INVISIBLE WOMEN:
Gender and Health Planning in Manitoba and Saskatchewan and Models for Progress

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and
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Executive Summary

The mandate of the Prairie Women's Health Centre of Excellence (PWHCE) includes generating new knowledge through the identification and analysis of research on women's health issues; and providing policy advice, analysis and information to governments, health organizations and non-governmental organizations. The purposes of this project were:

~ to generate new knowledge about the impact of the regionalization of health planning and service delivery by examining the degree to which gender sensitivity and women's health issues were reflected in the planning processes of regional health bodies in Manitoba and Saskatchewan; and

~ to provide information which the PWHCE could use in advising governments, regional health bodies and others on how to make regional needs assessments and health plans more sensitive to the needs of women.

"Women's health involves emotional, social, cultural, economic, spiritual and physical well-being and is determined by the social, cultural, political and economic context of women's lives as well as by biology."

S. Phillips, 1995

The research team developed evaluation frameworks based on the relevant literature and discussions with PWHCE staff and members of the PWHCE Theme Advisory Group on the Effects of Health Reform on Women. The frameworks were used to analyze needs assessment and health plan documents. This process was followed by interviews with key stakeholders within the regional health bodies that had provided written documents.

The framework for evaluating health plans addressed the following issues:

P evidence of women's health as a priority;
P recognition of context and determinants of women's health;
P approaches to women's health issues (primarily illness-focussed, or inclusive of health promotion and gender analysis of social conditions);

- sensitivity and proactive approach in addressing diversity;
- accessibility (to services, types of providers, community settings);
- types of collaborative relationships (with women, agencies);
- recognition of informal caregiver issues;
- recognition of effects of health care reform on employees (mostly female);
- evidence-based decision-making and evaluation.

The needs assessment evaluation framework addressed the following issues:

- inclusivity of consultations;
- minimizing barriers to participation;
- inclusion of data related to health determinants;
- disaggregation of data by sex;
- discussion of findings for specific groups of women;
- verification of findings with communities.

Guiding questions for representatives of regional health bodies (key informants) addressed:

- how decisions are made about health priorities;
- if/how gender-related issues are included in the health planning process;
- perceptions of the most important influences on women's health;
- ways of including women and organizations that work with women in health planning processes;
- use of evidence-based decision-making in planning;
- differential influences on women and men of determinants of health and health care reform (e.g., institution to community shift);
- collaborative initiatives with other organizations serving women;
- ways of addressing diversity in the health planning process, and related challenges;
- ways of including women and organizations that work with women in evaluation of health reform efforts;
- ways to be responsive to women's needs as health reform proceeds.

A. METHODS

1. NEEDS ASSESSMENT AND HEALTH PLAN DOCUMENTS

Each region/district received a letter from the Director of the Prairie Women's Health Centre of Excellence introducing the project and the project team members. They then received a follow-up letter from a member of the research team which requested that they provide:

- the most recent health plan for their region/-district;
- health needs assessments done for their region/district; and
- any other work which they may already have done on the health needs of women in their region/district.

This documentation was analyzed using two frameworks—one for the needs assessment documentation and one for the health plan documentation.

In all, eight of 11 Manitoba Regional Health Authorities (RHAs) responded. Seven of these provided health plan documents for review and analysis, and eight provided needs assessment documents. The two Winnipeg RHAs were excluded from the survey because they began operation in April 1998 and have not yet published their first needs assessment documents. In Saskatchewan, 17 of 32 Health Districts responded

to the request. Sixteen of those provided health plan documentation, and 12 provided needs assessment documentation. Documents submitted by regions/districts, in response to the request for information about any work undertaken on women's health, have also been included from both provinces.

In the information and analysis of the needs assessment and health plan documents which follow, the data from the two provinces has been combined. There were no substantial differences between responses from Manitoba and those from Saskatchewan.

2. INTERVIEWS WITH REPRESENTATIVES OF REGIONAL HEALTH BODIES

Regional health bodies were selected for interviews using the following criteria: the sample should be representative of both provinces (3 Manitoba, 5 Saskatchewan); and the sample should be geographically representative (north, south, rural, urban). In several cases, representatives of regional health bodies expressed interest in being interviewed for this project. All of these representatives were interviewed. In order to arrange the interviews, the Chief Executive Officer's office was contacted and the purpose of the interviews was explained. The interviewee was selected by the CEO. Their positions in the regional health bodies varied from Health Educator to Vice President to Medical Officer of Health. All interviews were conducted by telephone, by the same member of the research team. She took verbatim notes during the interview.

These transcribed interviews were imported into the *QSR NUD*IST* software program for qualitative data analysis. All transcripts were read by all of the research team members. One member conducted an analysis using the constant comparison method. The analyst moved back and forth between transcripts and analysis, uncovering similarities and differences, within and between interviews. Codes were applied to a section of a transcript, and then all sections of transcripts from interviews with the same codes were reviewed. The analyst went back and forth between sections of the transcript and the whole transcript to check context of quotes and verify interpretations. As sections were coded, categories and subcategories became apparent. As a result of this process, the interviews were reviewed several times. The analyst then wrote a narrative description of the data, following the coding. The process of writing and interpreting lead to returning to the transcripts, re-checking context, and searching the interviews for other codes and categories. The preliminary analysis was then sent to the other two researchers who checked the credibility of interpretation. Differences of opinion were few, but were discussed until consensus was reached. The variety in backgrounds of the three researchers enhances the transferability of the findings; in other words, there is less chance that the interpretation is narrowed by discipline or experience. In qualitative methodology, the term credibility is equivalent to validity and transferability to generalizability.

B. SUMMARY ANALYSES

1. NEEDS ASSESSMENTS

a. The needs assessment documents reviewed indicate that gender was rarely considered as a variable in assessing local health needs and that consequently, the health needs of women rarely were considered separately from those of men.

b. Regional health bodies published little sex-desegregated data. While gender analysis is much more than simply looking at health data for men and women both separately and together, the lack of availability of sex-desegregated data makes gender analysis impossible. Regional health bodies are also limited, since they did not have additional funds to order sex-desegregated data from other sources (such as Statistics Canada) for their areas, nor did either province undertake to provide this to them.

c. Although Manitoba Health has set women's health as one of its priorities, RHAs were given no background information about women's health, nor any guidance about how to specifically assess the health of women in their communities. This lack of information is reflected in their responses. In both provinces, only 25% of those participating included any data about gender in their needs assessments.

WHAT IS GENDER ANALYSIS?

"...a process that assesses the differential impact of proposed and/or existing policies, programs and legislation on women and men. It compares how and why women and men are affected by policy issues. It makes it possible for policy to be undertaken with an appreciation of gender differences, of the nature of relationships between women and men, and their different social realities, life expectations and economic circumstances. It is a tool for understanding social processes and for responding with informed and equitable solutions."

Adapted from Status of Women Canada, 1998.

2. HEALTH PLANS

a. Based on the review of these documents, it is evident that regional health bodies have not given a high priority to women's health. While four of the seven responding Manitoba RHAs listed women's health as a priority, and referenced Manitoba Health in doing so, there was little evidence of such prioritization in their health plans. Only one regional health body—in Saskatchewan—expressed a written commitment to gender equity.

b. Where women's health issues were considered, the most frequent references were to gender-specific health needs (reproductive health, breast and cervical cancer screening) and to women's role as mothers.

c. While both provinces officially promote a determinants of health approach, there is little evidence of it in the health plans reviewed for this project. Manitoba health plans contained, on average, reference to 2.4 health determinants, while Saskatchewan plans included, on average, only 1.5 of the 11 health determinants used in this project. Health plans tend to emphasize financial reporting and funding requests.

d. The documents reviewed do not demonstrate an appreciation for the differing health needs of diverse groups of women, including Aboriginal women, women from ethnic and visible minorities, lesbian women and women with disabilities.

e. Consistent with all of the above, none of the regional health bodies surveyed reported any training on gender issues for either staff, management or Board members.

f. There was no evidence that women's organizations, and organizations providing services to women are included in the health planning process.

g. Rather than recognizing the additional burden on women of providing informal care to family members and friends, regional health bodies have promoted this by emphasizing women's presumed role as gatekeepers of family health.

3. INTERVIEWS WITH REPRESENTATIVES OF REGIONAL HEALTH BODIES

Themes from the qualitative analysis of interview transcripts indicated that women's health was discussed in the context of three categories—reproduction, family members, and use of health services—rather than as a valued outcome in and of itself. Within these categories there was very little gender analysis with a few exceptions. Similarly, there was widespread understanding of the social determinants of health, but gender was seldom mentioned and the other determinants lacked a gender analysis. Major women's heath issues were identified, and this problem focus formed one of the main themes in talking about women's health, along with recognition of different populations of women, and of women's roles. Again, in general, there was, at best, the beginning of a gender analysis in these conversations. Many informants seemed reluctant to address gender at all. In some instances, "backlash" was noted: that is, people who believed that "all this attention to women's health" represents a loss for men and a threat to their health. As would be expected, the discussions of health planning and participation of women were not rich in examples of equity strategies used or gender differences addressed.

C. CONCLUSIONS

Conclusion 1. There was no significant difference in findings for Manitoba and Saskatchewan. This is noteworthy given their different political environments at the time the study was conducted; and the fact that Manitoba identifies women as one of its four priority populations, and Saskatchewan identifies women's special health needs as a priority budget area.

Conclusion 2. There is little evidence of gender analysis or gender-sensitive strategies among the regional health bodies participating in this study, as indicated by review of needs assessment and health planning documents, and interviews with representatives of the participating health bodies. For example, only 25% of the participating regional health bodies included any data about gender in their needs assessments.

Conclusion 3. While the reasons for this lack of evidence are multi-faceted, the primary reason is a lack of value placed on women's health in general, and therefore, on gender analysis in particular, as legitimate areas of concern. This is corroborated by our finding that there was no evidence of training on issues related to gender inequality that effect women's health. Where women's health issues were considered, the most frequent references were to biological sex-specific health needs (reproductive health, breast and cervical cancer screening) and to women's role as mothers.

Conclusion 4. Some reasons for this lack of value placed on gender analysis are as follows:

4.1 Many of the participants believed that women's primary health role is as gatekeepers and informal caregivers, responsible for the health of their families and communities. Regional health bodies have not recognized the additional burden on women of providing

informal care to family members and friends. Rather, they have potentially added to this burden by emphasizing women's presumed role as the gatekeepers of family health. Women's health did not appear to be valued in its own right.

4.2 Gender analysis did not appear to be valued by the provincial governments which fund the regional health bodies. For example, although Manitoba Health has set women's health as one of its four priority areas, RHAs appear to have been given no background information about women's health, nor any guidance about how to specifically assess the health of the women in their communities.

4.3 The overwhelming financial pressures faced by regional health bodies dealing with provincially-imposed funding restraints encourage a crisis-management focus (e.g., emergency staffing issues). Gender analysis is not seen as high priority in this environment.

4.4 There did not seem to be widespread anti-feminist sentiment or hostility toward women's health. Rather, women's health issues (beyond those related to reproduction) and gender analysis did not appear to be priorities to the health bodies participating in this project. This could be changed by involving women's organizations and organizations providing services to women in the health planning process. However, there was no evidence of such a collaborative approach in the documents reviewed.

These conclusions are, unfortunately, consistent with much current work in the field of population health. As Patricia Kaufert has noted in her analysis of four of the key texts on population health:

> "…[the authors'] decision to ignore women cannot be explained as a matter of chance or academic absent-mindedness. At some level, conscious or unconscious, the decision was made to ignore these differences, to treat them as taken for granted, 'no longer questioned, examined or viewed as problematic.' "[1]

Conclusion 5. Neither province requires that health data be desegregated by sex, although Manitoba does require that the sex of survey respondents be recorded. (Manitoba RHAs can therefore report the percentage of male and female respondents, but they have not reported if and how the responses of men and women differed.) While gender analysis is much more than simply looking at health data for men and women both separately and together, the lack of availability of sex-desegregated data makes gender analysis impossible. Regional health bodies are also limited, since they did not have additional funds to order sex-desegregated data from other sources (such as Statistics Canada) for their areas, nor did either province undertake to provide this to them.

Patricia Kaufert has described this tendency, found in the work of most population health experts, as follows:

> "For epidemiologists and statisticians, the aggregation of data, or their adjustment for age or sex, are simply routine procedures. This approach is so commonplace I did not question it myself until deliberately hunting for the women and finding they were missing or hidden within an aggregated data set."[2]

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[1]Kaufert, Patricia, "The vanishing woman: gender and population health" in *Sex, Gender and Health*, Cambridge University Press, 1999, p. 123.
[2]Kaufert, *op. cit.* p. 125.

In the health needs assessment surveys which were examined for this project, all of the regional health bodies which reported the sex of their respondents reported that more respondents were women. Their published results may therefore not adequately reflect the health needs of men in their local communities.

Conclusion 6. The documents reviewed do not demonstrate an appreciation for the differing health needs of diverse groups of women, including Aboriginal women, women from ethnic and visible minorities, lesbian women and women with disabilities.

Conclusion 7. The decision of the Manitoba government, and of those Health Districts in Saskatchewan which collected survey data, to use household rather than individual data also created problems of data interpretation. One does not know who is represented by the responses. Is the respondent speaking for her/himself or others in the household when answering a question about a particular health need, behaviour or interest? This type of proxy data is particularly questionable, for example, when obtaining information about reproductive health or mental health issues. It makes the disaggregation and analysis of data by sex more problematic.

Conclusion 8. While both provinces officially promote a determinants of health approach, there is little evidence of this in the health plans reviewed for this project. Manitoba health plans contained, on average, reference to 2.4 health determinants, while Saskatchewan plans included an average of only 1.5 of the determinants used in our framework. Health plans tend to emphasize financial reporting and funding requests.

Conclusion 9. Regional health bodies vary considerably in their level of technical expertise in assessment planning, data collection and analysis. Rural regions are at a serious disadvantage with regard to both research literature and access to technical assistance. Internet access is not sufficient to address their information needs.

D. RECOMMENDATIONS

Recommendation 1. Consistent with Canada's international commitments and in order to accurately assess community health needs, and to develop policies, programs and strategies to promote good health and meet health service needs, we recommend that the provincial ministries of health:

- require that regional health bodies collect and report sex-desegregated data in their needs assessments and health plans; and include gender analyses in their health plans; and
- provide regional health bodies with the necessary training, expertise and funds to accomplish these tasks.

Recommendation 2. We recommend that provincial governments ensure that regional health bodies, especially those in rural areas, have affordable access to information sources such as relevant research-based journals and ongoing information about gender analysis and women's health.

Recommendation 3. We recommend that in order to provide the necessary leadership, each provincial government should establish an appropriately-staffed office with expertise in gender analysis and women's health. The expertise of this office should be made available to the regional health bodies and to other government departments, the policies of which directly effect women's health, such as finance, social/-family services, housing and seniors' services.

Recommendation 4. We recommend that both the provincial governments and regional health bodies broaden their perspective on women's health beyond reproductive and family caregiving to encompass a broad determinants of health approach—including gender as a separate determinant—in practice as well as in their public relations materials. In addition, we recommend that eligibility for community-based health services not be based on the assumption that women are willing to provide unpaid caregiving services to family members.

Recommendation 5. The need to develop skills in gender analysis exists across Canada and is not limited to the two provinces examined in this project. Following from Canada's signature to the Beijing *Platform for Action* (1995), we recommend that the Federal government establish a Federal/Provincial/Territorial working group to synthesize and adapt existing policies and gender analysis frameworks and tools for use by regional health bodies across the country. In order to make the best use of existing knowledge, this group needs to work with the Centres of Excellence for Women's Health and other experts in the field.

Recommendation 6. There is a need to incorporate gender analysis throughout the whole planning process, especially at the policy-making and senior planning level, so that there is a systematic approach to addressing women's health needs and gender sensitivity. Though this research focussed on needs assessment and the development of health plans, we recommend applying the methods and tools of gender analysis to program implementation, evaluation and resource allocation as well. Some of the gender analysis tools and model approaches presented in this report can provide guidance.

Recommendation 7. We recommend that regional health bodies institute processes for ongoing input and feedback from diverse groups of women regarding their policies, programs and strategies and how well they meet the needs of women in their regions. Regional health bodies can draw from the expertise of community organizations that work with women as well as researchers with expertise in gender issues and participatory research approaches.

Recommendation 8. Some regional health bodies developed a keen interest in gender analysis during this project. We recommend that the PWHCE pursue opportunities to facilitate and promote gender-sensitive approaches by continuing to work with those regional health bodies which expressed an interest in gender analysis during the course of this project.

Recommendation 9. In addition to training for regional health bodies and provincial governments, it is important that women and organizations that work with women in the community have access to educational materials and events (e.g., workshops) on gender-based analysis and gender-sensitive health planning. Community organizations and concerned individuals often link with decision-makers in their various community roles, and would benefit from gaining the expertise to analyze policies and programs and as citizens hold decision-makers accountable for their actions. PWHCE could work with community stakeholders on this issue as well as with regional health bodies.

Recommendation 10. In order to monitor change and progress, we recommend that regional health bodies be studied again in five years regarding their use of gender analysis and gender-sensitive planning.

E. EXEMPLARY PRACTICES FOR APPLYING GENDER ANALYSIS TO THE HEALTH SECTOR

The most detailed tools to date applying gender analysis to the health sector have been produced by Schalkwyk, Woroniuk, and Thomas (1997) for the Swedish International Development Corporation Agency, the Gender and Health Group (1999), and the Pan American Health Organization. These are reviewed in depth in the full report. Some key issues they address include:

- increased representation of women in decision-making and opportunities for advancement in the health sector (e.g., as employees);
- recognition of social context influences on health (e.g., social and economic disadvantages);
- broadening the focus of women's health beyond reproduction, women's role as mothers, and conditions specific to or more prevalent among women (e.g., cervical and breast cancer);
- inclusion of men as well as women in redressing inequities and promoting women's health and equality (e.g., safer sexual practices);
- gender-sensitivity in all programs, not just those specifically for women;
- equality of outcomes, rather than sameness of activities or treatment (e.g., an equity focus), and inclusivity in developing indicators of success;
- disaggregation of data by sex as well as other demographics;
- training in women's health and gender issues (in both practice and research) for both decision-makers and staff;
- use of inclusive public consultation processes that take barriers to participation into account (e.g., child care, transportation);
- links to women's organizations and other sources of expertise in gender analysis as well as to organizations that address broader health determinants (e.g., food security);
- equitable distribution of resources, access and quality of services by gender as well as attention to the impact of health reform on unpaid care-giving and out-of-pocket costs (e.g., user fees);
- sensitivity to diversity (e.g., cultural); and
- inclusion of women in research—both as participants and in the planning process of research.

In addition to reviewing these health sector-specific tools, the full report also presents a number of exemplary projects being implemented in various jurisdictions that apply these principles—projects from Glasgow (Scotland), San Francisco, Brampton (Ontario), Calgary, Chicago, and Vancouver. In addition, the full report provides background information on determinants of women's health, different approaches to gender analysis both within and beyond the health care sector, additional tools from sectors other than health which may have relevance to health planning, and public participation in health planning.

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PART 1 INTRODUCTION

A. PROJECT PURPOSE

The mandate of the Prairie Women's Health Centre of Excellence includes generating new knowledge through the identification and analysis of research of women's health issues; and providing policy advice, analysis and information to governments, health organizations and non-governmental organizations.

The purposes of this project were:

~ to generate new knowledge about the impact of the regionalization of health planning and service delivery by examining the degree to which gender sensitivity and women's health issues were reflected in the planning processes of regional health bodies in Manitoba and Saskatchewan; and

~ to provide information which the PWHCE could use in advising governments, regional health bodies and others on how to make regional needs assessments and health plans more sensitive to the needs of women.

"Women's health involves emotional, social, cultural, economic, spiritual and physical well-being and is determined by the social, cultural, political and economic context of women's lives as well as by biology."

S. Phillips, 1995

The research team developed evaluation frameworks using relevant literature and discussions with PWHCE staff and members of the PWHCE Theme Advisory Group on the Effects of Health Reform on Women, and used these to analyze needs assessment and health plan documents. This process was followed by interviews with key stakeholders within the regional health bodies that had provided written documents. Specific content and methods for these processes are described in Part 2 of this report.

B. PROJECT CONTEXT

1. MANITOBA

It is noteworthy that in its 1997/98 Health Plan Guidelines, Manitoba Health identified women as one of its four provincial priority populations (the other three were seniors, Aboriginal people and children and youth). However, making women's health a priority does not necessarily mean that policies and programs are woman-centred.

Decision-makers can choose to prioritize women's health mainly because of women's roles as mothers and their potential to effect child health, or they can choose to value women and their health regardless of their roles with respect to children and families. Manitoba appears to have defined women's health mainly in terms of reproduction, parenting and diseases and conditions of the female anatomy. For example, a report prepared for Manitoba Health in 1997 on smoking during pregnancy focused mainly on harm to the fetus, with only a passing reference to adverse effects on the woman's health.[1] The extent to which the stated priority of women's health is reflected in Manitoba Health's role in setting standards for needs assessment and health planning by Regional Health Authorities (RHAs) will be discussed later in this report.

Gender is rarely mentioned elsewhere in the official documents of Manitoba Health, other than a reference to the greater prevalence of poverty among women and its effect on low birth weights,[2] and efforts to recruit and retain more nursing staff.[3] There is no discussion of nursing as a female-dominated profession or how to structure workplaces to support female health care workers (availability of child care options). In addition, the 1997/98 Annual Report[4] notes that home care "supplements, rather than replaces, the efforts of family and community," without acknowledging the risk of overburdening informal caregivers who are most often female.

The documents give a mixed impression of Manitoba's commitment to women's health. On the one hand, it is identified as a priority. On the other hand, the priority is narrowly focused on women's roles as bearers of children and providers of care.

In 1996/97, Manitoba Health was developing a document on gender analysis for Regional Health Authorities (RHAs) to use in planning, but it has never been released. However, in June 1999, the Minister of Health announced the establishment of a Women's Health Unit within Manitoba Health, the formation of a Women's Health Advisory Council, and the intention to develop of a Women's Health Strategy. The Council's mandate and membership has not yet been announced, and the Strategy is to be developed through public consultations.

There is much discussion in Manitoba Health documents about primary health care, health determinants, the Ottawa Charter for Health Promotion principles,[5] and community-based models.[6] For example, the Neighbourhood Resource Networks[7] presently being implemented in Winnipeg are intended to improve primary health care by increasing coordination among providers, enhancing the focus on health

[1] Hague & Gupton, 1997.
[2] Manitoba Health, 1997b.
[3] Manitoba Health, 1999.
[4] Manitoba Health, 1998a.
[5] World Health Organization, 1986.
[6] Manitoba Health, 1997b, 1997d, 1998b, 1998c.
[7] Manitoba Health, 1997d.

determinants, and increasing community involvement with the health system through consultation and other means of participation. This initiative is situated within the Winnipeg Community and Long-Term Care Authority (WCA), which exists alongside the much larger Winnipeg Hospital Authority (WHA). The Women's Health Clinic, one of only two feminist community health centres in Canada, has a representative on the Community Strategy Committee that designed the network framework, and continues to be involved in their implementation.

The commitment to an expanded role for community health centres (CHCs) within the networks is promising. CHCs in Manitoba and elsewhere historically have focused on primary health care within a social context in keeping with a health determinants approach. This approach could reduce the over-medicalization of women's health that often occurs in more conventional health care settings. CHCs have strong community connections that could facilitate innovative approaches to addressing health within the broader social context, provided they are able to maintain their autonomy and community governance. There is potential here for women's health and gender sensitivity issues to be addressed more comprehensively in the future.

