquez sur l'onglet avec le formulaire de consentement (version française ou anglaise) et le lien vers le sondage apparaîtra au bas du formulaire de consentement. Il y a 100 questions et il faudra 10-15 minutes à compléter. Les femmes qui sont prêtes à être interrogées, afin d'expliquer leurs réponses de manière approfondie, sont invitées à remplir le «Volontaire pour être interrogée» forme accessible sur le menu du haut. Un résumé est disponible via le même processus. Grâce à l'analyse des réponses des femmes, j'espère être en mesure de faire des recommandations pour améliorer la santé génésique des femmes du nord de l'Ontario.

Comme une incitation à la participation, je verserai 1 \$ pour chaque questionnaire rempli au Réseau canadien pour la santé des femmes.

Merci de votre aide pour diffuser le mot.

Cordialement,  
Lisa Morgan

## **60 Second Infomercial**

My name is Lisa Morgan and I am a PhD student with the School of Rural and Northern Health at Laurentian University. I am also a midwife and a lecturer in the Midwifery Education Program.

I am collecting information about women's perceptions of their reproductive healthcare. Through my study, I am seeking improvements to the current system of care for women in Northern Ontario. This study involves uncovering the mechanisms, enabling or disabling, which are producing the outcomes, uptake or lack of, in order to inform changes to the design of the reproductive healthcare system. Perceptions of health service quality have a positive impact on health service satisfaction and a positive impact on behavioural intentions (Dagger et al., 2007). It is postulated that by collecting information on perceptions of reproductive health service quality, improvements may be made which could increase satisfaction, leading to increased uptake of recommended reproductive healthcare.

I would like to hear from any women whose postal code starts with the letter "P", which identifies them as Northern Ontario residents. Participants must be over 18 years of age.

Every year approximately 500 women in Ontario are diagnosed with cervical cancer, resulting in 140 deaths. Studies have been done or are currently underway in Northern Ontario, examining Pap screening and alternatives. I am not aware of any studies examining reproductive healthcare overall, or any studies that apply a validated measure of perceived quality, indicating satisfaction and influencing behavioural intentions. If we want more women following recommended pap screening guidelines, preventing unwanted pregnancies, treating underlying STIs and engaging in family planning, we need to make our health system more responsive to the needs of women. Listen to Women!

You can find the link to my survey at [www.reproductivehealthcare.ca](http://www.reproductivehealthcare.ca). Please take the 15 minutes to complete my survey and have your opinions count!