Although the provincial government has set overall priorities and mandated core health services, there is allowance for variation among Manitoba's RHAs in the nature and comprehensiveness of specific services provided. While the stated reason for this is to allow RHAs to be responsive to local community needs, this could lead to limited access to some women's health services in some regions. For example, Tudiver and Hall (1996) have pointed out the risk that abortion services, various types of support groups, reproductive health care for teens, and midwifery might not be included in regions where local leaders find them controversial.

Also, the guide to community health needs assessment[8] makes no mention of sex or gender when discussing demographic characteristics used to describe communities, and does not require sex-disaggregated data even though the guide suggests that the sex of survey respondents be noted.

2. SASKATCHEWAN

A 1996 Saskatchewan Health progress report entitled "Health Renewal is Working" mentions issues relevant to women.[9] It notes that women and minorities are better represented on Health District Boards than at the start of the regionalization process. Respite programs for family caregivers increased, and there were more parenting and children's programs—areas in which women are highly involved. However, there is no mention of services specific to women themselves.

Saskatchewan Health's *Innovative Initiatives Portfolio* (1998) lists a number of initiatives by type, district and community clinic that appear to have some relevance to women's health, although programs are not described in detail. These include breastfeeding and parenting initiatives (which fall into a section specifically mentioning women) as well as respite services for family caregivers, home care services, and violence and abuse. Like Manitoba, much of the focus on women's health in the Saskatchewan Health documents focus on female-specific diseases and women's roles and mothers and caregivers.

Saskatchewan Health and the Saskatchewan Association of Health Organizations (1998) have described a vision for the health care system that includes a determinants of health focus (but

[8] Manitoba Health,1997c.
[9] Saskatchewan Health, 1996.

does not include gender and culture as determinants), community involvement and control, better balance between institutional and community-based services, and prevention, health promotion and population health. These areas of emphasis are similar to the vision outlined in the Manitoba documents, and have the potential to increase women's meaningful involvement in health care, provided that gender analysis is integrated into actual system reform (as opposed to rhetorical statements of vision). However, in the section on challenges to health within the same report, the only mention of gender relates to parenting (statements about the high rate of teenage parenthood and poverty of single mothers).

A recent promising development has been the addition of gender as a determinant of health in Saskatchewan Health's *Population Health Promotion Model: A Resource Binder*.[10] The gender section, which was added in 1999, includes a discussion of gender bias in health research and attitudes toward female patients, gender roles, stereotypes and socialization, gender influences on health-related behaviour (using examples of smoking, alcohol use, violence and physical activity), and gender-related media images. Action strategies include viewing women and men within broad roles and social contexts across the life span, addressing gender inequalities (especially around violence) as well as inequalities among women and among men, actively involving women and men in their own health as well as the health care system, and recognizing links between culturally-defined masculinity and femininity and individual health-related behaviours.

In February 1999, Saskatchewan Health published a *Needs Assessment Framework for Health Districts and Their Partners*.[11] This important document sets the framework for future needs assessments by Saskatchewan Health Districts. It is designed to guide Health Districts in the health needs assessment process. It includes a discussion of the determinants of health, but lists only the nine determinants adopted by the Federal/Provincial/Territorial Ministers of Health in 1994 (income and social status, social support networks, education, employment and working conditions, physical environment, biology and genetics, personal health practices and coping skills, healthy child development and health services). Notably, the framework document does not include the three determinants of health added since that time: gender, culture and social environments. Given the lack of recognition of gender as a determinant of health, there is no discussion of the need to desegregate data by sex, nor is there any discussion of the need to include women in the needs assessment process. In fact, the reverse is true. The document notes that one of the challenges of the needs assessment process is the need to involve males and recommends two strategies to get more male input: use a targeted telephone survey and host information days (e.g., "Farmers Day"—the assumption underlying this last suggestion seems to be the outdated notion that women are not farmers). The document does state that involving people with low incomes is a challenge in needs assessment, but there is no recognition of the increased burden of poverty borne by women, nor of the needs which that creates.

It is unfortunate that Saskatchewan Health and the Health Districts which participated in the development of this needs assessment framework guide have chosen to do so without reference to either the *Gender Inclusive Analysis* guide[12] already developed by the Saskatchewan

[10] Saskatchewan Health, 1997, 1998, 1999.
[11] Saskatchewan Health, 1999.
[12] Saskatchewan Women's Secretariat, 1998a, 1998b.

Women's Secretariat (1998), or the department's own work on gender as a determinant of health in the *Population Health Promotion Model: A Resource Binder*. This example clearly illustrates the challenges of implementing gender sensitivity in assessing community health needs, even in an environment which seems politically supportive.

Saskatchewan Health does recognize one area of women's health as important—maternal health. A working group comprised of representatives of the Health Districts, Saskatchewan Health, and the Health Services Utilization and Research Commission (HSURC) has developed a framework for district reporting on program effectiveness and health status. Four population groups have been specified for reporting under this framework: mothers and infants, children and youth, adults and seniors. Women's health is much more than perinatal health. Use of this framework will not allow Health Districts to capture important information about the specific health needs of women of all ages. It also seems significantly narrower than the range of issues addressed by the Minister of Finance in his March 1999 Budget Address, in which more resources for women's special health needs (e.g., osteoporosis, breast cancer) was identified as one of four health care spending priorities (the other three were shorter waiting times, improved access to cancer treatment, and better working conditions for health care workers). The Address also mentioned more funding for home care, which has the potential to reduce the work of unpaid informal caregivers.

3. GENDER SENSITIVITY IN REGIONAL HEALTH PLANNING PROCESSES

Little research has been conducted in Canada on the gender sensitivity of health planning processes in regional health bodies as regionalization is a relatively new initiative which began in the mid-1990s in most provinces. In fact, little published research on gender analysis and sensitivity in health planning in the context of health reform was located during the course of this project.

Early in Manitoba's regionalization process, the Women and Health Reform Working Group conducted community consultations with women and women's organizations in Winnipeg and two rural regions. The purpose was to gather women's concerns about the potential impacts of health reform on women so that those concerns could be considered in the planning processes associated with regionalization at the provincial and regional levels.[13] Recommendations for RHAs from that consultation process included:

- that gender analysis and gender-sensitive planning be incorporated into all policies and activities, especially needs assessments;
- that women be integrated into all levels of decision-making and evaluation in health care;
- that a representative women's health committee be established in each region to ensure that women's issues are addressed at the RHA Board level;
- that gender sensitivity training and information about the impact of gender on health be provided to regional Boards;
- that barriers to women's participation in needs assessments, RHA outreach processes, Boards and advisory committees be removed using inclusive consultation

[13] Women's Health Clinic, 1997.

methods that address those barriers (caregiving responsibilities, discomfort with public speaking);
- that mandated women-specific health services and reproductive choice be provided for diverse groups of women; and
- that a contact person be identified for outreach and advocacy for consumers of the health care system.

However, these recommendations have not been adopted by Manitoba Health or RHAs.

Thurston, Scott, and Crow (1997) surveyed nine of the 17 regional health authorities in Alberta[14] to determine how women's health was treated in administrative policies and programs once regionalization occurred. The Calgary region produced a feminist model recognizing women's lived experiences of health, and the influence of roles, economic resources, societal attitudes, culture, gender and social support on women's health. Calgary also has made women's health one of its priority areas.[15] Calgary's model is discussed in more detail in Part 3 of this report.

Urban centres had more comprehensive approaches than rural areas, and a specific focus on women's health was less evident in the rural regions. Only one rural region had a program labeled "women's health," and health services for rural women appeared to be limited to reproductive health and breast cancer issues. However, one region did have a policy for dealing with sexual assaults that involved collaboration between the hospital emergency department, police and the local sexual assault centre. One needs assessment survey asked female respondents about programs that would interest them. The survey report showed that woman-centred programming varied by region, and was narrowly—and medically—defined in most.

Thurston *et al*. also reviewed several Alberta Health documents related to goals, plans, strategies and public surveys, and found that a gender analysis was largely absent at the provincial level. As evident in the Manitoba and Saskatchewan documents, women's health is defined mainly in terms of reproduction and caring for children and other family members. This is not unique to the Prairies. In much of the medical and health services literature, women's health is defined in terms of the reproductive system or those diseases which are either specific to or most common in women, such as, osteoporosis and breast cancer. This focus has been criticized by some women's health researchers.[16] Doyal (1995) suggests that rather than focusing on diseases and their causes (traditional epidemiology), we need to start by identifying major activities of women's lives, and then examine how these activities affect women's health and well-being, consistent with a health determinants approach. Similarly, Kaufert (1994) has called for a feminist epidemiology that is informed by the lived experiences of women that includes women's voices in the research process. Thus, broader determinants-focused indicators of women's health and methods that invite women to share their experiences of health are needed.

There is a risk that the use of terms like "family health" can lead to decreased recognition of women's specific needs, unless the well-being of women is valued in and of itself. For instance, when children are involved, the focus is placed more on the health of the children than the parent(s). Thurston and O'Connor (1996) have pointed out that parental and child health are intertwined, and that resources to maintain the health balance of each are necessary. In most cases, the parent involved in such initiatives is the mother. Parent- and family-oriented programs that take a woman-centred approach

[14]Health care in Alberta has been regionalized since early 1995, with a transition period in year 1994-95.
[15]Thurston *et al.,* 1997.
[16]Kaufert, 1996.

recognize this balance (the "Nobody's Perfect" parenting program addresses many health determinants issues of mothers—such as poverty, isolation and violence—as well as providing parenting supports). Similarly, a feminist approach to smoking reduction does not encourage a pregnant woman to quit smoking only for the benefit of her fetus or newborn, but also for her own health. This approach recognizes the social contexts in which women smoke, and how they might view smoking as an important function in coping with adverse circumstances.[17]

Regarding issues of care-giving, Wuest (1993) points out that health policy-makers are heavily influenced by the ideology of familism, which places a high value on the altruism of caring for children and the elderly, and which nurtures the belief that care in the home is better than institutional care. Familism often is not explicit about who will do the caring, but when it is, women are clearly the caregivers. Many women's health researchers and advocates point out the risks of increasing care-giving demands on families and the volunteer sector which affect mostly women as services shift from institutions to community-based channels.[18] These authors point out that not only are women being asked to provide more care in the home, but also in institutions as nursing staff is reduced. The authors document some of the negative effects of this shift in terms of decreases in caregivers' ability to:

- work outside the home (including decreased employment opportunities in the relatively well-paying health sector);
- participate in educational opportunities; or
- take time for themselves or social activities.

For instance, Wuest (1993) has pointed out that community health care policy reinforces the traditional gendered division of labour (home care policies that consider the availability of a family member at home when assessing a client's need for home care). From a health determinants perspective, these factors all have the potential to impact negatively on women's health.

Health care restructuring also can have detrimental effects on health care staff, most of whom are women.[19] One example of a health Board showing sensitivity to the impact of restructuring on female employees is the Saskatoon District Health Board. In a presentation at the 1997 Canadian Evaluation Society conference, Chair Susan Wagner explained that when her region closed a hospital ward and long-term care facilities, union members were promised other positions across the region, and that most of those who had been laid off had been re-employed in some capacity within a year. With regionalization, staff were given increased opportunities to move across the district, seniority was recognized across locals, pay was equalized across locals, and salaries for lower-paid positions were raised. Several procedures for enhanced union involvement in decision-making were also put into place.[20] In another presentation, Wagner (1997b) pointed out that as the number of long-term care beds decreased, half the cost savings went to increasing staff in institutional health care because the level of care

[17] Greaves, 1996; Horne, 1995.
[18] Armstrong & Armstrong, 1996; Cohen & Sinding, 1996; Kaufert, 1996; Thurston & O'Connor, 1996; Tudiver, 1994; Wuest, 1993.
[19] Armstrong & Armstrong, 1996.
[20] Wagner, 1997a.

required by clients was heavier. The other half of the cost savings went to community health care (day care, respite care and home care).

C. GENDER AND HEALTH

Much research into the relationship between gender and health has been dominated by bio-medical, psychosocial, or epidemiological "lenses." The first two focus on the individual level (biology or personal change in behaviour and its psychological predictors). The epidemiological lens is broader. It considers behaviour and psychology as mediators between social factors and relative risks for morbidity and mortality, usually controlling for sex and socio-economic status. It is based on the idea that social constructs like gender and class are measured by these variables, rather than explicitly examining them for their effects.

In contrast, the society-and-health lens places the larger social, economic, cultural and political processes in the foreground, and allows examination of how social structures promote or constrain personal health choices and physical responses to risk factors. This approach is the most comprehensive in that it does not ignore biology, psychology and behaviour, but rather places these influences on health within a broader social context.[21] Bird and Ricker (1999) have called for an integration of biological and social approaches that also include consideration of how these interact with gender. In the Canadian context, Labonte (1994) has emphasized the need to address both the personal and the structural as means to empowerment with regard to people's health. This broad view is consistent with the health sector's present emphasis on health determinants.

[21]Walsh, Sorenson, & Leonard, 1995.

1. THE DETERMINANTS OF HEALTH

The twelve determinants of health as outlined by Health Canada (1996) are:

~ ***Income and social status.*** Health status improves at each step up the income and social hierarchy. High income determines living conditions such as safe housing and ability to buy sufficient good food. The healthiest populations are those in societies which are prosperous and have an equitable distribution of wealth.

~ ***Social support networks.*** Support from families, friends and communities is associated with better health. The importance of effective responses to stress and having the support of family and friends provides a caring and supportive relationship that seems to act as a buffer against health problems.

~ ***Education.*** Health status improves with level of education. Education increases opportunities for income and job security, and equips people with a sense of control over life circumstances—key factors that influence health.

~ ***Employment and working conditions.*** Unemployment, underemployment and stressful work are associated with poorer health. People who have more control over their work circumstances and fewer stress-related demands of the job are healthier and often live longer than those in more stressful or riskier work and activities.

~ ***Social environments.*** The array of values and norms of a society influence in varying

ways the health and well-being of individuals and populations. In addition, social stability, recognition of diversity, safety, good working relationships, and cohesive communities provide a supportive society that reduces or avoids many potential risks to good health. Studies have shown that low availability of emotional support and low social participation have a negative impact on health and well-being.

~ ***Physical environments.*** Physical factors in the natural environment (e.g., air, water quality) are key influences on health. Factors in the human-built environment such as housing, workplace safety, community and road design are also important influences.

~ ***Biology and genetic endowment.*** The basic biology and organic make-up of the human body are a fundamental determinant of health. Genetic endowment provides an inherited predisposition to a wide range of individual responses that affect health status. Although socio-economic and environmental factors are important determinants of overall health, in some circumstances, genetic endowment appears to predispose certain individuals to particular diseases or health problems.

~ ***Personal health practices and coping skills.*** Social environments that enable and support healthy choices and lifestyles as well as people's knowledge, intentions, behaviours and coping skills for dealing with life in healthy ways, are key influences on health. Through research in areas such as heart disease and disadvantaged childhood, there is more evidence that powerful biochemical and physiological pathways link the individual socio-economic experience to vascular conditions and other adverse health events.

~ ***Healthy child development.*** The effect of prenatal and early childhood experiences on subsequent health, well-being, coping skills and competence is very powerful. Children born in low-income families are more likely than those born to high-income families to have low birth weights, to eat less nutritious food and to have more difficulty in school.

~ ***Health services.*** Health services, particularly those designed to maintain and promote health, to prevent disease, and to restore health and function contribute to population health.

~ ***Gender.*** Gender refers to the array of society-determined roles, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis. Gendered norms influence the health system's practices and priorities. Many health issues are a function of gender-based social status or roles. Women, for example, are more vulnerable to gender-based sexual or physical violence, low income, lone parenthood, gender-based causes of exposure to health risks and threats (e.g., accidents, STDs, suicide, smoking, substance abuse, prescription drugs, physical inactivity). Measures to address gender inequality and gender bias within and beyond the health system will improve population health.

~ ***Culture.*** Some persons or groups may face additional health risks due to a socio-economic environment, which is largely determined by dominant cultural values that contribute to the perpetuation of conditions such as marginalization, stigmatization, loss or devaluation of language and culture and lack of access to culturally appropriate health care and services.

2. GENDER AND THE DETERMINANTS OF HEALTH

After the report of the Federal, Provincial and Territorial Advisory Committee on Population Health (1994), Health Canada added gender as a separate determinant of health. This is consistent with other recommendations. For instance, the "Overview of Women's Health" chapter in the report *Canada Health Action: Building on the Legacy*[22] produced following the 1997 National Forum on Health, suggests that gender should be added as a separate determinant of health. A similar recommendation has been made by the World Health Organization.[23]

The National Forum paper raises the question of whether health determinants (low income, unemployment, personal health practices) affect women and men the same way, and presents examples of women's experiences that may impact negatively on health (violence, sexual harassment, low-paying jobs with little control). As well, some researchers[24] present examples of how the social contexts of women's lives (violence, unemployment, power differentials with men) influence health behaviours such as substance use and high-risk sexual behaviour.

Although the determinants of health operate similarly for women and men at a broad level, women's *experiences* of some of the determinants may differ. For example, both women and men benefit from adequate incomes, employment and socially supportive environments. However, women are more likely to be living on low incomes (and heading lone parent families on those incomes), to be employed in lower-paying and less stable jobs, and to be encouraged by societal gender expectations to be the primary givers of support to others—even if this is detrimental to their own needs and health.[25] Thus, women's participation in the labour force often confers fewer benefits than men's participation, and women's employment patterns may leave them vulnerable to poverty. Overall, women have more contact with the health care system than men. Much of this difference results from women's reproductive roles,[26] but women are not always offered the same range of diagnosis and treatment options for some conditions, such as heart disease.[27]

As they age, women are more vulnerable than men to some types of disabilities, usually have less access to care from friends and relatives, and have fewer resources to pay for care.[28] Doyal uses the example of HIV/AIDS to demonstrate that the same biological disease process can operate differently for women and men (male-to-female transmission is more common than the reverse), and that health practices can have a gender component (women may not feel safe in insisting on safer sex practices from their male partners).

Women's greater involvement in social support networks can have negative as well as positive health benefits. Janzen (1998) noted that in some studies greater support was associated with increased mortality. Though some of the inconclusiveness in this literature is likely due to methodological differences between studies, Janzen points out that greater social network involvement may increase negative as well as positive interactions with network members. She also notes that women are more likely to be givers, and men receivers, of social support.

[22] National Forum on Health, 1997.
[23] Doyal, 1998.
[24] Cohen & Sinding, 1996; Doyal, 1995.
[25] Graham, 1998; Janzen, 1998; Kaufert, 1996; UK Department of Health, 1998.
[26] Mustard, Kaufert, Kozyrskyj, & Mayer, 1998.
[27] Doyal, 1998; Sharp, 1998.
[28] Arber, 1998; Doyal, 1998.

Though in many circumstances the same health determinants impact women more adversely than men, in some cases the reverse can occur. For example, men have higher rates of injuries from violence that does not involve intimate partners, accidental deaths from high-risk behaviours, and suicides.[29] Men may be more likely to suffer loss of self-esteem from unemployment because of societal expectations of men's work roles.[30]

In addition to experiencing the same determinants of health differently, women's and men's health may differ in which health determinants most strongly predict their health. Recent research using Canada's National Population Health Survey[31] found positive income, employment, family and social support circumstances to be more predictive of good health for women than men. Also, different behaviours were important determinants for men (smoking, alcohol use) than for women (physical inactivity and excess body weight). Although all these health determinants influenced both men's and women's health, the degree of influence differed.

Much work on determinants of women's health has focused on comparing women to men. It is also important to examine how determinants of health are experienced differently among women. In a recent review of the this issue conducted for the PWHCE,[32] the relationship between employment and health status, while positive overall, varied according to other factors such as marital status, number of children, degree of exposure to workplace hazards, and degree of social support outside of work. Culture can also influence other health determinants. The same review found higher unemployment and lower earned income among Aboriginal women, and differences in some health behaviours (higher smoking rates than for the general adult population). Health behaviour often varies among different groups of women. For example, smoking is much more prevalent among women living on low incomes.[33]

When addressing health determinants, it is important to take a comprehensive approach and to consider both "upstream" (income distribution, broad environmental factors) and "downstream" (individual behaviour) policies. For instance, a United Kingdom document on health inequalities[34] has numerous recommendations which address personal change (skills and behaviour), immediate social networks (sources of social support and peer education), health and social services (access to services, tailoring of services to disadvantaged groups) as well as strategies to reduce overall income inequalities at the societal level (education and employment opportunities, cash benefits). Recommendations also recognize different issues faced by people according to their gender, age, ethnicity, and socio-economic status.

Numerous women's health researchers have emphasized the need for more research that is inclusive of women's interests and voices and focused broadly on gender issues as well as sex-disaggregation of existing data.[35] Such research will further the knowledge base concerning the conditions and determinants of women's health.

Finally, women's health advocates need to be vigilant in their analysis of government bodies' use of the language of determinants of health, such as the importance of physical and social environments. Armstrong (1996) notes that despite the rhetoric, most health promotion initiatives still emphasize individual lifestyle change, with less attention to changing the social context in which behaviours occur. Armstrong also

[29] Doyal, 1998; UK Department of Health, 1998.
[30] UK Department of Health, 1998.
[31] Denton & Walters, 1999.
[32] Janzen, 1998.
[33] Graham, 1998.
[34] United Kingdom Department of Health, 1998.
[35] Doyal, 1998; Gender and Health Group, 1999.

notes that the language of empowerment attached to health reform strategies like community-based care and Total Quality Management (TQM) do not reflect the experiences of women as recipients and providers of health care. For example, she points out that the movement to community-based care can increase women's workloads as unpaid caregivers and that TQM initiatives can lead to less job security, deskilling of health care workers and loss of autonomy over one's work. Armstrong notes that despite the talk about social and economic conditions as key health determinants, governments have been cutting social programs and other public services, and working conditions for women are often sub-standard.

In the United Kingdom, Daykin (1998) reported that although most primary health care providers in her research understood the links between poverty and health, and the limitations of a focus on lifestyle change, the structures of the health care system seldom allowed them to move beyond the lifestyle approach even though they realized that broader approaches are needed. Poverty-related health promotion focused on activities such as budgeting skills and cooperative food-buying, and were usually directed to women on the assumption that they are responsible for their families. Daykin found explicit gender analysis to be lacking—providers saw poverty as the central issue and women as mothers and caregivers.

WHAT IS GENDER ANALYSIS?

"...a process that assesses the differential impact of proposed and/or existing policies, programs and legislation on women and men. It compares how and why women and men are affected by policy issues. It makes it possible for policy to be undertaken with an appreciation of gender differences, of the nature of relationships between women and men, and their different social realities, life expectations and economic circumstances. It is a tool for understanding social processes and for responding with informed and equitable solutions."

Adapted from Status of Women Canada, 1998.

In summary, understanding health determinants has the potential to broaden decision-makers' approaches to women's health beyond the individual medical and behavioural spheres, and to develop innovative strategies to promote women's health. However, there is a risk that the language will be appropriated without a commitment to following through on the principles, and/or that determinants rhetoric will be used to justify decisions that are more likely to undermine than to enhance women's health.

As Thurston (1999) has noted, unless feminist theory and critique is used, the model will fall short for women—it is not just gender analysis, but a commitment to gender equality, that counts.

D. GENDER ANALYSIS

Before the recent interest in applying gender analysis to the health sector, organizations working internationally were applying it in various forms to development projects in non-industrialized countries. A key focus of women and development projects was the role of economic development in women's lives. Two inceptive approaches—Women in Development and Gender in Development—are briefly described here:[36]

[36] Good overviews of these developments are provided by the Gender and Health Group of the Liverpool School of Tropical Medicine at the University of Liverpool; and Doyal, 1998.

1. THE WOMEN IN DEVELOPMENT (WID) APPROACH

The Women in Development (WID) approach was formulated during the United Nations Decade for Women (1976-1985). Policies focused on women as a group, emphasizing their productive—rather than reproductive—role. The approach assumed that women are marginalized[37] and that inequality could be addressed by equal opportunities, participation and access to services.[38]

WID led to practical improvements in some women's lives, but has been criticized[39] for isolating women from their social context; not recognizing that not all women are disadvantaged in the same way; and not challenging either men's behaviour or roles, or whether women's increased participation in "productive" activities is beneficial to women.

Initiatives based on WID have done little to alter most women's economic, social and political position in society. WID defined women as being in need of assistance, and ignored issues such as the systematic devaluation of women's work or their limited access to resources.[40]

2. THE GENDER IN DEVELOPMENT (GAD) APPROACH

The Gender and Development (GAD) approach is an outgrowth of WID critiques. GAD examines the social and economic roles of, and relationships between, women and men. It recognizes that these are often unequal with respect to whose activities are more highly-valued and who has more power. Relationships are further examined within different social classes, ages and ethnic groups. GAD emphasizes the necessity of analyzing development interventions in terms of whether they support or challenge gender ideologies and power structures that maintain inequities between women and men. In other words, the GAD approach is relational rather than specifically woman-centred.

The GAD approach and the associated mainstreaming of gender analysis, with its focus on policies and programs within institutions, has been recently criticized for emphasizing process over results, and for the assumption that bureaucracies can adequately represent the interests of women.[41]

Although gender mainstreaming was a focus of the Beijing *Platform for Action*, Baden and Goetz (1998) note that there were dissenting voices at the Non-Governmental Organization Forum at Huairou, such as Nighat Kahn of Pakistan, who argued that:

> "…gender analysis had become a technocratic discourse, in spite of its roots in socialist feminism, dominated by researchers, policy-makers and consultants, which no longer addressed issues of power central to women's subordination. She identified factors underlying this shift as the professionalisation or 'NGOisation' of the women's movement and the consequent lack of accountability of 'gender experts' to a grassroots constituency...[she] asserted that the focus on gender, rather than women, had become counter-productive in that it had allowed the discussion to shift from a focus on women, to women and men, and finally, back to men."[42]

[37] Doyal, 1998.
[38] Doyal, 1998; Gender and Health Group, 1999.
[39] Doyal, 1998; Gender and Health Group, 1999.
[40] Doyal, 1998.
[41] Baden & Goetz, 1998.
[42] Kahn, cited in Baden & Goetz, 1998, p. 21.

E. GENDER ANALYSIS IN THE HEALTH SECTOR

Many of the above issues from the area of women and development have influenced gender analysis in the health sector. For the most part, gender analysis in the health sector has been focused on either women's health needs or gender equity (also known as a gender inequality approach)[43]

1. THE WOMEN'S HEALTH NEEDS APPROACH

The women's health needs approach is concerned with epidemiological differences, and highlights the specific health needs of women and girls. This includes reproduction, but goes beyond it to be more holistic, addressing health needs across the lifespan.[44] Out of this approach comes recognition of the need to provide specific, woman-focused interventions and to compare their cost-effectiveness with a particular focus on infants[45] (matching the gender efficiency approach mentioned above). The cost-effectiveness component also raises the issue of fees for cost-recovery, and whether it negatively affects women and men differently. Standing (1997) notes that this approach to reform fits with the wider theme of "investing in women," where women are seen as the most effective conduit to improving household welfare, particularly that of children.

Overall, the women's health needs approach has many parallels to the WID framework, and has been criticized on the same grounds. It also overlaps in part with the "practical gender approach,"[46] which addresses health needs of women and men within their present socially-accepted roles and responsibilities, without trying to address inequities. The Gender and Health Group notes that the women's health needs approach also has emphasized women's health rights, as influenced by the feminist health movement.

2. THE GENDER EQUITY/GENDER INEQUALITY APPROACH

In contrast, the gender equity/gender inequality approach emphasizes power relations between women and men and is closer to GAD.[47] The approach invites analysis of the role of gender relations in vulnerability to ill health and/or unequal access or utilization of services. A gender equity/inequality approach also recognizes the need to examine how resources are allocated within households (rather than viewing the household as the unit of intervention), and to recognize the effects of changes made in the formal health care system on informal care-giving. Standing (1997) points out that gender influences vulnerability in that women:

- are over-represented among the most vulnerable groups (poorer, fewer income earning opportunities);
- have cultural restrictions on access to services (in some cultures women need permission from men to seek care, and their health needs may be valued less than men's);
- are more adversely affected by children's health problems; and
- have greater time constraints in seeking health care due to demands of household labour.

[43] Gender and Health Group, 1999; Standing, 1997.
[44] Gender and Health Group, 1999.
[45] Standing, 1997.
[46] Moser, 1989; cited in Gender and Health Group, 1999; Molyneux, 1985, cited in Young, 1997.
[47] Gender and Health Group, 1999; Standing, 1997.

The gender inequality approach also recognizes women's relatively low status as health care providers and patients compared to men.

Many of these points have been raised in the growing body of literature linking gender analysis to quality of care. For example, Pittman and Hartigan (1996) discuss providers' different attitudes toward and treatment of women and men and the need to remedy them, the male bias in medical research, the importance of focusing on equity of results versus equal treatment, sex-disaggregation of data, involving both male and female patients in prioritizing indicators (through focus groups), and using gender analysis throughout the quality management process. AbouZahr, Vlassoff and Kumar (1996) also have raised a number of the above issues, and note that the social conditions of women's lives (cultural issues, access, fragmentation of care) often are misunderstood by providers, and underlie what providers label as "non-compliance."

The gender equity/inequality approach has focused mostly on the relationship between gender relations and access to and use of the formal health care system.[48, 49] It is consistent with what Moser (1989)[50] calls a "strategic gender approach"[51] which seeks to address inequities in health and health behaviour by redistributing roles, responsibilities and power between men and women as well as addressing concrete health needs.[52] For example, Doyal (1998) notes that making it easier for a woman to get a job (practical need) may actually increase her overall burden of work if there is no change in the gendered division of domestic labour in the home (which requires a strategic approach). Young (1997) points out that practical and strategic approaches should not be seen as either/or categories. She emphasizes that women's practical concerns can be transformed into strategic concerns. Opportunities for women to interact and take action on their own concerns can lead to consciousness-raising and collective as well as individual empowerment. Also, practical needs have to be met in circumstances where broader change is likely to be long-term. For example, Al-Qutob, Mawajdeh, and Raad (1996) have developed a gender-sensitive model of quality prenatal care that includes access, convenience, continuity of care, provider competence and attitudes, and accurate information about health issues. They recognize that prenatal care is a narrow focus, but point out that it is a critical problem in countries having widespread illness, malnutrition, poverty and under-development, and that broader-based approaches to women's health may have limited effectiveness under such conditions.

Although the practical and strategic distinctions are more common in the women's health literature, there are a number of other classifications. For example, the Pan American Health Organization[53] outlines three classifications consistent with a practical approach—welfare (women as passive beneficiaries), economic self-reliance (focus on poverty without recognizing gender-based subordination of women) and efficiency approaches (women as under-developed human capital). They also outline two classifications consistent with a strategic approach—equality (affirmative action-focused) and empowerment (access to and control of resources).

[48] Gender and Health Group,1999.
[49] For the purpose of this women's health project we have focused on achieving equity for women, though we do recognize that a comprehensive analysis of gender equity would attend to men and gender relations between women and men to a greater extent.
[50] Cited in Gender and Health Group, 1999.
[51] Molyneux, 1985, cited in Young, 1997.
[52] Gender and Health Group, 1999.
[53] Hartigan, Gomez, de Schutter, & daSilva, 1997.

3. EQUALITY AND EQUITY

The Gender and Health Group (1999) also points out the difference between equity and equality as "sameness" versus "fairness" respectively.[54] An equality perspective suggests that people should not be discriminated against in health care on the basis of sex. In contrast, an equity approach suggests that women and men may have different needs and barriers, and these may lead to different degrees of disadvantage. All of this also is influenced by other factors such as age, social class and ethnicity. That is, not all women and men experience gender-related health problems and issues in the same way, depending on other social groupings of which they are a part. Standing (1997) points out that although women are most often disadvantaged, men may be as well in some cases (those on low incomes).

An equitable approach would mean allocating resources and designing, implementing and monitoring programs in ways that address these differences, rather than simply providing equal access to the same services for everyone. However, the Gender and Health Group (1999) point out that this process can be interpreted in different ways—access to basic health care for all versus a focus only on those in greatest need.

Policy researchers such as Schalkwyk, Woro--niuk, and Thomas (1997) and the Gender and Health Group (1999) have produced guidelines for mainstreaming gender that do recognize power differentials and address the tensions inherent in attempting to improve the status of women from within mainstream organizations and institutions. A number of the exemplary projects presented in Part 3 of this report have attempted to integrate gender sensitivity and a strong women's health focus into their policies and services also have confronted these issues.[55]

4. TOOLS FOR GENDER ANALYSIS IN THE HEALTH SECTOR

The most detailed tools to date applying gender analysis to the health sector have been produced by Schalkwyk, Woroniuk, and Thomas (1997) for the Swedish International Development Corporation Agency, the Gender and Health Group (1999), and the Pan American Health Organization.[56] These are described in Part 3 of this report. Some of the key issues they address include:

- increased representation of women in decision-making and opportunities for advancement in the health sector (as employees);
- recognition of social context influences on health (social and economic disadvantages);
- broadening the focus of women's health beyond reproduction, women's role as mothers, and conditions specific to or more prevalent among women (cervical and breast cancer);
- inclusion of men as well as women in redressing inequities and promoting women's health and equality (safer sexual practices);
- gender-sensitivity in all programs, not just those specifically for women;
- equality of outcomes, rather than sameness of activities or treatment (an equity focus), and inclusivity in developing indicators of success;

[54] In some of the documents reviewed for this report, the term "equality" is used in ways that suggest that the actual approach is one of equity. Although we use the language of the authors when discussing their work, keep in mind that most of the tools and models reviewed have an equity focus.

[55] Glasgow Healthy Cities, San Francisco Department of Public Health.

[56] Hartigan *et al.*, 1997.

- disaggregation of data by sex as well as other demographics;
- training in women's health and gender issues (in both practice and research) for both decision-makers and staff;
- use of inclusive public consultation processes that take barriers to participation into account (child care, transportation);
- links to women's organizations and other sources of expertise in gender analysis as well as to organizations that address broader health determinants (food security);
- equitable distribution of resources, access and quality of services by gender as well as attention to the impacts of health reform on unpaid care-giving and out-of-pocket costs (user fees);
- sensitivity to diversity (cultural); and
- inclusion of women in research—both as participants and in the planning process of research.

In 1996, the Commonwealth Secretariat, comprised of 54 member nations, produced 13 good practice principles for gender-sensitive women's health initiatives:[57, 58]

~ *Scope*

1. Women's health concerns extend over the life cycle and are not limited to reproductive problems.

2. Women's health problems include but are not limited to conditions, diseases and disorders which are specific to women, occur more commonly in women, or have differing risk factors or course in women and in men.

3. Health must be considered in broad terms and both positively as well as negatively. Dimensions of health include the physical, mental, social and spiritual.

~ *Determinants*

4. Women's health is directly affected by a range of socio-cultural, physical and psychological factors.

5. Women have gender roles and responsibilities which directly affect their level of access to and control of resources necessary to protect their health. These resources are external (economic, political, information/-education, a safe environment free of violence, and time) as well as internal (self-esteem, initiative).

6. Women are diverse in their age, class, race or ethnicity, religion, functional capacity, sexual orientation and social circumstances. These factors may lead to inequities which adversely affect their health.

~ *Community Participation*

7. Priority should be given to issues that have been identified as important by women themselves. Particular attention should be paid to those issues raised by women who are subject to inequities in their society.

8. Women from the target community should be involved in the planning, implementation and evaluation of projects involving their health.

9. Knowledge arising from projects must be accessible to all women but particularly women in the target community. This also means that information must be provided in forms appropriate to different levels of education and literacy.

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[57] Commonwealth Secretariat, 1996, p. 9.

[58] The Commonwealth Secretariat has developed a gender analysis guide that will be available soon on its Website: www.thecommonwealth.org/gender.

~ *Methods*

10. To address the complex issues affecting women's health a broad-based, interdisciplinary, gendered approach is needed, involving and bringing together the knowledge and methods of social and health scientists and other disciplines where appropriate.

11. Intersectoral approaches are needed to address the social factors affecting women's health and life chances. These may involve the working together of various governmental departmental, non-governmental and community-based groups and the private sector.

12. Knowledge from projects should also inform and influence government policies and plans, legislation, research and health care workers.

13. Where possible there should be resource-sharing of skills between regions.

The Secretariat (1998) also has prepared a brief on Gender Management Systems (GMS) for mainstreaming gender within policies and programs at all levels of government. Issues raised in their brief are similar to those addressed in the more in-depth gender analysis tools mentioned above (inclusion of women in decision-making, use of sex-disaggregated data, consideration of social context and broad determinants of health, collaboration among multiple sectors, commitment at political and administrative levels, training of decision-makers in gender analysis). The Commonwealth Secretariat has been piloting workshops on gender analysis and has found that there is:

- widespread awareness of the need for progress on issues affecting women's equality, but gender concepts are poorly understood by decision-makers;
- lack of distinction between women-specific programs and broader initiatives to address gender equality; and
- reluctance to adopt the concepts of gender equality and mainstreaming, for reasons including perceived threats to status or activists' fear of slowing down progress.

The brief emphasizes the importance of gaining acceptance of the gender perspectives underpinning the GMS before proceeding with the detailed structures and processes needed to implement it. Furthermore, those piloting the workshops have found the pace of progress variable, and mainly determined by the degree of political commitment at the highest levels (Health Minister and Cabinet colleagues). Finally, the Secretariat notes the need for training materials on gender concepts as well as advocacy to national governments and other stakeholders (in the Canadian context this would include provincial government given their responsibility for health services) to facilitate broad participation in the GMS process.

5. BARRIERS TO THE USE OF GENDER ANALYSIS

Baden and Goetz are critical of how the definition of the term "gender" has become flexible to suit organizational needs, and how the meanings given to it by activists, policy-makers and some researchers often are not informed by feminist theory and methods. If gender is used in a descriptive way, the focus on power relations can be lost. They also are critical of narrow statistical approaches to analysis, such as the emphasis on sex-disaggregated data. Though they recognize the value of such data, they also express concern that the approach de-emphasizes issues of power relations between women and men that maintain gender inequalities:

> "Bureaucratic requirements for information tend to strip away the political content of information on women's interests and reduce it to a set of needs or gaps, amenable to administrative decisions about the allocation of resources. This distillation of information about women's experiences is unable to accommodate or validate issues of gender and power."[59]

They also caution against addressing gender issues simply as a means to other ends, such as improved efficiency or service provision.

Another issued raised by Baden and Goetz is how gender is defined. The most common way to define gender is as a social context—roles, behaviours, and so on—that are separate from one's biological sex.[60] Because this definition of gender makes reference to biological sex, it is limiting in that it can de-emphasize differences among women (across cultures, for example). However, they also take issue with the more recent postmodern concepts[61] which see biology as well as social relations as socially constructed, so that sex *is* gender. They point out that if feminists cannot agree on who women are, it is difficult to make political demands on behalf of women. Regardless of the limitations of these definitions, Baden and Goetz suggest that it is critical to view "woman" as a socially-constructed category when pursuing activism and policy work.

The availability of gender analysis tools does not guarantee their use. For example, a public consultation project of the New Brunswick Women's Research Collective (1998) found a number of barriers to use. Focus group participants (both women's organization representatives and individuals interested in gender equality) pointed out that many women outside larger urban centres were unaware of gender-based analysis and related tools, and those who were familiar were mainly professionals, academics and government employees with a focus on women's issues. Participants noted that women and women's groups already performed gender analysis (in terms of evaluating policies, programs and laws as to how women would be affected). Jargon was identified as a problem, as the guides are usually written for researchers and government officials. There was also some observation that despite the availability of tools, individual departments were not conducting gender-based analysis of their own policies and programs, and that shifting political priorities and funding restraints makes it difficult to perform gender analysis—even for those who are interested. Interviews with government department representatives showed that there was no systematic implementation of gender-based analysis. Participants recommended training workshops for women's groups to enhance understanding, but viewed government as responsible for actually conducting the analysis and proving that it has done so for specific policies. Women's groups and other community-based groups would play an advocacy role. Identification of key players, use of accessible language, and setting clear objectives for equality also were discussed.

Departments with women in senior positions showed the most interest, and some departments have held discussions, but gender-based analysis would not be performed in a formal way unless directed by senior management. A planning meeting of women's groups and government officials recommended the formation of a coalition of groups, with the New Brunswick Advi-

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[59] Baden & Goetz, 1998, p. 22.

[60] We have used this distinction for the report, as this way of looking at sex and gender is still most prevalent in most of the women's health literature. Therefore, when we encounter terms such as "gender-disaggregated data," we consider such data to be "sex-disaggregated," as those keeping population-level data would have little gender-related information about people other than their assigned sex—female or male.

[61] Butler, 1990.

sory Council on the Status of Women as the central agency and the Women's Research Collective as an interim steering committee. The next phase will involve education and training, networking and public relations.

The New Brunswick experience illustrates that the availability of guidelines and tools is not sufficient for action. Decision-makers and community-based advocates need opportunities for dialogue and education to apply the principles to specific situations.

In addition to formal gender analysis tools, decision-makers may find useful some questions posed by Quinn (1996) in her critique of existing government policy analysis frameworks which take a gender-neutral approach. She suggests asking questions about how underlying issues, current situations, and past remedies and their outcomes differ for women and men. As well, Quinn suggests questioning assumptions (women are caregivers), short- and long-term effects on women's lives (on employment and pensions), how the policy will be evaluated, and what changes will be made to increase the responsiveness of the policy (or related programs) to women.

6. INDICATORS OF GENDER EQUALITY AND WOMEN'S HEALTH

There is a need for further development of indicators to evaluate progress toward the gender equality that we intend to achieve when we undertake gender-based analysis. Several Canadian government departments and various experts in statistics and gender analysis participated in a symposium on gender equality indicators in the spring of 1998, from which a proceedings document was released.[62] The proceedings note strengths and limitations of numerous existing indicators and the need for further indicator development and refinement as well as reaffirm the importance of gender analysis in policy and program development.

However, at this point, there is no specific, user-friendly guide available on indicators and how to develop, choose or measure them. One model for this type of practical guide might be the gender indicators guide developed by the Economic Commission of Latin America and the Carribean.[63] These are based in part of measures recommended in the Beijing *Platform for Action*. The health indicators include the areas of teen pregnancy and birth rates, HIV/AIDS, workplace safety, breast and cervical cancer screening, malnutrition in children under three, life expectancy and health programs for elderly women. In addition to the health indicators (which are more focused on absence of disease), the report includes sets of indicators focusing on women's conditions with respect to poverty, education and training, violence, armed conflict, the economy, power and decision-making, institutional mechanisms for the advancement of women, human rights, the media, the environment and the girl-child. Indicators tend to be numbers-focused, so would need to be supplemented with additional qualitative data to better understand the meaning of progress rather than simply the extent of it.

A recent overview of women's health indicators from British Columbia, while not a "hands-on" indicators guide, nevertheless provides a broad perspective for measuring progress against goals and objectives.[64] This report is based on the health goals and objectives of B.C., which are in turn based on a health determinants approach. In addition to the usual indicators of morbidity and mortality, the report addresses many social issues such as employment, education, housing,

[62] Stone, Karmen & Yaremko, 1999.

[63] Perez, 1999.

[64] Women's Health Bureau, 1999.

safety, poverty and environments. A recently produced document on population health indicators at the community level[65] also discusses various gender equality indicators (with respect to income, education, decision-making power) and stresses the importance of using sex-disaggregated data to better understand community issues and needs.

7. GENDER ANALYSIS AND HEALTH REFORM

Much of the recent focus on gender analysis in the health sector has coincided with health care reform efforts by governments. Policy researchers see opportunities both to study and influence the effects of health care reform on women's health care and women's health status. The Centres of Excellence for Women's Health established across Canada have various major projects concerning women and health care reform in progress at present. For example, the Maritime Centre of Excellence in Women's Health (1998) recently released a paper on applying gender analysis to home care policy and planning, emphasizing that the majority of formal as well as informal caregivers are women. Past research in this area has been more prevalent in the United Kingdom. The U.K. has health regions similar to those in many Canadian provinces, but regionalization in the U.K. has been in place for a longer period of time.

Cassels (1995)[66] has outlined six main components of health sector reform in the UK. For each component, Standing raises key issues related to gender, many of which also pertain to the Canadian context, and are addressed in the exemplary tools and frameworks presented in Part 3 of this report:

~ ***The impact of restructuring jobs on the gender balance in staffing and on relationships among different professions (particularly male- and female-dominated jobs)***—some aspects of restructuring, such as multi-skilling, can open up opportunities for women at lower levels of the health care hierarchy, but at the same time, may threaten the power of female-dominated professional groups such as nursing.

~ ***The circumstances under which decentralization improves access or further marginalizes vulnerable groups***—Standing suggests developing a "vulnerability index" for regions so that resources can be allocated to districts in ways that take equity into account. Decentralization has the potential to establish more local participation and control over health care, but at the same time may burden local communities with increased responsibilities for financing it.

~ ***Issues of central versus local community accountability of health professionals.***

~ ***How to deal with local preferences for treatment services without neglecting broader preventive and public health initiatives.***

~ ***The need to study the impact of other types of system changes, such as managed competition and use of private sector services on women's access to health care.***

~ ***The need to question how priorities are set and how cost-effectiveness is determined as well as how user fees impact on different groups***—disaggregating "the poor" by gender, age and urban/rural location.

[65] Hancock, Labonte and Edwards, 1999.
[66] Cited in Standing, 1997.

F. INCLUSION OF WOMEN FROM THE COMMUNITY IN THE PLANNING PROCESS

Health planning traditionally has been the domain of professional "experts." This approach has been criticized by women's health researchers, who stress that participation in the planning process is essential to women having power in the health care system.

For example, Taylor and Dower (1997) describe a San Francisco project focused on the development of a model for women's health care service and delivery. Diverse focus groups of women were consulted to review the draft of an "ideal model" and provide feedback and input for a revised model that could be implemented. Women's Health Advisory Committee members co-facilitated the discussions with culturally representative members of the groups consulted (cancer survivors, seniors). Focus groups were held in locations that were comfortable and convenient for the women. Results of the discussions clearly indicated that women wanted to see changes in both the attitudes and behaviours of health care providers (insensitivity to diversity issues such as culture, sexual orientation, disabilities; lack of respect for women's concerns and experiences; poor quality of care including incorrect use of medications and unwanted touching). Beyond individual provider issues, women spoke of the need for the overall health care system to address problems with access (economics, diversity, time and location, and language) and to move beyond narrow views of health (address the whole person in the context of her life circumstances; include a wellness focus and complementary therapies). Women made recommendations as well as identifying problems. For example, they recommended training in "cultural competence" to address diversity issues, and more direct involvement of consumers in quality assurance issues. The women consulted offered to play a greater role in leadership and governance, as long as supports such as child care and transportation were provided. This model and others are presented as exemplary approaches in Part 3 of this report.

Feather, McGowan, and Moore (1994) have pointed out that a health needs assessment:

> "…can bring the community into an active and more equal partnership in health decisions, enabling people to take ownership of their own health challenges and to exert some control over health planning decisions, based on a shared vision and community-based analysis of need. It can be empowering and therefore health promoting." (p. 7)

They contrast a community development approach to needs assessment with the more conventional medical science (disease focused) and health planning (program and service focused) approaches.[67] Citizen empowerment and a broad determinants of health approach are key to the community development approach. Needs assessments may use a combination of these approaches.

Feather *et al*. point out that both the "owners of the need" (those who can speak from their lived experience) and the "experts on the need" (those who provide service to people in need) should be heard. They also point out that people who seem uninterested in participating in the needs assessment process may have barriers to participation and/or may feel powerless in having any control over decision-making. They state that people need a commitment that the information they provide will be used, and that their participation in the needs assessment process must be ensured without resorting to tokenism. Finally, they point out that interactive methods with

[67] Based on Bracht, 1990, cited in Feather *et al.*, 1994.

members of the public (focus groups, community forums) provide more opportunities for participation than key informant interviews, statistical data and surveys.

There are some good examples of how community organizations have conducted needs assessments that are inclusive of women's voices, although there is little from health authorities/-districts to date. One good Prairie-based example is the Saskatoon Community Clinic's older Aboriginal women's project, which took a participatory action research approach to needs assessment.[68] The framework used covered various health determinants (finances and social relationships), and involved extensive discussions with grandmothers about their perceptions of health as well as their self-perceived strengths and life concerns (in addition to more conventional health status and behavioural information). This framework focused on strengths as well as needs, and the results were used to make service decisions.

Public participation needs to go beyond just the needs assessment stage. For example, Griffiths and Bradlow (1998) describe a process over several years where a British regional health authority both solicited public input about the health issues that concerned it and requested organizational and public feedback on health strategies that grew out of previous needs assessments. Some changes and additions were made to health services based on this feedback. (One area on which feedback was sought was the health authority's women's health strategy.)

Ongoing communication with community organizations and individuals can raise decision-makers' awareness of issues affecting diverse segments of the population. Cohen (1998) notes that "when women are given a voice, they identify problems which sometimes have received little validation and seldom have been the focus of discussions of women's health."[69] Tudiver and Hall (1996) discuss how diverse social and cultural communities of women (lesbians, women with disabilities, women from cultural and ethnic minority groups including First Nations, and rural and farm women, and survivors of abuse) offer different vantage points from which to witness impacts of such circumstances of poverty, discrimination and violence and physical and emotional well-being. They offer several examples of unique health issues faced by each of these groups of women as well as barriers they encounter when trying to access the health care system. Cohen and Sindling (1996) emphasize the need for health services to be accessible to women in a wide variety of ways (convenient times and places, adaptable to disabilities, appropriate language, respectful of diversity). Kaufert (1996) points out that poverty and racism influence other health determinants such as access to education, nutrition, health care, housing and safe environments.

There are varying levels of public participation, from manipulation ("rubber stamp" citizen positions on committees for public relations purposes) through to citizen control such as governance of a program or institution.[70] Labonte (1995) lays out a framework for assessing the type of community participation (professionally dominated, locally dominated, or negotiated equity) in various aspects of health planning and delivery (including needs assessment and management). He focuses on health promotion, but the framework could be applied more broadly to other aspects of the health system as well.

Tudiver and Hall (1996) point out that the criteria used in planning and evaluating programs and services must include the expertise and insights of the women's health movement. From a health determinants perspective, it is important

[68] Dickson, 1995.

[69] Cohen, 1998, p. 192.

[70] Defined by Arnstein, 1969; addressed in MacKean & Thurston,1996; Wiebe, MacKean, & Thurston, 1998.

that women's health organizations are defined broadly (include those dealing with violence against women). They describe community health centres (the community-governed model) as an example of a type of primary health care service that is holistic, provides meaningful community involvement, service coordination, and addresses prevention, promotion and health determinants. Many CHCs in Canada have programs that specifically address women's needs. The Women's Health Clinic in Winnipeg and the Women's Health in Women's Hands centre in Toronto serve women exclusively.

Health Canada has recently released a framework for planning and evaluating community-based health services.[71] While it does not address gender specifically, some aspects of the model promote community participation. For example, it addresses client choice, consumer involvement in planning, delivery and evaluation of health services, and partnerships between the health sector and other community organizations. However, the failure to address gender specifically may reflect lack of awareness of this major social construct and its implications. For instance, much discussion of the value of community fails to acknowledge the differential value by sex, race, socio-economic status and other social characteristics. At present, not making gender explicit is equivalent to ignoring it.

Use of feminist research methods is essential to ensuring inclusive and meaningful participation in both needs assessment and program and policy evaluation. Some practical guidelines for feminist research processes are outlined in Barnsley and Ellis (1992), Ellis, Reid, and Barnsley (1990), Kirby and McKenna (1989), and Ristock and Parnell (1996). In addition, a model linking feminist research methods to health promotion in particular is presented by O'Connor, Denton, Ahmed, Williams and Zeytiniglu (1998).

[71]Wanke, Saunders, Pong, & Church, 1995.

Thurston *et al*. noted that in 1990 the Federal/Provincial/Territorial Working Group on Women's Health recommended a number of principles for developing programs and policies—including addressing inequities, fostering greater public participation, support to care-givers, comprehensive and integrated service models, respect for diversity, collaboration with women's groups and other community organizations, and developing mechanisms to implement policies and programs to promote women's health. Cohen and Sinding note that the *Federal Plan for Gender Equity*[72] points to some ways in which women could benefit from health care reform (access to alternative providers such as nurse practitioners and midwives; increased support for citizen involvement in decision-making). The Plan also recognizes that early patient discharge and home care can lead to increased unpaid care-giving by women.

G. CANADA'S INTERNATIONAL COMMITMENTS TO GENDER EQUALITY

Though a detailed review of these commitments was beyond the scope of this project, some highlights from the *Platform for Action* from the 1995 Fourth World Conference on Women in Beijing,[73] the 1994 International Conference on Population and Development in Cairo,[74] and the United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)[75] provide additional context for gender analysis as applied to health. These clauses address health issues at various levels—policy and planning, direct service, and health-related behaviours—and link health to human rights.

[72]Status of Women Canada, 1995.
[73]United Nations, 1995.
[74]Cited in Schalkwyk *et al.*, 1997.
[75]CEDAW; United Nations, 1981.

Canada participated in all three of these international gatherings and made commitments to take action on gender equality as well as others such as the Nairobi Forward Looking Strategies in 1985.[76] The *Federal Plan for Gender Equity* was prepared as Canada's contribution toward the goals of the Beijing *Platform for Action*. CEDAW is a legally binding international agreement to examine the effects of legislation for its potential to be gender-discriminatory and to take actions to correct historical patterns of discrimination. Canada is a signatory to CEDAW, which took effect as an international treaty in 1981.[77] The health-specific commitments made by signatories to CEDAW is Article 12:[78]

> "States parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning....States parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services when necessary, as well as adequate nutrition during pregnancy and lactation."

Other articles of CEDAW call for the elimination of discrimination against women in education (Article 10), employment (Article 11), legal matters (Article 15), marriage and family (Article 16), and other areas of social life such as access to credit, family benefits and recreation and sport (Article 13). Article 14 of CEDAW also calls for attention to the above issues specific to the context of rural women (including access to health services). Articles 4 and 5 address maternity issues.

In addition, the following excerpts from the Beijing *Platform for Action* are especially relevant to women's health and gender-sensitive policy development and planning:

> "Women have the right to the enjoyment of the highest attainable standard of physical and mental health. The enjoyment of this right is vital to their life and well-being and their ability to participate in all areas of public and private life. Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Women's health involves their emotional, social and physical well-being and is determined by the social, political and economic context of their life, as well as by biology." (Paragraph 89)

> "In addressing inequalities in health status and unequal access to and inadequate health care services between women and men, governments and other actors should promote an active and visible policy of mainstreaming a gender perspective in all policies and programs, so that, before decisions are taken, an analysis is made of the effects for women and men, respectively." (Paragraph 105)

Paragraphs 106 to 110 contain strategic objectives related to women and health:

> "1. Increase women's access throughout the life cycle to appropriate, affordable and quality health care, information and related services;
> 2. Strengthen preventive programmes that promote women's health;
> 3. Undertake gender-sensitive initiatives that address sexually-transmitted diseases, HIV/AIDS, and sexual and reproductive health issues;
> 4. Promote research and disseminate information on women's health; and
> 5. Increase resources and monitor follow-up for women's health."

[76] See Status of Women Canada, 1995, p. 6-7.
[77] The *Platform for Action* and resolutions from Cairo are not binding conventions.
[78] United Nations, 1995.

The *Platform for Action* Summary contains the following recommendation:

> "Integrate gender perspectives in legislation, public policies, programmes and projects; ensure that before policy decisions are taken, an analysis of their impact on women and men is carried out."

Various points under Action 206 (actions by national, regional and international statistical services) that are most relevant to the present report include:

- data disaggregation by sex, age and other socio-demographic indicators;
- involvement of centres for women's studies and research organizations in development and testing indicators and methodologies to strengthen gender analysis;
- strengthen vital statistical systems and incorporate gender analysis into publications and research, examine gender differences to improve morbidity data, and improve data on access to health services (particularly reproductive and maternal); and
- develop sex-disaggregated data for specific issues such as violence and people with disabilities.

Action 207 addresses government action. It suggests a regular statistical publication on gender suitable for non-technical users (with regular review by both producers and users and improvement as needed), quantitative and qualitative studies by diverse organizations on the sharing of power and influence in society, and use of gender-sensitive data in the development and implementation of policy and programs.

Some examples from the 1994 International Conference on Population and Development in Cairo are:[79]

> "Advancing gender equality and equity and the empowerment of women, and the elimination of all kinds of violence against women, and ensuring women's ability to control their own fertility, are cornerstones of population and development-related programmes. The human rights of women and the girl child are an inalienable, integral and indivisible part of universal human rights." (From Cairo, Principle 4)

> "Men play a key role in bringing about gender equality since, in most societies, men exercise preponderant power in nearly every sphere of life, ranging from personal decisions regarding the size of families to the policy and programme decisions taken at all levels of government....Special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour, including family planning; prenatal, maternal, and child health; prevention of sexually transmitted diseases, including HIV; prevention of unwanted and high-risk pregnancies; shared control and contribution to family income, children's education, health and nutrition; and recognition and promotion of the equal value of children of both sexes. Male responsibilities in family life must be included in the education of children from the earliest ages. Special emphasis should be placed on the prevention of violence against women and children." (Excerpts from Cairo, paragraphs 4.24 and 4.27)

[79] Cited in Schalkwyk *et al.*, 1997.

PART 2 EVALUATION OF DOCUMENTS AND INTERVIEWS WITH REPRESENTATIVES OF REGIONAL HEALTH BODIES

A. CONTENT OF THE EVALUATION FRAMEWORKS

The preceding review of academic, government and organizational literature on gender analysis issues in health planning and evaluation formed the basis for developing the framework for assessing the gender-sensitivity of needs assessments and plans; and the specific questions asked of key informants.

The ***needs assessment framework*** addressed the following issues:

ISSUE 1 **INCLUSIVITY OF CONSULTATIONS**

ISSUE 2 **MINIMIZING BARRIERS TO PARTICIPATION**

ISSUE 3 **INCLUSION OF DATA-RELATED TO HEALTH DETERMINANTS**

ISSUE 4 **DISAGGREGATION OF DATA BY SEX**

ISSUE 5 **DISCUSSION OF FINDINGS FOR SPECIFIC GROUPS OF WOMEN**

ISSUE 6 **VERIFICATION OF FINDINGS WITH COMMUNITIES**

The ***framework for evaluating health plans*** addressed the following issues:

ISSUE 7 **EVIDENCE OF WOMEN'S HEALTH AS A PRIORITY**

ISSUE 8 **RECOGNITION OF CONTEXT AND DETERMINANTS OF WOMEN'S HEALTH**

ISSUE 9 **APPROACHES TO WOMEN'S HEALTH ISSUES** (primarily illness-focussed or inclusive of health promo-tion and gender analysis of social conditions)

ISSUE 10 **SENSITIVITY AND PROACTIVE APPROACH IN ADDRESSING DIVERSITY**

ISSUE 11 **ACCESSIBILITY** (of services, types of providers, community settings)

ISSUE 12 **TYPES OF COLLABORATIVE RELATIONSHIPS** (with women, agencies)

ISSUE 13 **RECOGNITION OF INFORMAL CAREGIVER ISSUES**

ISSUE 14 **RECOGNITION OF EFFECTS OF HEALTH CARE REFORM ON EMPLOYEES** (mostly female)

ISSUE 15 **EVIDENCE-BASED DECISION-MAKING AND EVALUATION**

The ***guiding questions for key informant interviews*** addressed:

- How decisions are made about health priorities;
- If/how gender-related issues are included in the health planning process;
- Perceptions of the most important influences on women's health;
- Ways of including women and organizations that work with women in health planning processes;
- Use of evidence-based decision-making in planning;
- Differential influences on women and men of determinants of health and health care reform (e.g., institution to community shift);
- Collaborative initiatives with other organizations serving women;
- Ways of addressing diversity in the health planning process, and related challenges;
- Ways of including women and organizations that work with women in evaluation of health reform efforts; and
- Ways to be responsive to women's needs as health reform proceeds.

B. METHODS

1. NEEDS ASSESSMENTS AND HEALTH PLANS

Each region/district received a letter from the Director of the Prairie Women's Health Centre of Excellence introducing the project and the project team members. They then received a follow-up letter from a member of the research team which requested that they provide:

- the most recent health plan for their region/-district;
- health needs assessments done for their region/district; and
- any other work which they may already have done on the health needs of women in their region/district.

This documentation was analyzed using two frameworks—one for the needs assessment documentation and one for the health plan documentation.

In all, eight of 11 Manitoba Regional Health Authorities (RHAs) responded. Seven of these provided health plan documents for review and analysis, and eight provided needs assessment documents. The two Winnipeg RHAs were excluded from the survey because they began op-

eration in April 1998 and have not yet published their first needs assessment documents. In Saskatchewan, 17 of 32 Health Districts responded to the request. Sixteen of those provided health plan documentation, and 12 provided needs assessment documentation. Documents submitted by regions/-districts, in response to the request for information about any work undertaken on women's health, have also been included from both provinces.

Most of the questions used a three-point scale. Where the researcher found at least one piece of documented evidence, the "Some" category was used. Where a regional health body documented significant efforts into, consideration of, or research about, a particular issue, the "Extensive" category was used.

In the information and analysis of the needs assessment and health plan documents which follow, the data from the two provinces has been combined. There were no substantial differences between responses from Manitoba and those from Saskatchewan.

2. INTERVIEWS WITH REPRESENTATIVES OF REGIONAL HEALTH BODIES

Regional health bodies were selected for interviews using the following criteria:

- the sample should be representative of both provinces (3 Manitoba; 5 Saskatchewan); and
- the sample should be geographically representative (north/south; rural/urban).

In several cases, representatives of regional health bodies expressed interest in being interviewed for the project. All of these were interviewed.

In order to arrange the interviews, the Chief Executive Officer's office was contacted and the purpose of the interviews was explained. The interviewees were selected by the CEO. Interviewees' positions ranged from Health Educator to Vice-president to Medical Officer of Health.

All interviews were conducted by telephone by the same member of the research team. She took verbatim notes during the interview.

These transcribed interviews were imported into the QSR NUD*IST software program for qualitative data analysis. All transcripts were read by all of the research team members. One member conducted an analysis using the constant comparison method. The analyst moved back and forth between transcripts and analysis, uncovering similarities and differences, within and between interviews. Codes were applied to a section of a transcript, and then all sections of transcripts from interviews with the same codes were reviewed. The analyst went back and forth between sections of the transcript and the whole transcript to check context of quotes and verify interpretations. As sections were coded, categories and subcategories became apparent. As a result of this process, the interviews were reviewed several times. The analyst then wrote a narrative description of the data, following the coding. The process of writing and interpreting lead to returning to the transcripts, re-checking context, and searching the interviews for other codes and categories. The preliminary analysis was then sent to the other two researchers who checked the credibility of interpretation. Differences of opinion were few, but were discussed until consensus was reached. The variety in backgrounds of the three researchers enhances the transferability of the findings; in other words, there is less chance that the interpretation is narrowed by discipline or experience.

C. FINDINGS: NEEDS ASSESSMENTS

ISSUE 1 INCLUSIVITY OF CONSULTATIONS

1a. Inclusion of organizations that work with or for women in the needs assessment process? (e.g., service or advocacy)	EXTENSIVE	SOME	NONE
Within the health sector	0	1	19
Outside the health sector	0	9	11

Ninety-five per cent of regions/districts did not include health care organizations that work with or for women. Fifty-five per cent did not include any organizations that work with women.

1b. Inclusion of women who are users (or potential users) of health services in the needs as-sessment process?		
EXTENSIVE	**SOME**	**NONE**
0	18	2

Women were included through surveys, focus groups, key informant interviews and public meetings.

Manitoba RHAs were required to conduct surveys of their populations using a format designed by the Province. Regions were allowed to add additional questions. The province required that RHAs ask the sex of the respondents. There was, however, no requirement that the data gathered be disaggregated by gender. The fact that no sex-disaggregated data was published may reflect:

- Manitoba RHAs' practice of providing only those data required by the Province.
- The belief that the views of women and men need not be considered separately in analyzing community health needs. If the views of women as a whole are not considered to be significant and potentially different than those of men, then it follows that these RHAs and Health Districts would not take the next step and consider the needs of particular groups of women. (We learned in the interview process that one RHA does have sex-disaggregated data, but this has not been published.)
- A lack of understanding of the importance of sex-disaggregation of survey data. In the surveys done by most RHAs/Health Districts, more women responded than men. Without disaggregating the data, the needs of men may therefore be understated in the published survey results.
- An organizational culture which is not open to the consideration of the many ways in which gender influences health. Even if those responsible for the survey believed that the needs of women and men should be examined both separately and together, and even if they understood the importance of sex-disaggregation of data, this would only be accomplished with the support of senior management.

1c. Groups of women specifically consulted?	EXTENSIVE	SOME	NONE	DON'T KNOW
Aboriginal	0	1	18	1
Francophone	0	1	18	1
Cultural groups from outside North America or Western Europe	0	0	19	1
Rural	0	3	16	1

CONTINUED . . .	EXT.	SOME	NONE	DK
Single mothers	0	1	18	1
Adolescents	0	0	19	1
Lesbians	0	0	19	1
Abuse survivors	0	0	19	1
Women with disabilities	0	0	19	1
Women living on low incomes	0	0	19	1
Women with low literacy skills	0	0	19	1
Others (specify): P "mothers of young children"	0	1	18	1

In three of the seven cases where the views of women were sought separately, it was because of their relationship to either their children (single mothers, mothers of young children) or to men. One focus group was held for "farmers' wives," language which does not recognize the work of these women as farmers in their own right and part of a farming team with distinct needs. At one public meeting, a participant was reported as saying, "Rural women are a forgotten race." This attitude was evident in a farm health survey which was circulated with the instructions that it be completed by "the farmer, his wife or his worker."

In some regions/districts, the lack of consultations with ethnic and cultural groups reflects their small numbers.

1d. Public/community consultations held?	
YES	NO
19	1

TYPES OF CONSULTATIONS*	EXTENSIVE	SOME	NONE
Meetings with women's organizations or groups	0	3	17
Focus groups	5	9	6
Forums	7	7	6
Input from community development staff who are in regular contact with women and women's groups	0	1	19
Other (specify): P Key informant interviews	5	1	14
P Forum for women	1	0	19
P Youth survey	1	0	19

*This question solicited information about consultations in general. Regions/districts understand that consulting with the public is part of their mandate. Note that meetings by one region/district with "ladies auxiliaries" is included in 4a.

1e. Narrative as well as quantitative data?			
EXTENSIVE	SOME	NONE	DON'T KNOW
5	14	0	1

ISSUE 2 MINIMIZING BARRIERS TO PARTICIPATION

2a. Mechanisms to minimize barriers?	YES	NO	DON'T KNOW
Child care available for public consultations	0	18	2
Transportation available to public consultations	0	18	2

CONTINUED . . .	YES	NO	DK
Flexibility of times to participate (e.g., choice of time to be surveyed, choice of public meetings to attend)	15	4	1
Consultations in both small and larger communities	18	1	1
Reimbursement for out-of-pocket expenses	0	19	1
Honoraria for time spent providing information (e.g., survey, interviews, meetings)	0	19	1

Regions/districts understood their mandate to include public consultations. While many noted the low numbers of participants at such consultations, they did not consider measures such as transportation, child care, reimbursement for out-of-pocket expenses or honoraria for participants as potential means to increase participation and access. All of these would have involved some additional expenditure for the region/district.

Although no regions/districts reported providing transportation assistance, during the interview process we did learn of one which did so.

2b. Background information to enable meaning-ful input? (e.g., why their participation is important, is-sues to be discussed)

YES	NO	DON'T KNOW
1	18	1

2c. Opportunity for anonymous verbal input?

EXTENSIVE	SOME	NONE	DON'T KNOW
1	1	17	1

One region reported on an anonymous phone survey.

2d. Opportunity for anonymous written input?

EXTENSIVE	SOME	NONE
1	14	6

ISSUE 3 INCLUSION OF DATA-RELATED TO HEALTH DETERMINANTS

3a. Reporting of data regarding health determinants?	EXTENSIVE	PARTIAL	NONE	DON'T KNOW
Income and social status	4	9	7	0
Social support networks	0	12	8	0
Education	1	11	8	0
Employment and working conditions	0	10	10	0
Physical environments	4	6	10	0
Biology and genetic endowment	0	2	18	0
Personal health practices and coping skills	3	11	6	0
Healthy child development	1	9	10	0
Health services	5	7	8	0
Gender	0	5	15	0
Culture	0	5	15	0

Knowledge about determinants of health varied among regions/districts, as did the ability to obtain data for their specific areas. Manitoba Health has set "women's health" as one of its priority areas, yet only two of the eight participating Manitoba RHAs included any documentation about gender as a determinant of health. Only 25% of all RHAs/Health Districts reported any information about gender.

Regions/districts were more likely to report information about individual determinants of health, such as personal health practices and coping skills, than about structural determinants of health, such as income, employment and education.

Some of the data included demonstrated the need for a greater understanding of gender and women's issues in particular. For instance, one region/district classified child day care as a "recreational program," while others classified the commercial weight loss program offered by Weight Watchers as a "health promotion" program.

ISSUE 4 DISAGGREGATION OF DATA BY SEX

4a. Disaggregation of data by sex for the following?	EXTENSIVE	SOME	NONE	DON'T KNOW
Morbidity	1	5	13	1
Mortality	1	6	12	1
Service utilization	0	4	15	1
Social indicators (health determinants other than gender—e.g., income)	1	1	17	1
Health survey data (e.g., behaviours, knowledge, attitudes)	0	8	11	0
Community surveys of opinions / preferences regarding health care	0	1	18	1
Community consultations (forums, focus groups)	0	1	17	2
Other	None reported			

Regions/districts relied heavily on data provided by their respective provincial governments. Some were able to supplement this with data obtained from other bodies, such as Statistics Canada, or data gathered locally. One interprovincial difference did emerge in response to this question. While only one of eight participating Manitoba RHAs included any sex-disaggregated about health behaviours, seven of twelve participating Saskatchewan Health Districts did so. This was most often data from youth surveys and focus groups.

The lack of sex-disaggregated data reflects the lack of understanding of gender as a determinant of health. It also contributes to that lack of understanding, since without data on gender differences in the determinants of health, health status and health service utilization decision-makers may not understand the ways in which gender influences health.

ISSUE 5 DISCUSSION OF FINDINGS FOR SPECIFIC GROUPS OF WOMEN

5. Discussion of specific needs assessment findings for any of the following groups of women?	EXTENSIVE	SOME	NONE	DON'T KNOW
Aboriginal	0	2	17	0
Francophone	0	0	19	1
Cultural groups from outside North America or Western Europe	0	1	18	0
Rural	0	0	19	1
Single mothers	0	0	19	1
Adolescents	0	1	18	1
Lesbians	0	0	19	1
Abuse survivors	0	0	19	1
Women with disabilities	0	1	18	0
Women living on low incomes	0	0	19	1
Women with low literacy skills	0	0	19	1
Others: (specify) P one focus group of young mothers	0	1	19	0

Some RHAs/Health Districts reported on the needs assessment findings for Aboriginal people, rural people, those living on low incomes or with low literacy skills. However, since data was not disaggregated by sex, regions/districts were unable to report on the health needs of any of the above groups of women.

ISSUE 6

VERIFICATION OF FINDINGS WITH COMMUNITIES

6a. Process for checking needs assessment with the following?	EXTENSIVE	SOME	NONE	DON'T KNOW
Organizations that work with/for women				
P within the health sector	0	0	18	2
P outside the health sector	0	0	18	2
Organizations that advocate on behalf of women	0	0	18	2
Women who are users (or potential users) of the health system	0	2	16	2

6b. Description of how needs assessment information is to be used in further planning specifically for women's health?			
EXTENSIVE	SOME	NONE	DON'T KNOW
0	0	18	2

D. SUMMARY ANALYSIS OF NEEDS ASSESSMENTS

1. The needs assessment documents reviewed indicate that gender was rarely considered as a variable in assessing local health needs and that consequently, the health needs of women rarely were considered separately from those of men.

2. Regional health bodies published little sex-disaggregated data. While gender analysis is much more than simply looking at health data for men and women both separately and together, the lack of availability of sex-disaggregated data makes gender analysis impossible. Regional health bodies are also limited, since they did not have additional funds to order sex-disaggregated data from other sources (such as Statistics Canada) for their areas, nor did either province undertake to provide this to them.

3. Although Manitoba Health has set women's health as one of its priorities, RHAs were given no background information about women's health, nor any guidance about how to specifically assess the health of women in their communities. This lack of information is reflected in their responses. In both provinces, only 25% of those participating included any data about gender in their needs assessments.

E. FINDINGS: HEALTH PLANS

ISSUE 7

EVIDENCE OF WOMEN'S HEALTH AS A PRIORITY

7a. Women's health identified as a priority area in the health plan?	YES	NO
Identified as priority	5	18
Plan includes a statement of commitment to gender equity	1	22

The Province of Manitoba has set women's health as one of its four priority areas. Of the seven responding Manitoba RHAs, four identified women's health as a local priority. Only one district in Saskatchewan expressed a written commitment to gender equity.

7b. Number of regions/ districts identifying woman-specific initiatives by num-ber of initiatives?	2/3 PROGRAMS	1 PROGRAM	NO PROGRAMS
Current programs	6	2	15
Proposed programs	5	4	14

The programs specified were as follows:

- ***General health:*** women's health fair; women's health newsletter.
- ***Cardiovascular health:*** women's heart health program.
- ***Cancer prevention and detection:*** anti-tobacco programs; part-time colposcopy clinic; communication re: screening; programs for cervical and breast cancer; mobile breast cancer screening.
- ***Reproductive health:*** teen pregnancy program; women's health centre (outpatient gynecological clinic); menopause education ($100 budget).
- ***Children's health programs targeted to women:*** breastfeeding service; lactation consultant; "Successful Mothers" program; maternal, child, youth interagency task force; Métis women's life skills ($7,500 budget).

Most of the programs documented by regions/-districts fit a narrow definition of women's health, focussing only on gender-specific health needs (reproductive health, breast and cervical cancer screening), or on women's role as mothers (lactation services, maternal/child programs, mothers' programs).

7c. Percentage of total budget allocated to woman-specific initiatives within the time frame of the health plan's budget?
This information was not reported by any region/district.

7d. Women's health advisory committee?	YES	NO
4a. In place	0	23
4b. Planned	0	23

No regions/districts reported having a women's health advisory committee in place.

7e. Consultation with broad-based women's health coalitions or networks? (e.g., Women and Health Reform Working Group in Manitoba, Women's Health Advocacy Coalition in Saskatchewan, Canadian Women's Health Network, PWHCE)		
EXTENSIVE	SOME	NONE
0	1	22

Regions/districts also did not report consulting with women's health networks.

ISSUE 8 RECOGNITION OF CONTEXT AND DETERMINANTS OF WOMEN'S HEALTH

8a. Degree of recognition of life experiences that influence women's health and access to services? (e.g., transportation, child care needs; women's greater exposure to violence; higher prevalence of poverty among women)		
EXTENSIVE	**SOME**	**NONE**
0	1	22

8b. Consideration of health determinants?	**EXTENSIVE**	**PARTIAL**	**NONE**
Income and social status	0	3	20
Social support networks	0	3	20
Education	0	1	22
Employment and working conditions	0	2	21
Physical environments	0	4	19
Biology and genetic endowment	0	1	22
Personal health practices and coping skills	0	6	17
Healthy child development	0	6	17
Health services	0	7	16
Gender	0	4	19
Culture	0	4	19
Recognition that health determinants can affect women and men differently	0	0	23

Regions/districts follow a framework specified by their respective provincial governments in their health plans. Both provincial governments allow their regional health bodies to expand on the core documentation required.

Since regions/districts use their health plans to convey financial information to the respective provincial governments, and since many have encountered financial difficulties, many of the plans reflect the high priority given to these issues. For example, one region/district stated "the number one priority during this current year will be to focus on our fiscal responsibility and deliver an attainable, balanced budget."

Neither of the two provincial governments required that RHAs/Health Districts include reference to population health issues, including any findings from their needs assessments, in their health plans. Fifty-seven per cent of the reporting Manitoba RHAs included consideration of at least one health determinant in their health plans, while only 25% of the Saskatchewan Health Districts did so. On average, the 16 Saskatchewan Health Districts mentioned 1.5 health determinants in their plans. Those most frequently mentioned were physical environments (4), personal health practices, and healthy child development and health services (3). The seven Manitoba RHAs mentioned, on average, 2. 4 health determinants. Those most frequently mentioned were health services (4), and personal health practices and healthy child development (3). Those mentioned most frequently are the closest to traditional definitions of health. The structural determinants of health, including income, education, employment and working conditions, gender and culture were rarely mentioned.

Neither Manitoba's nor Saskatchewan's provincial government framework makes any reference to gender, although Manitoba Health documentation lists women's health as one of four priority areas. Only four of 23 RHAs/Health Districts included any discussion of gender in their health plans—two in Manitoba and two in Saskatchewan. These four were more likely than others to have included other determinants of health in their plan, including on average 6.25 determinants. All of these four also made reference to personal health practices, healthy child development and health services.

ISSUE 9 APPROACHES TO WOMEN'S HEALTH ISSUES

9a. Degree to which health plans define the following as women's health issues?	EXTENSIVE	SOME	NONE
Conditions related to reproductive system and associated services	0	5	18
Conditions more prevalent in women (e.g., breast cancer, osteoporosis) and related services	0	1	22
Family and child health initiatives (e.g., groups for new mothers and babies)	1	4	18
Woman-specific needs for diseases common among both women and men (e.g., heart disease)	0	1	22
Women's health care across the lifespan (not just during reproductive years)	0	1	22
Woman-specific "healthy lifestyle" promotion initiatives (e.g., tobacco reduction, healthy eating, physical activity)	0	1	22
Holistic services that go beyond physical health (e.g., include mental, emotional and/or spiritual health)	0	0	23
Initiatives that address women's life situations (e.g., violence, poverty, child care responsibilities, housing, transportation, discrimination)	0	2	21

9b. Family/child health services recognize the need to also focus on the following needs of women? (e.g., pre/postnatal)	EXTENSIVE	SOME	NONE
Health needs	0	3	20
Social needs	0	1	22
Financial needs	0	1	22

9c. Strategies to avoid images suggesting women are/should be subservient or focussed on appearance? (e.g., in health messages)

EXTENSIVE	SOME	NONE
0	1	22

9d. Strategies to avoid implying that women should be judged more harshly than men for similar behaviours than fathers? (e.g., substance abuse, parenting difficulties)

EXTENSIVE	SOME	NONE
0	0	23

ISSUE 10 SENSITIVITY AND PROACTIVE APPROACH IN ADDRESSING DIVERSITY

10a. Services specific to the following specific "priority" groups of women?	EXTENSIVE	SOME	NONE
Aboriginal	0	2	21
Francophone	0	0	23
Cultural groups from outside North America or Western Europe	0	0	23
Rural	0	1	22
Single mothers	0	1	22
Adolescents	0	0	23
Lesbians	0	0	23
Abuse Survivors	0	0	23
Women with disabilities	0	0	23
Women living on low incomes	0	0	23
Women with low literacy skills	0	0	23

10b. Manager training on issues related to gender inequality that affect women's health? (e.g., abuse, low income, discrimination, economic dependency, power imbalances in relationships, cultural norms about male authority)

EXTENSIVE	SOME	NONE
0	0	23

10c. Board training on issues related to gender inequality that affect women's health? (see above examples)		
EXTENSIVE	**SOME**	**NONE**
0	0	23

10d. Staff training on issues related to gender inequality that affect women's health? (see above examples)		
EXTENSIVE	**SOME**	**NONE**
0	0	23

10e. Focus on diversity among women? (e.g., cultural)		
EXTENSIVE	**SOME**	**NONE**
0	1	22

Since management and Boards appear to have little recognition of gender as a determinant of health, and since they neither require or receive sex-disaggregated data, it follows that they would not prioritize training on these issues.

ISSUE 11

ACCESSIBILITY

11. Types of access?	**EXTENSIVE**	**SOME**	**NONE**
Recognition that some barriers to access may be more prevalent for women (e.g., lack of child care, transportation, out-of-pocket costs)	0	0	23
Availability of assistance with child care, transportation and other barriers to get to service sites	0	2	21
Interpretation services (e.g., sign language)	0	0	23
One-stop access to a wide range of services (social as well as health)	0	11	12
Range of services in communities where people live	0	17	6
Services that reach people in their day-to-day environments (e.g., schools, workplaces, homes, drop-ins, malls)	0	0	23
Strategies to minimize costs for services provided outside hospital settings or mandated public health services (e.g., those not part of Medicare or core public health funding)	0	0	23
Degree of access to the following types of providers:			
P Female doctors on request in hospitals and clinics	0	0	23
P Referrals to female mental health practitioners on request	0	0	23
P Nurse practitioners	0	1	22
P Midwives *(Note: Midwifery was not legally practised in Manitoba until July 1, 1999. Midwifery is still not legally practised in Saskatchewan.)*	N/A	N/A	N/A
P Complementary therapies	0	1	22
P Support or self-help groups	0	4	19
Plans for shift of institutional budget savings to community-based services	0	4	19

11b. Patient advocate to whom users can speak directly if problems?	
YES	**NO**
4	19

ISSUE 12 TYPES OF COLLABORATIVE RELATIONSHIPS

12. Types of collaboration?	EXTENSIVE	SOME	NONE
Collaborations with actual and/or potential participants or users to design initiatives that incorporate their input	1	0	22
Collaborations with community organizations that provide health services to women	0	1	22
Collaborations with other sectors of government in the delivery of women's health initiatives	0	2	21

ISSUE 13 RECOGNITION OF INFORMAL CAREGIVER ISSUES

13a. Recognition that women are more likely to be informal caregivers than men?		
EXTENSIVE	SOME	NONE
0	1	22

13b. Recognition that children's health issues are most likely to be dealt with by mothers?		
EXTENSIVE	SOME	NONE
0	5	18

13c. Home care policies are independent of presence of family members in the home? (Not implying family members should provide unpaid care)		
YES	SOME	NO
0	0	23

In both provinces, home care programs assume the availability of family members to provide care. In one region/district, the need for home care to take on "heavy housekeeping and yard work" was repeatedly identified during the needs assessment process. The response of the region/district was a "communication strategy" to inform family members that this was their responsibility. Another region/district stated that "in the past, the district has let demand drive the level of service that is being delivered" and planned to stop this practice in order to reduce home care services.

13d. Community care plans include assistance from paid care providers?		
EXTENSIVE	SOME	NONE
0	23	0

Both Manitoba and Saskatchewan have provincially-mandated home care programs. Responsibility for operating these programs, within provincial guidelines, has been devolved to the regions/districts.

ISSUE 14 RECOGNITION OF EFFECTS OF HEALTH CARE REFORM ON EMPLOYEES

14a. Recognition that the majority of staff affected by health reform are likely to be women?		
EXTENSIVE	SOME	NONE
0	0	23

14b. Efforts to minimize layoffs during restructuring? (e.g., through attrition, transfers)		
EXTENSIVE	SOME	NONE
0	3	20

14c. Opportunities to upgrade skills to work elsewhere in system? (e.g., community, critical care)		
EXTENSIVE	SOME	NONE
0	1	22

14d. Percentage of women on Boards and in senior management, by number of regions/ districts?	LESS THAN 10%	11 TO 40%	GREATER THAN 40%	NOT REPORTED
Boards of Directors	1	6	5	11
Senior managers	0	0	7	16

Because of the large number of regions/districts not reporting this information, it would not be meaningful to consider the connection between the percentage of women on Boards and senior management with gender-sensitivity as measured in this study.

14e. Are there any diversity initiatives in place? (e.g., to recruit Boards members, managers, staff from particular cultures)	
YES	NO
2	21

Regional health bodies did not include in their documentation evidence that they understood the implications of health care reform for their women employees. This is consistent with the lack of gender analysis when examining the impacts of programs and services on women health care consumers and informal caregivers.

ISSUE 15 EVIDENCE-BASED DECISION-MAKING AND EVALUATION

15a. Use of community needs assessment data in health plans?	EXTENSIVE	SOME	NONE	DON'T KNOW
Priorities in the health plan reflect the identified needs of women as well as men	0	3	19	1
Specific examples of collaborations suggested in the needs assessment are carried forward into the health plan	0	3	19	1

Most regions/districts did not identify women's health needs, so they could not use that information to set priorities. One region that did stated "If the RHA is to begin to address the priorities identified in the Community Health Assessment, a minimum of approximately $969,000 will be required over the next three years." Of this amount, the budget for programs specifically addressing women's health issues was $46,000.

No collaborations with women's groups were specified.

15b. Acknowledgment there is less health research with women than men for use in evidence-based decision-making?		
EXTENSIVE	SOME	NONE
0	0	23

15c. Mention of gender-specific norms/ standards?		
EXTENSIVE	SOME	NONE
0	0	23

15d. Health plans include indicators specific to women's health initiatives?		
EXTENSIVE	SOME	NONE
0	0	23

15e. Narrative methods included? (e.g., interviews, focus groups)		
EXTENSIVE	SOME	NONE
6	12	2

15f. Plans to disaggregate data by sex in evaluations of the following?	EXTENSIVE	SOME	NONE
Morbidity	0	2	21
Mortality	0	3	20
Service utilization	0	0	23
Social indicators (income, etc.)	0	0	23

CONTINUED . . .	EXT.	SOME	NONE
Health survey data (e.g., behaviours, knowledge, attitudes)	0	0	23
Outcome data for specific initiatives that cater to both women and men (e.g., programs to enhance seniors' functional capacity for independent living, smoking prevention and cessation programs	0	0	23
Service satisfaction data	0	0	23
Community surveys of opinions/-preferences concerning health care	0	0	23
Community consultations (forums, focus groups)	0	0	23

15g. Inclusion of satisfaction assessment concerning the following?	EXTENSIVE	SOME	NONE
Choices offered	0	2	21
Interpersonal interaction with health care professionals (e.g., feeling respected)	1	2	20
Convenience of services	17	4	2
Wait times	1	3	19
Information given	0	2	21
Time spent with service user	0	2	21
How questions answered	0	2	21
Follow-up offered	0	1	22
Referrals to other providers or agencies (if applicable)	0	2	21

15h. Inclusion of costs of informal care to individuals in cost-effectiveness evaluations? (time, out-of-pocket expenses)

EXTENSIVE	SOME	NONE
0	0	23

15i. Consultation during indicators development with organizations that work with women?

EXTENSIVE	SOME	NONE
0	0	23

15j. Consultation during indicators development with women users (or potential users) of health services/initiatives?

EXTENSIVE	SOME	NONE
0	0	23

F. SUMMARY ANALYSIS OF HEALTH PLANS

1. Based on the review of these documents, it is evident that regional health bodies have not given a high priority to women's health. While four of the seven responding Manitoba RHAs listed women's health as a priority, and referenced Manitoba Health in doing so, there was little evidence of such prioritization in their health plans. Only one regional health body—in Saskatchewan—expressed a written commitment to gender equity.

2. Where women's health issues were considered, the most frequent references were to gender-specific health needs (reproductive health, breast and cervical cancer screening) and to women's role as mother.

3. While both provinces officially promote a determinants of health approach, there is little evidence of it in the health plans reviewed for this project. Manitoba health plans contained, on average, reference to 2.4 health determinants, while Saskatchewan plans included, on average, only 1.5 of the 11 health determinants in this report. Health plans tend to emphasize financial reporting and funding requests.

4. The documents reviewed do not demonstrate an appreciation for the differing health needs of diverse groups of women, including Aboriginal women, women from ethnic and visible minorities, lesbian women and women with disabilities.

5. Consistent with all of the above, none of the regional health bodies surveyed reported any training on gender issues for either staff, management or Board members.

6. There was no evidence that women's organizations, and organizations providing services to women are included in the health planning process.

7. Rather than recognizing the additional burden on women of providing informal care to family members and friends, regional health bodies have promoted this by emphasizing women's presumed role as gatekeepers of family health.

G. FINDINGS: INTERVIEWS WITH REPRESENTATIVES OF REGIONAL HEALTH BODIES

1. WOMEN'S HEALTH

We asked what influenced women's health, but we did not ask interviewees specifically to articulate what women's health encompassed, or how it might be defined. During the interviews, however, women's health was discussed. In one interview, for instance, a question about "gender-related issues" produced comments about teen pregnancy, breastfeeding, mobile mammography, and women's health education in clinics. Women's health was discussed in one or more of three overlapping contexts: the health of their families; reproduction; and utilization of health services.

a. Family Health

One respondent rationalized that women's and family's health should be kept together because women tended to talk about their families in the health needs assessments:

> "When we did the needs assessment, a lot of women's comments focussed on their families. Do we separate that or should we keep it together?" (1)

Later the respondent noted that women were responsible for maintenance of the family during times of stress:

> "…women have a role as caregiver, they need to be the stalwart ones who keep everything together." (1)

Several respondents raised, in different parts of the interview, the importance of the role of women in promotion of family health:

> "The community heath assessment identified a number of important issues about women's health. We felt that it was important, not only for women as individuals, but for women as custodians of the health of their families." (2)

> *Question:* "…were there any gender-related issues?"
> *Answer:* "Not that arose as gender issues. They came up as care issues, then after analysis, you can see gender, but our approach is to include the whole family." (3)

> "To me, it's very complex, often a very big interplay between things. Certainly poverty is one thing that's very critical. Social supports and support in the community, those are also tied to how women see themselves, which is of course so complex. You know those very things of feeling that you can make a difference for yourself or anybody. I guess the whole thing of self-esteem and parenting. It's tied to parenting and your environment…". (5)

Most people were unable or unwilling to focus on women themselves because of women's roles as "gatekeepers" (2) of family health:

> "We say that the best way to influence the health of men is to prioritize women. Women make the health decisions for the family—decide about food choices, medical appointments, exercise, etc. We can reach the health of all members of the family through women." (2)

> "The health of the population starts so much sooner with baby-friendly initiatives and breastfeeding. [There's a] better chance for the next crop of children, and those children are in all income categories." (3)

> "I know that from a women's perspective here, we are embarking now on a very strategic planning process which would look at a functional plan for women's and children's services, including female children and adolescents. In terms of sensitivity to women, we are looking very carefully, at research for example." (6)

Some respondents associated opportunities to participate in health planning by individual women or women's organizations with child and family issues:

> "[There's a] very strong, interdisciplinary, interagency committee on children and their families." (2)

> "Women have had opportunity to participate through the Provincial Task Force on Balancing Work and Family." (4)

> "…we had a lot of concerns from parents of children with disabilities." (7)

> "[Organization X], a lot of their care is directed towards women and children." (3)

b. Reproduction

For many years, women's health was defined within the health system as synonymous with obstetrics and gynecology. This legacy is difficult to shake:

> *Question:* "So you make efforts to include women of different ages?"
> *Answer:* "Yes. We look at preconception to post menopause. It would be that whole span." (6)

> "There were lots of issues in the women's health area, particularly in pregnancy-related—fetal alcohol, breastfeeding and some of the illnesses that affect people later in life, breast cancer and menopausal issues." (7)

Some health policy-makers claim that health is generic, but they still see breastfeeding and other reproductive health issues as the responsibility of women. The following respondent, for instance, disavowed any tendency to separate men and women's health, and actually used the generic "people" earlier in the interview when discussing breastfeeding rates:

> "I don't think of this as women versus men's health issues. When we do the breastfeeding thing or the women's health clinic in [---] then we consult more with women." (8)

The status quo is normative or is not questioned within such a framework. The status quo is a system of health care that was established when little research was done for and by women, sexism was not questioned, violence against women and social discrimination were unexamined, and few women participated in decision-making roles. A lack of gender analysis leaves unquestioned the ability of women to change factors that impede breastfeeding (such as store or restaurant policies). Closer to home, the importance of the father's role in supporting breastfeeding is not raised or examined, except possibly from the woman's point of view. This serves to legitimize the view of women as re-

sponsible for care-giving and for their own health in two ways: first, care-giving and women's services are highlighted as the legitimate arenas for women's participation; and secondly, the idea that women's needs might take precedence over men's or children's needs is denied.

When respondents talked about women's health in terms of reproduction, they were not necessarily forgetting the social and cultural norms influencing women. When asked what actions the health region/district could take to make sure the health system was responsive to the needs of women, for instance, one respondent referred to an "infant feeding project" as an example. Earlier, however, she had stated:

> "Is it right to beat them about the head and tell them that they must breastfeed until 6 months? I think that this [project] will get to the heart of a number of the issues about being a mother in today's society." (2)

The latter respondent made equity issues explicit. In other cases, sensitivity to equity for women was not made explicit. In the following quotations, respondents discuss infant health issues in terms of women's behaviours and choices without ever discussing the inequities among groups of women based on poverty, education, race, access to services, social discrimination, and so on. Reproductive technologies, for instance, are largely available only to women with disposable income, while poverty is a major factor in alcohol dependency and poor nutrition that may lead to poor birth outcomes for the child.

> "We're trying to get a pediatrician so children can be diagnosed. Without diagnosis, there's no special programming. We're trying to even get baseline information on how many pregnant women have alcohol dependency and other dependency during pregnancy. That is particularly a female prevention issue. Our baby-friendly initiatives involve the whole family, not just females." (3)

> "Right across the country. It [infant mortality] is edging up a little bit. Despite all of our wonderful efforts, the health status of that childbearing population is less than we would like it to be. The other issue along with that is preterm births. We're just not getting a han-dle on that, it's on the increase. You have the potential for higher infant mortality and morbidity. It's related to reproductive technologies that are running away on us. We've got significant increases in multiple births. That is a big concern." (6)

c. Health Services

Respondents often spoke of women's health in terms of the services that women needed:

> "…also the whole area of women's health that came up as an issue. We didn't have enough of that prevention, promotion piece, actual clinics. We're trying to implement those things. It's not quite as easy in the rural areas, because you don't have as many physicians who are specialists. You have to work with public health, etc." (8)

> "I know that from a women's perspective here, we are embarking on now a very strategic planning process which would look at a functional plan for women's and children's services…." (6)

The latter respondent went on to mention emergency, psychiatric, cardiology, and other mental health services.

Sometimes the analysis of women's health "needs" was service focussed:

> "What I would like to see is more community planning, more planning coming straight from the community and women's groups and other agencies having the ability to tell us what their vision is in health care in their community and what their needs are." (1)

> *Question:* "What actions can your health region or district take to make sure the health system is responsive to the needs of women in your region as health reform proceeds?" *Answer:* "Education and awareness program development through [---], need to lobby for women's health care centre, make sure they [funders] are aware of what we do and what we don't do." (4)

Two respondents did state that health services were only one of the determinants of women's health. Some did link service needs to other factors:

> "We have a fairly high risk population, most of it is socioeconomic stuff. What we see is people with low socioeconomic status and no social support. Then everything else flows from that. They don't know how to access services, how to get out of bad situations, abusive situations." (7)

2. INFLUENCES ON WOMEN'S HEALTH

As can be seen in the following table, there was general consensus that poverty is an important influence on women's health and social support was also commonly cited. Otherwise, the respondents had varied perceptions of the most important factors that influenced women's health. No one mentioned the status of women in society, discrimination, or sexual stereotyping. In fact, while two people mentioned the health determinants as a general category, the examples of determinants highlighted were poverty and health service use. No one mentioned that gender is included in federal government documents and research as a determinant of health.

NUMBER OF RESPONDENTS CITING EACH "MOST IMPORTANT INFLUENCE ON WOMEN'S HEALTH"	
Social economic status (SES) or poverty	6
Supports (social, family, community)	4
Knowledge (more than information)	3
Health determinants	2
Access to health services	2
Environment or living environment	2
Single parent family	2
Individual self-esteem	2
Culture	1
Literacy	1
Being empowered	1
Information	1
Education	1
Mental health status	1
Sexuality and sexual preference	1
Baby-friendly initiatives (breastfeeding)	1
Aging	1
Balancing work and family	1
Relationship with primary physician	1

3. WOMEN'S HEALTH ISSUES

While we did ask specifically if "gender-related issues or concerns" arose in needs assessments or health planning, issues were also identified in other parts of the interviews. The women's health issues that respondents talked about can be grouped under three broad themes: problem health issues; populations; and roles of women.

a. Problem Health Issues

We grouped the specific problem health issues that were mentioned as: family violence; mental health; reproductive health-related; and other diseases or conditions.

~ ***Family violence*** was identified as a problem by 4 health regions/districts. It was stated that family violence was identified as a problem by people in surveys, by staff, and sometimes by both. One respondent noted that the problem was worse than anyone knew:

> "Some women said we remain silent sometimes. There is more family violence than is being said out there. [X] per cent of our respondents to a [general community] survey indicated family violence was an issue...that tells us that there are difficulties." (1)

In another region, however:

> "Family violence was never even brought up by anybody." (5)

The respondent went on to say that violence clearly existed, but was an issue that people had difficulty facing:

> "I also think that in rural areas as far as violence is concerned, it's difficult. We do have a crisis centre in [---], but in rural areas violence may be there, but because people are in a rural area it is more difficult for them to access help." (5)

Another respondent talked about family violence in terms of concerns about reproduction:

> "My concern is that it extends beyond the normal that we talk about. In pregnancy it increases three-fold. In post-partum another three-fold." (6)

~ ***Mental health*** problems were discussed both in terms of stress and psychiatric diagnoses. Stress was particularly associated with multiple roles and being a rural farm woman.

> "Mental health…stress was the big one. Seventy percent of our respondents were women. The major health concern was stress. I think that's what's coming out is that women are working and have so many roles to play, community, family. Some families are undergoing some financial difficulties…farming…stress is really high, women have the role as care-giver, need to be the stalwart ones who keep everything together." (1)

> "One thing we didn't mention as a big effect on women's health is stress, probably the outcome of all of those other factors. It's one of the big issues in rural living, obviously in teens, with suicides. It used to be identified more with men in the workplace, now everyone, women are a new group to that area." (3)

> "In our region we have enormous mental health issues with women and no where near the services to help even with minimal kinds of attention and resources....We have women coming in with overdoses [who] are being certified....I would say in our area, mental health issues with women probably rank number one." (6)

~ ***Reproductive health*** problems that were mentioned include: teen pregnancy; lack of breastfeeding; menopause; birthing and midwifery services; infant mortality; Fetal Alcohol Syndrome (FAS)/Fetal Alcohol Effect (-FAE); reproductive health generally; and reproductive technologies. Every respondent mentioned at least one of these issues, but no one mentioned more than four (see following table). The only pattern in response was that two respondents mentioned more of these issues more than the others.

REPRODUCTIVE HEALTH TOPICS MENTIONED BY REGION/DISTRICT								
TOPIC	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
Menopause				P	P	P	P	
Teen Pregnancy			P					
Breastfeeding		P	P				P	P
Midwifery	P	P					P	
Reproductive Health	P		P					
Reproductive Technology						P		
Infant Mortality					P	P		
FAS/FAE			P			P	P	

To see how breasts were discussed we searched all of the files for use of the term. The following table indicates that breasts were only mentioned in the context of breast cancer or breastfeeding, with the latter taking precedence.

CONTEXT IN WHICH WORD "BREAST" WAS USED (Number of times and approximate number of segments of conversation in brackets)								
TOPIC	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
Breastfeeding		5 (2)	12 (6)		1 (1)		1 (1)	5 (5)
Breast cancer (includes screening)	1 (1)		1 (1)		1 (1)		2 (2)	2 (1)

Two people mentioned breastfeeding quite often during their interviews. The titles that people held in regions/districts did not predict these patterns.

~ ***Other diseases or conditions***, especially breast cancer, were mentioned quite often. The others mentioned, although not with any consistency, were: heart disease; stroke; and osteoporosis. These were mentioned in six of the eight interviews.

b. Populations

The populations of women mentioned in the interviews were: women of different ages; rural women; Aboriginal women; women with disabilities; and lesbians. Women of specific groups were often mentioned when respondents discussed inclusion of diverse groups of women in the planning process.

Teens were mentioned most often in terms of pregnancy. In terms of possible problems of teens, anorexia, eating disorders, date rape, assault and child sexual abuse were not mentioned. One respondent referred to women of child-bearing age:

> "…the health status of that child-bearing population is less than we would like it to be." (6)

Another referred simply to the health service needs of adult women:

> "I think that in the adult years there may be more need for women to have health issues addressed. Therefore I think that there are more services required for women." (8)

Age was often associated with states like menopause and health problems and diseases like osteoporosis. Elderly women were an issue for some respondents:

> "That's why we did identify women. There were issues....First of all, seniors, the elder women, after the age of 75 or 85, the majority of the population are women, some of them are alone. They don't all live in personal care homes. We need to ensure that women who are that age are able to live well, safe and with quality." (1)

One person talked about caregiver support as a seniors' and women's health program, but it was unclear if the women were the caregivers who needed support or the ones needing care. Naturally, the needs and issues of rural women were

mentioned quite often. Six respondents used the term "rural." One talked about the multiple roles of farm women and the inherent stress of being the "stalwart ones who keep everything together" (1). Others mentioned access to health services and specialists, lack of child care services; and cultural norms and expectations as a problem for rural women. For instance:

> "There is also very much in the control, the men being ***the*** decision-maker, as they say out here, "the boss." I get this a lot at home. I don't buy that one. That whole power, control, who is the boss, that's part of rural talk. Even women have said that to me. Whether or not people have a driver's license. If men can keep their wives from driving, they can control what they do. I see driver's licenses as one aspect of influencing women's independence, dependence and interdependence. It's women too. Some women won't get a license because they think that they can control their husbands that way. But I'm sure that has never come up at any meetings of the [region/district]." (5)

One respondent mentioned that it was difficult to get rural women together; another, the lack of organizations or groups with a specifically political or policy-orientated agenda.

> "So there aren't a lot of women's organizations that look at the collective good of women that come with a feminist perspective. The word feminist is more than likely seen in a negative light." (5)

Aboriginal issues were mentioned by six of the interviewees. Some reported using culturally-sensitive approaches to ensure inclusion in the needs assessment and planning processes. One stated, however, that special programs were considered a form of discrimination. One person linked the impact of culture to health beliefs and to past collective experiences of abuse and poverty. One respondent seemed to link sexism and racism as additive problems for Aboriginal women:

> "We can talk about Caucasian women at Emergency not getting the attention of their male counterparts, but it's even more true for Native women." (6)

Women with disabilities were mentioned once:

> "…there is a very great need for service for handicapped people, think about handicapped women, sexuality, there's no way they can have the specialists [in rural areas]." (6)

Sexual orientation was mentioned by one person in terms of not having access to preferred services. However, the term "lesbian" was never used in the interviews.

The other groups or populations of women mentioned were: Francophones; Germans; Mennonites, Ukrainians and Hutterites (including Paraguayan immigrants). The issues for these groups of women that were identified include different cultural beliefs and language barriers. Fewer women than men may speak English in these groups.

c. Roles

Only five respondents talked about women's health issues in terms of roles:

> "Numerous priorities that we had identified…they included, parenting, body image, including active living, stress, balancing work and family, family violence including child, sexual, emotional, physical. For a few people violence was very important. Communicating, herbal products, living within a limited budget and financial planning." (5)

> "We felt that it was important not only for women as individuals but for women as custodians of the health of their families." (2)

> "…concern was stress, I think that's what's coming out is that women are working and have so many roles to play, community, family." (1)

The fourth respondent also talked about the stress women experience. Two of the above and the fifth respondent specifically mentioned parenting roles.

4. UNDERSTANDINGS OF GENDER

We specifically raised the issue of gender in the interviews without providing a definition or framing respondents' responses. There were hints that some people may think about gender, but in general, there was little understanding of gender and a clear reluctance to address it at all.

The following quotes highlight some of the gaps in understanding of gender. Women are characterized as very powerful social actors and the gatekeepers of family health. At the same time, they are characterized as vulnerable, and in need of care and protection—like children and seniors. To be old, poor and female is a triple vulnerability. These stereotypes of women do little to foster equity, but the first group does not propose equity; they want to see all humans as equal.

> "They responded, the Board readily acknowledged women's roles as gatekeepers of health for their families. The Board identified women as one of five vulnerable populations [others are children and youth, seniors, resi-dents of the [---]part of the region, residents in socioeconomic disadvantage]....For them to include this in their health planning, this was not a major leap, this was where the evidence was, so they did it. They have values too, they have been through a process of identifying values, mission, vision. One of their values is respect. They're into equality of human beings. They're quite the good group." (2)

> "In some groups, [breastfeeding is] as high as 45% at 6 months. But across the board, it's still about 2% using only breastfeeding at 6 months. It's an issue of food security and mothering."
> *Question:* "Can you tell me what you mean by food security?"
> *Answer:* "You lose food security for your family when you do not breastfeed. We're trying to tell them that it's important to have food security for your family for the whole month. Breastfeeding is part of that." (3)

In the last quote, women are seen to have the power to ensure food security for their families, and part of that power rests in the ability to breastfeed. If you cannot or will not breastfeed for some reason, in this scenario, you are jeopardizing food security for the whole family, not just the baby.

In the following quote, female gender is again equated with being poor and disempowered, or even worse, without a male companion—a single parent.

> "Women need to feel they are important and empowered. Until that happens, it's difficult because so many women because of single parent status and poverty are just disenfranchised. You need to look at community strategies, small neighbourhood groups. That's a much bigger issue than we are here at the [---], we need lots of provincial collaboration. When you're poor and have babies you feel that there's no hope. If there's no way to present some hope it becomes a very huge challenge and I don't think that we've provided a lot of hope yet for those single parent families." (6)

By contrast to those who saw no differences in the needs assessment data, or did not bother to look at disaggregated data, regions/districts that recognize some of the characteristics that oppress women are sympathetic. Nevertheless, there is a lack of gender analysis.

> *Question:* "Do you recall any major differences in findings for women and men?"
> *Answer:* "Not that I can recall." (7)

The equation of sex with gender leaves the nature of gender unexamined. Those who attribute gender difference to sex ignore the social aspects of relationships. The following quote,

for instance, assumes that sex is the problem, without asking how the situation is different for older women and older men, and what there is about gender that will modify interventions:

> "First of all, seniors, the elder women, after the age of 75 or 85, the majority of the population are women, some of them are alone. They don't all live in personal care homes. We need to ensure that women who are that age are able to live well, safe and with qual-ity." (1)

The same respondent went on later in the interview to make a convincing analysis of gender and use of health information:

> "…when I think of cultures, obviously, different cultures have different approaches to the roles of men and women. Cultures associated with political establishments….I think women use information differently than men, women seek out information. When they see a concern, they will try to look for information to help solve their concern, they will seek for their families, have a tremendous influence on their family, in essence on the health of the community. Men have accepted that that is the role of the woman. That may be why they don't seek the information. They will say "get it for me." When they are in crisis, women will look for health information to prevent the crisis from happening. They will look at nutrition more than men will, since they are preparing the meals, that's changing, but not tremendously yet in rural [province]." (1)

Another respondent alluded to gender influences on breastfeeding:

> "The high school girls told us that they had made up their minds about breastfeeding before Grade 12. We won't convince women to breastfeed in prenatal groups, will we? Is it right to beat them about the head and tell them that they must breastfeed until 6 months? I think that this [project] will get to the heart of a number of the issues about being a mother in today's society." (2)

Similarly, the following respondent identified social roles, stereotypes, economic factors, norms and beliefs as having a differential impact on women and men:

> "Men have fewer issues [about] balancing work and family. Men generally have higher income, higher education, better access to transportation. Men have better relationships with primary care MDs, [they're] not put on meds as regularly…fewer men [are] single parents…more emphasis on women to care for aging parents…women live longer than men…[it's] no longer easy to get into nursing home…less income to purchase necessary health care and home maintenance services… women [are] afraid to live alone…women may be offered less service, assume self sufficiency [in home care] whereas they assume that men are helpless. Early discharge from acute care [assumes] women will care for family members after discharge…early obstetrical discharges affect the entire family, but women to a greater extent." (4)

The reference discussed earlier to use of drivers' licenses to control the other spouse's behaviour is another topic of gender.

In other cases, power and social relationships and how these might affect women's health through the policy process were not part of the analysis. Respondents seldom identified the participation of women and the power of women to be heard as issues. Simply creating more of the same venues will not empower women. When asked about including women or women's organizations in the needs assessment process, the following was said:

> *Question:* "Did you invite any organizations?" *Answer:* "We looked at the community. There aren't a lot of organizations. The invitations went to the whole community. The [---] councils are often representative of organizations. Where we've looked at inviting organizations is in intersectoral groups. One of the things we try to do is send our information to organi-

> zations and other places where we think it might be useful….I just think the invitation. There has to be an invitation there. There have to be different ways. Some people are better at forums, at surveys, focus groups on specific issues. I get a lot more specific information, people talk more about what they really need." (8)
>
> "…a multitude of different opportunities. People need feedback on what they've told us, confidence that it matters. Lots of opportunities to participate and to define participation. Any information that people give us is information worth having—opinions, experiences, stories." (2)

Then there are analyses that demonstrate an understanding of roles, power, and social influence, but lack a clear understanding of history or social change:

> "Men, because of their socialization, do not have the same enjoyment that women do in being able to discuss their needs. They don't have a forum. I know that there are some vain attempts at that. Men are at a disadvantage frankly. The balance is going to topple. We have more than 50% females enrolled in medical schools now. It can't help but sway much of the policy decisions towards women." (6)

This slippage between demonstrating some understanding of elements of gender analysis and subsequently showing no integration into what the elements might mean for programs, policies or interventions was very common throughout the interviews.

One of the concepts of population health promotion of relevance to gender is equity; that is, the belief that equal treatment may be inappropriate and discriminatory in the face of certain social conditions. There was also a tendency not to understand this concept:

> "I had an [---] ask me about special programs for Aboriginal women. I said that all our patients are special. I think that those kinds of programs lead to reverse discrimination, my husband calls it apartheid. I think it leads to belief that they are too stupid to do it themselves." (3)
>
> "[We are] trying to be inclusive, focussing on common needs and goals rather than differences, facilitate support and consultation rather than trying to do everything for everybody." (4)

5. RELUCTANCE TO ADDRESS GENDER

The interviews revealed a reluctance on the part of health regions/districts to address women's issues or gender. One respondent simply explained that there was a stigma associated with women's health that was not explicitly vocalized, but was an undercurrent at work and linked to sexualization of women in society. Another just talked about strategies to reach men when asked how actions might help women:

> "Well, I mean there is a certain stigma to women's health issues. I think we all understand that. I think that in the adult years there may be more need for women to have health issues addressed. Therefore I think that there are more services required for women than for men, that's not always recognized."
> *Question:* "Tell me a little about that stigma?"
> *Answer:* "…well, I just sort of think of it still as socially puts women in a different place. The sarcastic remarks about women's health issues, perhaps a more sexual connotation to that." (8)
>
> "We look at age groups, where the boomers are going to end up. I think that whole area of making services more appropriate is a big part of our planning process. Not so much looking at gender-specific, but looking at ages and needs." (8)

> "At several of our meetings, we have heard from men that if we keep focussing on the health of women and kids, we are ignoring the health of men. Usually it's the physicians who say this. We say that the best way to influence the health of men is to prioritize women. Women make the health decisions for the family—decide about food choices, medical appointments, exercise, etc. We can reach the health of all members of the family through women." (2)

> *Question:* "…were there any gender-related issues?"
> *Answer:* "Not that arose as gender issues, they came up as care issues, then after analysis, you can see gender, but our approach is to include whole family. We want to avoid du-plication with others doing the same work." (3)

> "At the Board and senior management, I don't know how women's issues are perceived." (5)

> *Question:* "Which of those actions do you think are especially helpful to women?"
> *Answer:* "We're going to change this [advertising] to social issues. For example, at [---] football games, they throw footballs into the crowd. We want health messages on those footballs. There are some messages that have to get to men and there are certainly lots of men there." (6)

One respondent felt that times had changed and there were no barriers to addressing women's health issues. Other issues were more contentious at meetings; however, the issues identified in that region were pregnancy-related (e.g., fetal alcohol syndrome, breastfeeding), menopause and illnesses like breast cancer.

One interesting gender issue that was raised in four regions/districts was the demand by women for female doctors. There was little analysis given as to the implications of this trend, but it certainly affects program success rates and consumer satisfaction.

6. DIVERSITY AND HEALTH PRIORITY SETTING

People talked about various demographic issues as being important, such as age, race, location, and income level. At least one person talked about demographics as something the strategic health plan could not do anything about:

> "A lot of the productive workforce has exited [province]. We're left with the poor young and old and frail and the few of us that are left are taking care of them and paying taxes." (3)

The issues raised, however, might just be what a strategic plan sensitive to diversity would address. Another said that sex [gender] was one demographic not considered.

> "Not so much looking at gender specifically, but looking at ages and needs." (8)

One respondent stated that the idea of including gender in planning was new for her health authority and this seems to be the case throughout both provinces:

> "We're starting to recognize what their needs are and they're not what has been generally accepted by the health system as their needs….We don't have the option as a health system of addressing income, availability of jobs, education, we can make others aware of importance, but we can't have a direct impact. We can help them cope with the limitations that these socioeconomic factors place on women. We have to look at new types of programming. I think that we're beginning to do that." (2)

In terms of meeting the needs of diverse groups of women, the key response was consulting with them or trying to encourage their participation in processes such as focus groups. Some people did talk about the need for programs that were

flexible and responsive to needs, but few gave any concrete examples of how diversity among women was addressed in the region's health plan. Several people raised cultural sensitivity, especially sensitivity to Aboriginal cultures, but the issue of the role of gender in ethnocultural sensitivity was not raised by any respondents.

In both provinces, the use of volunteers to deliver programs, even to do needs assessments was raised. In terms of gender and the impact of policies on women and men, the use of volunteers needs to be thought about critically. Many respondents seemed to realize that many women were stretched in use of personal resources like time, but also that women played a more active role than men in the health system. These interrelated factors should be important to strategic planning.

7. THE PROCESS OF HEALTH PLANNING

Restructuring of the health system across Canada has been done with speed and at least two people mentioned that this affected the planning process. Either more attention was given to restructuring than to planning per se or the needs assessments and planning processes had been expedited.

> "It was quite time compressed, lots of pressure, exciting process, didn't drag on." (3)

> "We're working so hard to keep the wheels from falling off, lots of crisis management." (1)

> "We are in a very different health care environment than in the last year. The pressures on the system are completely different. We are having to completely redesign our priorities and care processes." (6)

When the process was described, there was variation between authorities in how priorities were set and what influenced these; however, it was clear that Boards and senior management made the decisions. Therefore, women and women's organizations need to have specific information on how things are done in their health authority if they are to find opportunities to participate. They also need to know their Boards and management structures. In addition, in both provinces, the priorities set by the government affected how some authorities made plans, so women can still influence the system centrally. In one urban authority, private funders were described as influencing program decisions by where they were willing to put dollars.

When asked about how to make the system more responsive to women, four respondents talked about information dissemination and/or education as a strategy for making the health system more responsive to women's needs. For the most part, the focus was specifically getting information out to women and populations, rather than getting information from women. It is difficult to see how this would make the system more responsive and we did not challenge people to explain this. In future studies, this may need clarification.

Three respondents from Manitoba, where there is a well organized network of healthy communities, mentioned healthy communities as a goal of their regions. Gender issues can play a major role in the healthy community approach to health promotion; however, it may just as easily be overlooked in that model and, as articulated by these respondents, it seems to have been overlooked in these regions.

8. PARTICIPATION OF WOMEN AND WOMEN'S ORGANIZATIONS

The concept of participation was limited almost exclusively to consultation, that is, women can provide information to the health system. A number of strategies were identified for reaching women and getting their points of view: providing transportation, child care, or food;

going to malls; having focus groups with specific sub-populations; and going to existing councils (e.g., seniors). There was no discussion of how women or women's organizations could actually be involved in decision-making, although one person said that she would like to see:

> "...more community planning, more planning coming straight from the community and women's groups and other agencies having the ability to tell us what their vision is in health care in their community and what their needs are." (1)

The consultation agenda was seen to be principally driven by the authorities. One person stated explicitly that women's organizations would be consulted "when appropriate". Two people acknowledged that women's organizations that were explicitly political and advocacy orientated might be disliked. Another commonly perceived problem is a lack of formal groups or organizations that will advocate for women, especially in rural areas; however, this is an issue that deserves further analysis in terms of accuracy. One person did note that lack of time might be a barrier to participation of women's organizations, but few potential barriers were identified. Potential barriers include: lack of financial resources for calling, faxing, copying, travelling, etc.; reliance on volunteers; too many demands for service; lack of knowledge of the decision-making system and people; and lack of trust in the process.

9. ADDITIONAL ISSUES MENTIONED ASSOCIATED WITH GENDER

The following comments were not discussed extensively enough by respondents to be considered themes, but provide some additional information on respondents' thoughts about women's health and gender issues.

a. Power Between Men and Women

- "…the men being ***the*** decision-maker, as they say out here, 'the boss.' "
- "If men can keep their wives from driving, they can control what they do. Some women won't get a license because they think that they can control their husbands that way."
- "Men have accepted that information getting is the role of the woman. That may be why they don't seek the information. They will say 'get it for me.' "
- "The socio-economic status, low economic status, education level, job opportunities—women are at significant disadvantage."
- "I have observed the women are the leaders."
- "[It's] difficult just to find ways of getting women together to support each other—transportation, distance, child care, lots of logisti-cal problems."
- "[It's] related to women's roles and that part of the power and control impacts on people in their ability to take initiative or their ability to put themselves first."
- "A male issue is violence."
- "I think for women who tend to cope and make do, they feel that they've failed if they can't do it all anymore."
- "Men don't talk and disclose in the same way. That's why women's health is at the forefront. Women are more vocal. We've always had a vocal minority who've greased the wheels and gotten things done."
- "Men, because of their socialization, do not have the same enjoyment that women do in being able to discuss their needs. They don't have a forum."
- "We'd have certain groups advocating on behalf of women, for example, midwifery, that's sort of routine. Lots of advocates for children. Very few groups advocate for men."

b. Culture

- "Different cultures have different approaches to the roles of men and women."
- "…cultures associated with political establishments."

c. Health Practices

- "I think women use information differently than men, women seek out."
- "I feel that a lot of women would like to volunteer their time to plan what their community needs are."
- "Women have such tremendous organizing skills."
- "In terms of knowledge about life and health, we find that men are at a significant disadvantage....Women aren't the gatekeepers for no reason. Women are the ones who listen."
- "The men can go into town on coffee row. Women don't necessarily feel that same freedom."
- "…prevention of handicaps, that's gender-based."
- "…suicides, that's gender-based."
- "In girls it shows up in teen pregnancy, largely a self esteem issue."
- "Men have better relationships with primary care MD, not put on meds as regularly."
- "The community garden would definitely affect women."

d. Health Policies

- "Women were more interested in health promotion and programs and men were more interested in institutional type of activities, the economic side of it, things like jobs in the community."
- Men are more interested in the brick and mortar, women are more interested in program side."
- "Maybe we need more women at senior levels."

e. Inequities

- "How do women get child care? How do they get their children cared for?"
- "Women and Infant nutrition program—social workers are being judgmental about who they are referring."
- "Men have fewer issues re: balancing work and family."
- "Men generally have higher income, higher education, better access to transportation."
- "Fewer men [are] single parents."
- "…organizing small timeframes which women can handle."
- "In terms of things affecting women's health, with decreased institutionalization there is also that increased expectation to provide care and supplement care of older people and others who need care. The majority of that falls on women."
- "The poverty issues and the children living in poverty with these women, are fundamental to the healthiness of our society."
- "It seems to be that the women and language issue is really big in some cultures. We find that men speak some English but often women speak less."

H. SUMMARY ANALYSIS OF THE INTERVIEWS

Women's health was discussed in the context of three categories: reproduction; other members of their families; and use of health services, rather than as a valued outcome in and of itself. Within these categories there was very little gender analysis with a few exceptions. Similarly, there was quite widespread understanding of the social determinants of health, but gender was seldom mentioned and the other determinants then lacked a gender analysis. Major issues for women's health were identified and this problem focus formed one of the main themes in talking about women's health, along with recognition of different populations of women, and of women's roles. Again, in general, there was

at best the beginning of a gender analysis in these conversations. Many people seemed reluctant to address gender at all and the exceptions really stood out. We also saw examples of what is called backlash, that is, people who believed that "all this attention to women's health" represents a loss for men and a threat to their health. As would be expected, the discussions of health planning and participation of women were not rich in examples of equity strategies used or gender differences addressed.

I. CONCLUSIONS

Conclusion 1. There was no significant difference in findings for Manitoba and Saskatchewan. This is noteworthy given their different political environments at the time the study was conducted.

Conclusion 2. There is little evidence of gender analysis or gender-sensitive strategies among the regional health bodies participating in this study, as indicated by review of needs assessment and health planning documents, and interviews with representatives of the participating health bodies. For example, only 25% of the participating regional health bodies included any data about gender in their needs assessments.

Conclusion 3. While the reasons for this lack of evidence are multi-faceted, the primary reason is a lack of value placed on women's health in general, and therefore, on gender analysis in particular, as legitimate areas of concern. This is corroborated by our finding that there was no evidence of training on issues related to gender inequality that effect women's health. Where women's health issues were considered, the most frequent references were to biological sex-specific health needs (reproductive health, breast and cervical cancer screening) and to women's role as mothers.

Conclusion 4. Some reasons for this lack of value placed on gender analysis are as follows:

4.1 Many of the participants believed that women's primary health role is as gatekeepers and informal caregivers, responsible for the health of their families and communities. Regional health bodies have not recognized the additional burden on women of providing informal care to family members and friends. Rather, they have potentially added to this burden by emphasizing women's presumed role as the gatekeepers of family health. Women's health did not appear to be valued in its own right.

4.2 Gender analysis did not appear to be valued by the provincial governments which fund the regional health bodies. For example, although Manitoba Health has set women's health as one of its four priority areas, RHAs appear to have been given no background information about women's health, nor any guidance about how to specifically assess the health of the women in their communities.

4.3 The overwhelming financial pressures faced by regional health bodies dealing with provincially-imposed funding restraints encourage a crisis-management focus (e.g., emergency staffing issues). Gender analysis is not seen as high priority in this environment.

4.4 There did not seem to be widespread anti-feminist sentiment or hostility toward women's health. Rather, women's health issues (beyond those related to reproduction) and gender analysis did not appear to be priorities to the health bodies participating in this project. This could be changed by involving women's organizations and organizations providing services to women in the health planning process. However, there was no evidence of such a collaborative approach in the documents reviewed.

These conclusions are, unfortunately, consistent with much current work in the field of population health. As Patricia Kaufert has noted in her analysis of four of the key texts in population health:

> "…[the authors'] decision to ignore women cannot be explained as a matter of chance or academic absent-mindedness. At some level, conscious or unconscious, the decision was made to ignore these differences, to treat them as taken for granted, 'no longer questioned, examined or viewed as problematic.' "[1]

Conclusion 5. Neither province requires that health data be disaggregated by sex, although Manitoba does require that the sex of survey respondents be recorded. (Manitoba RHAs can therefore report the percentage of male and female respondents, but they have not reported if and how the responses of men and women differed.) While gender analysis is much more than simply looking at health data for men and women both separately and together, the lack of availability of sex-disaggregated data makes gender analysis impossible. Regional health bodies are also limited, since they did not have additional funds to order sex-disaggregated data from other sources (such as Statistics Canada) for their areas, nor did either province undertake to provide this to them.

Patricia Kaufert has described this tendency, found in the work of most population health experts, as follows:

> For epidemiologists and statisticians, the aggregation of data, or their adjustment for age or sex, are simply routine procedures. This approach is so commonplace I did not question it myself until deliberately hunting for the women and finding they were missing or hidden within an aggregated data set.[2]

In the health needs assessment surveys which were examined for this project, all of the regional health bodies which reported the sex of their respondents reported that more respondents were women. Their published results may therefore not adequately reflect the health needs of men in their local communities.

Conclusion 6. The documents reviewed do not demonstrate an appreciation for the differing health needs of diverse groups of women, including Aboriginal women, women from ethnic and visible minorities, lesbian women and women with disabilities.

Conclusion 7. The decision of the Manitoba government, and of those Health Districts in Saskatchewan which collected survey data, to use household rather than individual data also created problems of data interpretation. One does not know who is represented by the responses. Is the respondent speaking for her/himself or others in the household when answering a question about a particular health need, behaviour or interest? This type of proxy data is particularly questionable, for example, when obtaining information about reproductive health or mental health issues. It makes the disaggregation and analysis of data by sex more problematic.

Conclusion 8. While both provinces officially promote a determinants of health approach, there is little evidence of this in the health plans reviewed for this project. Manitoba health plans contained, on average, reference to 2.4 health determinants, while Saskatchewan plans included an average of only 1.5 of the determinants used in our framework. Health plans tend to emphasize financial reporting and funding requests.

Conclusion 9. Regional health bodies vary considerably in their level of technical expertise in assessment planning, data collection and analysis. Rural regions are at a serious disadvantage with regard to both research literature and access to technical assistance. Internet access is not sufficient to address their information needs.

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[1] Kaufert, Patricia, "The vanishing woman: gender and population health" in *Sex, Gender and Health*, Cambridge University Press, 1999, p. 123.
[2] Kaufert, *op. cit.* p. 125.

J. RECOMMENDATIONS

Recommendation 1. Consistent with Canada's international commitments and in order to accurately assess community health needs, and to develop policies, programs and strategies to promote good health and meet health service needs, we recommend that the provincial ministries of health:

- require that regional health bodies collect and report sex-disaggregated data in their needs assessments and health plans; and include gender analyses in their health plans; and
- provide regional health bodies with the necessary training, expertise and funds to accomplish these tasks.

Recommendation 2. We recommend that provincial governments ensure that regional health bodies, especially those in rural areas, have affordable access to information sources such as relevant research-based journals and ongoing information about gender analysis and women's health.

Recommendation 3. We recommend that in order to provide the necessary leadership, each provincial government should establish an appropriately-staffed office with expertise in gender analysis and women's health. The expertise of this office should be made available to the regional health bodies and to other government departments, the policies of which directly effect women's health, such as finance, social/family services, housing and seniors' services.

Recommendation 4. We recommend that both the provincial governments and regional health bodies broaden their perspective on women's health beyond reproductive and family caregiving to encompass a broad determinants of health approach—including gender as a separate determinant—in practice as well as in their public relations materials. In addition, we recommend that eligibility for community-based health services not be based on the assumption that women are willing to provide unpaid caregiving services to family members.

Recommendation 5. The need to develop skills in gender analysis exists across Canada and is not limited to the two provinces examined in this project. Following from Canada's signature to the Beijing *Platform for Action*, we recommend that the Federal government establish a Federal/Provincial/Territorial working group to synthesize and adapt existing policies and gender analysis frameworks and tools for use by regional health bodies across the country. In order to make the best use of existing knowledge, this group needs to work with the Centres of Excellence for Women's Health and other experts in the field.

Recommendation 6. There is a need to incorporate gender analysis throughout the whole planning process, especially at the policy-making and senior planning level, so that there is a systematic approach to addressing women's health needs and gender sensitivity. Though this research focussed on needs assessment and the development of health plans, we recommend applying the methods and tools of gender analysis to program implementation, evaluation and resource allocation as well. Some of the gender analysis tools and model approaches presented in this report can provide guidance.

Recommendation 7. We recommend that regional health bodies institute processes for ongoing input and feedback from diverse groups of women regarding their policies, programs and strategies and how well they meet the needs of women in their regions. Regional health bodies can draw from the expertise of community organizations that work with women as well as researchers with expertise in gender issues and participatory research approaches.

Recommendation 8. Some regional health bodies developed a keen interest in gender analysis during this project. We recommend that the PWHCE pursue opportunities to facilitate and promote gender-sensitive approaches by continuing to work with those regional health bodies which expressed an interest in gender analysis during the course of this project.

Recommendation 9. In addition to training for regional health bodies and provincial governments, it is important that women and organizations that work with women in the community have access to educational materials and events (e.g., workshops) on gender-based analysis and gender-sensitive health planning. Community organizations and concerned individuals often link with decision-makers in their various community roles, and would benefit from gaining the expertise to analyze policies and programs and as citizens hold decision-makers accountable for their actions. PWHCE could work with community stakeholders on this issue as well as with regional health bodies.

Recommendation 10. In order to monitor change and progress, we recommend that regional health bodies be studied again in five years regarding their use of gender analysis and gender-sensitive planning.

PART 3 THE WAY FORWARD: STRATEGIES FOR ENHANCING GENDER ANALYSIS AND SENSITIVITY

A. KEY GENDER ANALYSIS GUIDELINES AND TOOLS FOR THE HEALTH SECTOR

The Swedish International Development Agency, the Gender and Health Group of the Liverpool School of Tropical Medicine, and the Pan American Health Organization have produced the most in-depth gender analysis tools to date.

1. SWEDISH INTERNATIONAL DEVELOPMENT COOPERATION AGENCY (SIDA)

In 1997, the Health Division and Gender Equality Unit at SIDA produced a document for applying a gender perspective to the health sector.[1] It addresses gender issues in a developmental context, viewing positive health for both women and men as essential for social and economic development and productivity.

SIDA emphasizes that gender equality does not mean that women and men become the same, but that women and men equally enjoy socially-valued goods, opportunities, resources and rewards. An important aspect of equality is the empowerment of women to influence what is valued in their society and to share decision-making. SIDA points out that because women are the ones excluded and disadvantaged with respect to social and economic resources and decision-making, efforts to redress imbalances have focussed on women. However, strategies to promote gender equality must also focus on men and the relations between men and women if real change is to occur. For example, a gender perspective would address men's role in child health, fertility regulation and safer sex practices. Health education to promote women's

[1] Schalkwyk, Woroniuk & Thomas, 1997.

health and equality also needs to be targeted to men, and can promote equality as well as health (men's responsibilities related to sexual behaviour, for example). SIDA also notes that gender analysis needs to be culture-specific for different countries and local contexts.

The SIDA document points out that although women predominate as both formal and informal givers of health care, they are under-represented at policy, management and decision-making levels in the system as well as in community and in some cases, household, decision-making with respect to health issues and resources. Much of the focus on women's health has been in relation to children, which may neglect both women's health issues that are independent of children and men's health issues. Having women represented among those who make policy and management decisions is not only an issue of equal opportunities, but also provides opportunities to incorporate women's priorities as providers and consumers of health care. Providing training to lower-paid workers (mostly women) can enhance their capacity, effectiveness and status in their communities.

Gender differences in health status, health practices and access to services are not only shaped by biology, but also by the socio-economic and cultural contexts of different groups of women and men. For example, women often have less autonomy and power within relationships, which puts them at risk for abuse and limits their ability to negotiate sexual practices to protect themselves from sexually transmitted diseases. Other socio-economic and cultural health risks noted by SIDA pertain to:

- cultural practices such as female genital mutilation, early marriage and childbearing, and preferential allocation of food to males;
- occupational risks in female dominated work environments such as garment factories, electronic assembly plants and some aspects of agriculture; and
- poverty's impact on environments such as housing and workplaces, health-related behaviours such as nutrition, and vulnerability to illnesses.

SIDA notes that socio-economic and cultural issues can have a direct impact on women's access to health care—such as when public services are cut back, user fees are introduced, or there are barriers to access such as clinic hours that conflict with household and child care activities or lack of transportation. In some cultures women do not travel alone or see male health care providers. SIDA suggests outreach services as well as convenient location and hours for all services.

SIDA also points out that the health system must recognize the opportunity costs of women taking on additional health education and care responsibilities in their homes and communities. Women must be part of decision-making about these issues.

The SIDA document is critical of initiatives that focus mainly on increasing women's participation in activities. Rather they support equality strategies that:

- focus on impact of an initiative on women, men and equality, rather than on activities and inputs; and
- focus on equality as an objective rather than women as a target group.

The latter may include changes in institutional practices, legislation and planning methods, and would include men as well as women. SIDA also notes the importance of recognizing that gender inequalities in power and decision-making on health status, behaviours and service delivery. These approaches fit with a mainstreaming strategy which:

> "…requires the integration of equality concerns into the analyses and formulation of policies, programmes and projects, with the objective of ensuring that these have a positive impact on women and reduce gender disparities... inclusion of the interests, needs, experiences and visions of women in the definition of development approaches, policies and programmes and in determining the overall development agenda. This requires strategies to enable women to formulate and express their views and participate in decision-making across all development issues." (Chapter 1, p. 3)

However, a mainstreaming strategy does not exclude initiatives specifically designed to recognize the specific needs of women. These complement the broader approach.

A particular strength of this document is its handbook for how to apply a gender perspective. This consists of questions to ask, why the questions are important and steps that can be taken to address the issues raised by the questions. Main areas of emphasis are:

a. Sector Analysis

This includes analysis of needs, policies, programs, and human resource issues in the health care system. Important considerations include using sex-disaggregated data and research to assess health status and problems and use of services; giving attention to socio-economic and cultural influences on health; making public and other consultations inclusive of men and women as well as tapping the expertise of organizations and individuals involved in gender equality issues; assessing access and barriers to services; considering community capacity for participation in health services; using international gender equality documents (such as Beijing) in policy and planning discussions; training in women's health and gender analysis skills for planners and managers; identifying and supporting advocates of gender equality; increasing representation of women in planning, management and decision-making; addressing workplace safety concerns (e.g., harassment); and assessing the impact of restructuring of staff and providing staff training and development opportunities which include gender analysis.

b. Project Formulation and Appraisal

Areas addressed in this category include consultation processes, gender analysis, project objectives and implementation strategies, expectations of agencies, reporting and monitoring, and revision and renewal of projects. Issues raised include the need for consultation processes with diverse women and men regarding objectives and activities of projects; a variety of consultation methods to facilitate women's participation; inclusion of women's organizations in the consultation process; inclusion of gender analysis in project planning (health status and needs, community participation in health initiatives); connecting gender analysis to overall project goals, objectives, targets and indicators; involvement of both women and men in determining indicators of process and impact/outcome; providing feedback; monitoring systems that provide sex-disaggregated data; specific strategies and associated resources to implement the project, including expertise in women's health and gender issues, and assessment of constraints to women's participation and strategies to deal with them; commitment of the implementing agency to gender equality (staff guidelines, resource commitment, links to women's health advocates and researchers); and ongoing review and modification of projects from a gender perspective (the more comprehensive approach to sexuality and women's health evident in documents from the Beijing and Cairo conferences, increased commitment of project partners to gender equality).

c. Annual Review

Areas for review include changes in health trends (HIV/AIDS among women and men); legislation and policies (shift to community-based services); new research; conditions affecting standard of living and health (food security, incomes); new funding initiatives; new women's organizations and networks; opportunities arising from international commitments; project targets and progress toward them; and stakeholder understanding of gender issues and analysis.

This annual "scan" of issues, trends and opportunities is intended to be used as a basis for revisiting and modifying previous analyses, plans and project strategies. Research and consultation with women's organizations and partnering agencies can provide information about the above issues.

d. Evaluation

Areas covered in this category of the framework are terms of reference, project design and implementation, project resources and activities, project outcomes with respect to health, socio-economic impacts, evaluation process and methods and lessons learned. Issues include specification of issues and questions about women's health and gender equality; incorporation of gender analysis in project planning (understanding of differences in health status, needs, constraints, priorities; being sensitive to both women's and men's capacity for community involvement); gathering sex-disaggregated baseline data for later assessment of change; inclusion of both women and men in consultations and decisions; setting objectives and activities specific to women's health and gender equality; availability of services, information and training to both women and men; opportunities to develop gender analysis skills and more gender-sensitive research; examination of outcomes for health status and behaviour, organizational capacity and socio-economic changes—including analysis of gender differences; and involving participants in defining important outcomes; discussion and dissemination of lessons learned.

SIDA identifies a number of themes that may arise when gender analysis is conducted:

- clear recognition that gender-based discrimination and inequality are contributing factors to women's health needs and problems and the need to respond to these and support women's empowerment;
- sex-disaggregated data and research on health problems, needs and use of services;
- health care strategies that respond to gender-based differences in health problems and access to health services, and that consider women's concerns and needs as individuals as well as in relation to children and childbirth;
- strategies that target men as well as women regarding child health, fertility and safer sexual practices;
- expansion of women's role in decision-making about policies and priorities at various levels, considering that women provide most of the paid and unpaid work in health care;
- health policies that result in equitable distribution of costs and benefits of investments and approaches to the provision of care (rural areas, poorer socio-economic groups, service accessibility, support for women's organizations, involving men as well as women in care, providing training opportunities for community-level workers);
- identification of ways health authorities can support the initiatives of other agencies that create the conditions for health, particularly for women (food security, access to economic resources, employment standards, human rights).

Many of the issues raised are similar to those we included in our own evaluation frameworks prior to receiving the SIDA document. That their consulting team and ours came up with many similar questions independently provides some initial validation for our framework. However, the focus of our framework and analysis was primarily women, and we did not explore the role of men in as much depth as the Swedish framework does.

2. GENDER AND HEALTH GROUP, LIVERPOOL SCHOOL OF TROPICAL MEDICINE

The Group's guidelines for gender analysis in the health sector grew out of concern that existing guidelines did not provide enough information to guide the work of policy-makers, practitioners or researchers. Work began in 1996 and the final guidelines were published in 1999. In between, the guidelines were discussed at a number of conferences and workshops and feedback was incorporated into the final version.[2] A critical review of literature is in progress to complement the guidelines and to inform policy-makers and practitioners of developments and debates in gender theory and practice relevant to health. Though the focus will be on infectious disease in "developing" countries, aspects of the review are likely to be useful in Canada as well, as the Group has an interest in health sector reform.

The guide begins with background information on gender and gender analysis, with a focus on how gender roles are relational (between women and men) and unequal with respect to power and resources. There is an example of how past economic development policies in developing countries has increased men's power while diminishing women's. The guide points out that gender inequities are reflected in vulnerability to illness, health status, access to preventive and curative measures, burdens of ill health, and quality of care. The guide also differentiates between the biomedical and social understandings of health, noting that the latter includes economic, psychological, sociocultural, environmental, gender and other influences on experiences of health and illness (not just the medical concept of disease).

The Group guide next presents a framework for gender analysis and action. It has three parts or stages:

Part 1: Patterns of Ill Health—*who gets ill, when and where?*

This stage involves examining sex-disaggregated data on morbidity and mortality (health outcomes data). Questions would pertain to what types of women and men get what illnesses (age, socio-economic and ethnic groups), when they get sick (time of year), and where they get sick. Some data may not be disaggregated and/-or may not be available for all groups (if only some populations are screened for a condition because they are assumed to be "high risk"). Additional data may need to be collected to fill gaps and address biases.

Part 2: Factors Affecting Who Gets Ill—*why do different groups of women and men suffer from ill health?*

The guide provides a matrix and questions about influences on health (the environment, activities of women and men, bargaining positions, access to and control over resources, and gender norms) with respect to the contexts of household, communities and influence of states, markets and international relations. Influences on health are further defined in the guide. Various sources of qualitative as well as quantitative data can be used to answer the questions.

[2]Gender and Health Group, 1999.

Part 3: Factors Affecting Responses to Illness—*how are these affected by gender?*

A similar matrix presents the same questions about influences on health, but in contexts of household, communities and available health services. For both Parts 2 and 3, the guide asks users to consider if their answers apply across different social groupings and if there are information gaps or biases.

Gender-Sensitive Planning

The guide next focuses on gender-sensitive planning in two settings—the formal health care system and research. This section of the guide moves from analysis to response, and asks questions in a number of areas. The ***formal health care system*** is subdivided into:

~ ***Policy:*** Is gender explicitly considered, and if so is the policy followed and effective? Does policy assume women's and men's health needs are the same or different? How could policy and planning address barriers women and men face in accessing health care? Are particular groups targeted? Why? Do the choices involve stereotypes, such as targeting reproductive programs to women only? Who makes and influences policy, and how could representation be improved? What level of understanding of gender do managers have and how could this be improved? Are there mechanisms to include women and men (including those who are disadvantaged) in policy-making, planning, monitoring and evaluation?

~ ***Human and financial resources:*** How are decisions made about resource allocation and are different groups of women and men equally positioned to benefit? Are user fees assessed for differential impacts on women and men? Are expectations about community resources assessed and are they based on stereotypes (about women being willing to provide unpaid care-giving)? Do staffing decisions consider barriers faced by different groups of women and men (cultural norms about women undressing in front of male providers)? How are male and female employees rewarded?

~ ***Service provision:*** Are services accessible to both women and men (location, times, costs)? Do providers have different standards for women and men and if so, how can these be challenged (providing more information about sexually-transmitted diseases (STDs) to men than women)?

~ ***Information systems:*** Are all data disaggregated by sex, age and other relevant social groupings (social economic status, ethnicity)? Are staff trained in analyzing this data? Does the data include indicators relevant to disadvantaged groups (needs and access)? Is qualitative as well as quantitative data considered?

The guide goes through a similar process for ***research*** (Are women included in studies? Do research questions challenge power relations and stereotypes? Do questions consider that risks, impacts and treatments of a disease may differ for women and men? Are there different benefits and risks to women and men of participating in research, and are there different drop-out rates by gender? Are results disaggregated?)

The guide provides numerous strategies for working both inside and outside the health sector to promote gender equity. Working inside the health sector is designed to address factors addressing responses to ill health, such as barriers to access and stereotypes and inequities in service provision. The main areas of focus are:

~ ***Improving access and quality:*** These are interdependent, and training and equitable resource allocation are seen as essential to improving both access and quality. A num-

ber of examples are provided of services that have a "one stop" approach, are sensitive to life circumstances (cultural beliefs, sexual orientation, income, power imbalances in relationships), and that assess and address barriers to participation.

~***Improving information systems:*** Limitations of present methods are presented, such as lack of local input into what is collected, lack of time and skills for analysis, and lack of qualitative data. Training in both data collection (including qualitative) and use is sug-gested, along with more participation of communities in data collection and an-alysis. The guide also emphasizes data disaggregation and development of gender-sensitive indicators (disaggregated data for morbidity and mortality, use of services, satisfaction, feedback from staff and communities, staff understanding of gender issues, involvement in consultation and decision-making bodies, assessments of provider sensitivity, number of women who feel able to insist on condom use).

~ ***Training and awareness-raising:*** Focusses on the use of both training materials and courses as well as creative methods such as games, role playing and arts. Training content needs to question assumptions about gender roles and power relations, and educate as to how assumptions influence health care practices.

~ ***Mainstreaming gender in policy:*** Focusses mainly on developing a gender policy that brings a gender perspective to all policy, planning and research initiatives. The policy development process needs to spell out objectives, roles and responsibilities of senior management, resources, skills and training needed to implement it, mechanisms for input to and promotion of the policy, and monitoring for accountability.

Working with sectors outside of health care is designed to address both responses to ill health and factors affecting who gets ill (Part 2 of the framework). The focus here is on:

~ ***Improving the environment:*** For example, through assessing the gender equity and health impacts of plans in other sectors (natural resource and agricultural initiatives); advocacy for improved housing and infrastructure in disadvantaged areas; and legislation to protect disadvantaged groups of workers.

~ ***Personal and community development and empowerment:*** Through individual skills training and self-help opportunities; organizational challenges to negative norms and unequal power relations (and the barriers related to these); and improving women's access to income and credit and creating peer linkages for discussion of and action on issues.

The guide shares numerous real examples of applying the above strategies inside and outside the health sector as well as detailed case studies applying all the steps in the guide (framework, gender-sensitive planning and more examples of strategies).

3. PAN AMERICAN HEALTH ORGANIZATION

This resource is a workshop facilitators' guide.[3] The workshop has seven modules plus an introduction. The ***first module*** covers various aspects of adult education and group process. The guide then states the overall workshop objectives, audience, group size, methods, duration in hours, trainers and necessary background, and facilities and materials needed. The introductory module includes:

[3]Hartigan, Gomez, deSchutter, & daSilva, 1997.

- the difference between the Women in Development (WID) approach and the Gender, Health and Development approach (GHD) which is similar to the GAD approach outlined in Part 1 of this report, but health-specific;
- "ice-breaker" exercise for participants; and
- an overview of objectives for the rest of the workshop: to examine the difference between sex and gender; to discuss the gender approach and its particular relevance to the areas of health and human development; and to acquire skills and methodologies to enable participants to ensure that their work in health and development is grounded in a gender approach.

The expected outcome is that participants understand that the gender approach is essential for health planning and sustainable human development. The first module covers the difference between sex and gender, and participants discuss what differences between women and men are biological or socially constructed as well as issues of gender and power, diversity, changeability over time, and social systems that support gender distinctions.

The ***second module*** addresses gender roles, access to and control of resources and household stereotypes. Participants discuss various types of work done by women and men—productive (for cash or in-kind compensation), reproductive (childbearing, parenting and care of household members), and community management (usually volunteer). The facilitator leads discussion on how these roles are related, the extent to which they are valued, and how people (women in particular) play multiple roles. Implications of the gendered division of labour for health and gender-responsive planning also are discussed. This module also addresses the implications of gender roles for access to and control over resources. It distinguishes between the two, noting that access to resources does not always mean control over their use (e.g., condoms). Various types of internal and external resources, and gender differences in power and value are discussed. This module addresses stereotypical assumptions of families and households (women's wages are secondary), and stresses the importance of recognizing the diversity of families and households in existence. Finally, the module has participants discuss how a health crisis within a household would affect members' roles and responsibilities, access to and control of resources, how the household could make changes so responsibility for dealing with the crisis does not fall on one person, and the relationship of all of these to gender roles.

The ***third module*** addresses the origins of health needs, specifically the relationships among biological, psychological and social factors. It gives examples of conditions that are sex-specific (maternal mortality); have a higher prevalence in one sex (iron deficiency anemia in women; mortality from violence in men); present different characteristics for men and women (STDs); and generate a different response from individuals, family, and institutions depending on whether the person is male or female (cardiovascular disease, family planning services). The effects of gender on addressing various health conditions is discussed (diabetes is more prevalent in women, but diabetic men are more likely to have modified diets; women are more likely to ensure an appropriate diet for their partners than for themselves). The module then examines different risk factors for the sexes, different degrees of severity of consequences, and different responses from women and men, the health sector and society. The example of HIV is used to demonstrate how both biological and psychosocial factors make women more vulnerable (infectious semen remains in vaginal tract; male rejection of condoms and female re-luctance to

question male sexual history; women feel they are worth less than men). The module emphasizes the importance of sex-disaggregated data.

The ***fourth module*** distinguishes between practical and strategic approaches to gender needs as well as mechanisms to promote empowerment. The module emphasizes that both approaches can be used together (a strategic approach is unlikely to work if services are practically inconvenient to access; a practical approach of promoting condom use is unlikely to be effective unless strategic actions are taken to challenges gender roles by encouraging women to assert themselves and men to listen and respond). The module next addresses empowerment (using Labonte's continuum from interpersonal through political coalitions), and again emphasizes the important difference between access to and control over resources. The module concludes with an exercise to apply both practical and strategic approaches to a number of example health interventions (breastfeeding, tuberculosis, mental health of elderly, and tobacco addiction).

The ***fifth module*** further discusses differences between women, health and development approaches (like WID) and gender, health and development approaches (like GAD). The WID-type approaches are the welfare, anti-poverty and efficiency initiatives; the GAD approaches are the equality and empowerment initiatives. The module concludes with an exercise to classify various health interventions by these approaches plus the practical/strategic dimension from the previous module.

Modules six and seven have participants apply concepts from the first five modules to case studies and existing health projects, respectively.

B. ADDITIONAL GUIDES TO GENDER ANALYSIS AND GENDER EQUITY

In addition to the tools developed by the Gender and Health Group (1999), Hartigan *et al.* (1997), and Schalkwyk *et al*. (1997), there are a number of step-by-step guides to gender analysis and the use of a "gender lens" from sectors other than health, or for policy-makers in general. The tools described here raise issues that were considered in the development of this project's evaluation frameworks.

1. *SETTING THE STAGE FOR THE NEXT CENTURY: THE FEDERAL PLAN FOR GENDER EQUALITY* (Status of Women Canada, 1995)

This document was prepared in advance of the Fourth United Nations World Conference on Women in Beijing, China, as Canada's contribution to the *Platform for Action*. It has a specific section on women's physical and psychological well-being which raises a number of important issues, including:

- the importance of social determinants of health;
- the need to recognize that the diversity of women (culture, socio-economic status, age) will influence their health and health needs;
- inattention to gender-specific aspects of such diseases as cardiovascular disease and AIDS, and to health behaviour such as smoking and other addictive behaviours;
- under-funding of women's health research and exclusion of women from research;
- lack of comprehensive data for women's health issues;
- the need for evidence-based decision-making;

- the over-medicalization of women's health and normal life processes such as reproduction;
- the need for alternate providers (nurse practitioners and midwives);
- the need for citizen responsibility for personal health and health system decision-making (while recognizing effects of cuts and deinstitutionalization on women as informal caregivers); and
- the need for more balance between health care and prevention/promotion initiatives.

2. *GENDER-BASED ANALYSIS: A GUIDE FOR POLICY-MAKING* (Status of Women Canada, 1996)

This document addresses the importance of considering a number of issues when conducting gender analysis:

- gender- (sex-) disaggregated data;
- including both women and men in consultations;
- considering that women differ among themselves by such factors as age, socio-economic status, etc.
- defining outcomes that are gender-sensitive (access to child care);
- being aware that gender-specific factors can influence the success of policy or program outcomes (harassment, informal care-giving); and
- including women in research that is gender-sensitive.

This document also points out the need for equity or fairness, which may mean different rather than the same treatment of women and men. It notes that in turn, equity leads to equality of status: "gender equality is therefore the equal valuing by society of both the similarities and differences between women and men, and the varying roles that they play."[4]

[4]Status of Women Canada, 1996, p. 3.

3. *GENDER LENS: A GUIDE TO GENDER INCLUSIVE POLICY AND PROGRAM DEVELOPMENT* (British Columbia Ministry of Women's Equality, 1997)

This document covers much of the same ground in its emphasis on equity, diversity, public consultation, (emphasizing women's organizations, other community groups and the general public); the need for gender-sensitive outcomes and sex-disaggregated data; and the inclusion of women in research. It strongly emphasizes a participatory approach to research and a mix of both qualitative and quantitative methods. It gives attention to health determinants, even though health is not the primary focus of the document. Readers are encouraged to consider how their own values and perspectives influence their analysis. Illustrative hypothetical cases are used to illustrate key points.

4. *GENDER-BASED ANALYSIS GUIDE: STEPS TO INCORPORATING GENDER CONSIDERATIONS INTO POLICY DEVELOPMENT AND ANALYSIS* (Human Resources Development Canada, 1997)[5]

This guide covers issues similar to those outlined in the British Columbia document. Like the B.C. document, it also provides hypothetical cases to illustrate key points. The guide is accompanied by the *Gender-Based Analysis Backgrounder*,[6] which covers some of the same issues of equity and diversity as in the previously-discussed documents. It also presents a brief summary of statistics on issues such as gender

[5]Morris, 1997.
[6]Morris, 1997.

differences in individual earnings and income (including seniors), household income, occupational segregation, self-employment, education, unpaid work, lone parents, violence (including harassment, physical and sexual assault, homicide), and discrimination. It includes a section on frequently-asked questions (and misconceptions) about gender analysis (Is it biased against men? Does it turn everything into a "women's issue?"). The guide explains ways in which gender-based analysis benefits both women and men and promotes fairness and equality.

5. *GENDER-INCLUSIVE ANALYSIS: AN OVERVIEW* and *A GUIDE FOR POLICY ANALYSTS, RESEARCHERS, PROGRAM MANAGERS AND DECISION-MAKERS* (Government of Saskatchewan, 1998)[7]

The overview document and its companion detailed guide examines many of the same issues as the documents described above. The documents also point out the difference between gender analysis and diversity, noting that diverse groups of people are all affected by the gendered division of labour, the resulting differences in social and economic status, and how these differences affect women's and men's access to resources. Gender analysis does not replace other aspects of attention to diversity, but rather broadens and deepens it. The conceptual framework in the documents focus on two questions: how to address full participation and equality on the positive side, and discrimination on the negative side. Key concepts are similar to other gender analysis documents, and address gender as a social and political construct that permeates all facets of our lives, reinforcing the need for analysis beyond those policies specifically targeted to women. The documents use a definition of equality that is focussed on equality of status rather than sameness of treatment, requiring an equity approach that attempts to achieve results and differential treatment to compensate for historical and social disadvantages, and considers the process of analysis as well as outcomes. The guiding principles are:

- reflect on values, goals and knowledge; understand how individual, organizational and government values interact and affect questions asked, recommendations made, and the ability to conduct gender-inclusive analysis;
- understand that the dominant values in society have been based on a male perspective of the world, and that the result of gender-based analysis may differ from societal norms;
- identify ways to increase understanding of gender analysis through gathering resources and interacting with those who have this expertise (such as organizations that work with women);
- consider key factors in women's lives, such as family status and its relationship to unpaid work (including care-giving), poverty and employment issues, income and earnings and their relationship to labour force participation patterns, unpaid work and transfer programs (such as Old Age Security/Guaranteed Income Supplement), violence against women (including physical and sexual assault and harassment), and the effects of these acts on women's independence and career choices;
- gather comprehensive information, including quantitative and qualitative data disaggregated by sex and other demographic factors, data that are inclusive of outcomes that go beyond skills and behaviour (self-confidence), include program participants, staff and non-participants (to find out why people are not participating); community consultations (including informal mechanisms such

[7]Saskatchewan Women's Secretariat, 1998a, 1998b.

as phone contact) to gather diverse stakeholder input from women's groups in particular (to gain first-hand perspectives on how decisions might impact women as well as innovative approaches to addressing issues);

- emphasize the importance of recognizing diversity, minimizing barriers to participation (addressing child care and transportation), respecting time and resource constraints of voluntary organizations and individuals, and respecting confidentiality and personal safety; and
- incorporate gender into the communications strategy (to increase the likelihood of successful implementation), include diverse groups in the design and testing of strategies, make messages audience-specific (different messages geared to women and men), use inclusive language and images, and use channels most likely to reach each intended audience (including women's organizations).

The more detailed guide for researchers and practitioners[8] also differentiates between gender inclusive analysis (which identifies how public policy can affect women and men differently) and gender-neutral analysis (which assumes that all people are affected the same way).

There are numerous additional resources not covered here.[9] An excellent annotated bibliography of gender analysis guides available in Canada and elsewhere is on the Website of the Maritime Centre of Excellence in Women's Health (see References section for Website address). Many of these tools are readily available on the Internet and/or are in the public domain through government departments.

[8]Saskatchewan Women's Secretariat, 1998b.

[9]From Justice Canada, Canadian International Development Agency.

6. *GUIDELINES FOR GENDER-INCLUSIVE ANALYSIS* (Government of Newfoundland and Labrador, 1998)[10]

The Women's Policy Office of Newfoundland has published a guide similar to those of other provinces (Hebert, 1998). The Office's *Guide for Gender Inclusive Analysis* provides several examples of how women and men are affected differently in the areas of family structure, economics, violence, health and social issues, and legal and policy decisions. The guide also notes economic and social benefits of gender analysis (although the latter includes care-giving without questioning why it should be women's role). The guide also points out that gender-inclusive analysis is a strategy of "responsive government" in terms of both effectiveness and efficiency in public policy. The latter half of the guide applies gender-inclusive analysis to six policy development steps: identifying issues; defining desired goals and outcomes; conducting research and consultation; analyzing options and making recommendations; communicating the policy/program decision; and implementing and evaluating the policy/program. Many of the issues raised are similar to the B.C. and Saskatchewan materials in particular, but the examples are specific to Newfoundland (e.g., types of em-ployment opportunities). The guide emphasizes the need to include other types of diversity with-in gender analysis (e.g., age, race, ethnicity, sexual orientation, ability/disability) and notes that equity or fairness in addressing historical and social disadvantages (rather than identical treatment) is necessary for achieving equality (which they define as equitable results).

[10]Herbert, 1998.

C. MODELS OF GENDER-INCLUSIVE HEALTH PLANNING

1. SAN FRANCISCO CITY AND COUNTY DEPARTMENT OF PUBLIC HEALTH WOMEN'S HEALTH ADVISORY COMMITTEE

This model is intended to assist the health care system in moving away from a focus on specific health problems toward a focus on broader solutions to promote women's wellness. It was developed and refined through focus group consultations with women as health care consumers, advocates and practitioners from 1993 to 1996. The model refers to women's wellness rather than women's health, because the women consulted viewed wellness as a broader state of being. The report also notes that adopting the model also would improve health care for men and children, so the model can be applied outside woman-specific health settings.

The overall wellness model developed by this committee consists of five goals. Under each goal the group discusses ways in which the health care system can be responsive to the needs of women.[11]

Goal 1: Planning Women's Health Services

> "To improve and preserve the health of women by making plans and developing policies for their current and future health and by making women integral to that process." (p. 45)

[11]San Francisco City and County Department of Public Health Women's Health Advisory Committee, 1996.

The report notes that women want and need to be involved in identifying needs and monitoring health, identifying important health concerns, promoting community health, and planning and implementing strategies to improve their health. Diversity is also emphasized (age, culture, sexual orientation, income). The Women's Advisory Committee offers some important components of an optimal planning process that is inclusive and gender-sensitive:

~ ***Bringing diversity together:*** In addition to the use of questionnaires, interviews and focus groups for identifying women's needs, concerns, supports and cultural issues, ongoing input should be sought from women who are actually receiving services so that they can be involved in the planning of their own wellness (through follow-up interviews and support groups). Planning is seen as something that occurs both at the health care system level and the individual level, and women need to be involved in policy and program development as well as feedback to practitioners. There is a need to provide assistance for women to participate in health planning through such means as child care, transportation costs, stipends and training. The report suggests reviewing other studies of client needs from various jurisdictions, and networking with other providers as to how they include women in their planning processes.

~ ***Understanding cultural socialization and empowering women to prioritize their wellness:*** The importance of egalitarian relationships between women and health care providers is emphasized—health decisions are a mutual responsibility. Women's involvement in determining their own health care is likely to promote more positive health outcomes. Cultural background influences the extent to which women are willing to

take an active versus passive role in their health care, and that providers need to be sensitive to this while still encouraging involvement in decisions.

~ ***Providing appropriate information:*** Women need to know as much as possible about their general health and specific conditions in order to make informed decisions.

~ ***Avoiding duplication:*** Various organizations and individual providers need to co-ordinate their efforts and seek out collaborative opportunities. This includes identifying different settings in the community that contribute to health care—such as schools, religious organizations, day care facilities and families.

Goal 2: Evaluating Women's Health Services

> "To improve and preserve women's health by regularly evaluating their health services against agreed upon standards and by making women integral to the development, implementation and evaluation of those standards." (p. 45)

The report emphasizes the use of evaluation in planning as well as assessing progress toward goals and adherence to standards. Standards for women's health care are of particular concern. The Committee defines standards in a broad sense, to cover "caring" as well as "curing," and to address ethics, respect, relationships and healing as well as academic knowledge. Women need to be involved in determining what these standards are. Issues related to standards are:

~ ***Linking expectations to education:*** In order to meet standards, practitioners need to know what is expected of them. Practitioners need education and support to learn about the diversity of women's health issues on an ongoing basis.

~ ***Outlining standards according to principles of a women's wellness model:*** Standards need to cover several broad areas of women's health—primary care, care coordination, health promotion and disease prevention, and community development for various communities of women. Women's health care delivery standards need to be community-specific—including geographic (urban/rural, type of neighbourhood); type of health care needs (chronic disease, gender-specific); life span needs (age-specific); and culture (broadly defined to include ethnicity, race, religion, sexual orientation). A brief example is provided of a community health centre that holds regular meetings for staff and volunteers to examine their own beliefs and experiences concerning different communities of women with whom they work as a way of integrating ethical with medical practice.

Women need to be involved in setting standards and assessing the achievement of outcomes. Client surveys and focus groups are suggested as ways of soliciting feedback on services, and having practitioners use services themselves so they can experience them from the client perspective.

Goal 3. Delivering Women's Health Services

> "To improve and preserve women's health by providing high quality, accessible, comprehensive an co-ordinated health services that are integrated into one system and into the broader community." (p. 45)

The report addresses both primary health care delivery and care coordination. There is an emphasis on woman-centred settings and inclusion of broader determinants of health. The elements of the model for women's health services are:

~ ***Integration of primary and speciality care services across the life span:*** Women's care requires collaboration among a wide range of health care providers within a broad public health framework which integrates specialty services for women. The report provides a number of examples of lifespan issues. For example, it is noted that young girls need health promotion and disease prevention programs (physical activity, nutrition, substance use prevention). Adolescents need opportunities to address concerns about self-image and self-esteem, career planning and goal setting, sexuality education (including communication, boundaries and making choices), and help with issues around injury control, depression, violence and conflict resolution. In mid-life there would be emphasis on early detection of disease, developmental transitions (e.g., menopause), and issues related to juggling multiple roles such as worker, parent and caregiver.

~ ***Incorporating experiences of survivors of various kinds of abuse:*** The report emphasizes the importance of support to women who are recovering from substance, physical or sexual abuse. There is an example of a community health centre that hires staff with diverse backgrounds to which clients can relate—including many staff who are survivors of abuse themselves. Life experience is valued and staff are provided with support when their work with clients "triggers" their own past traumas.

~ ***A team approach to enhance continuity of care:*** The report emphasizes multidisciplinary teams and their importance in providing multiple sources of support to clients and mitigating the effects of staff turnover. For example, in clinics where medical care is provided by short-term residents, a nurse care manager or peer advocate can provide continuity of care. Team members also can provide support to each other, encourage commitment, and improve service cost-effectiveness.

~ ***Follow-up services:*** The report suggests that if women know someone is going to call them to see how they are doing, they will be more likely to both follow provider advice and feel that providers care about them. Follow-up can also bring client changes to providers' attention.

~ ***Flattening organizational structures:*** The report calls for less hierarchy and more lateral structures. The benefits include staff buy-in to a women's wellness model, more teamwork and collaboration to enhance services and reduce redundancy, and fewer "us versus them" attitudes. The report recognizes that providers may need more training and assistance to learn to work in teams. It also gives examples of abuse survivors working as staff, and students and community groups involved in program administration.

~ ***Alternatives to individual treatment:*** The report notes that the women consulted suggested that in some cases women could meet in groups rather than having individual treatment—particularly for health promotion, disease prevention, and dealing with stressful life events such as grief or serious illness. Women could learn from and support each other in such groups.

~ ***Coordination of health care needs:*** The report emphasizes the need to make health care less fragmented and more holistic. This is especially important for women with complex health care needs (women dealing with major life changes, homeless women, teen

mothers, women with disabilities, immigrant and refugee women). Some examples of co-ordination include access to spiritual care for women with disabilities and cancer; a neighbourhood support service to address health emergencies; elder care issues such as the loneliness and isolation of the elderly and homebound; and the integration of health services with social and vocational assistance (e.g., child care, job training).

~ ***Use of care coordinators:*** The Women's Advisory Committee has adopted the term "care coordinator" rather than "case manager," to convey a focus on advocating for rather than "managing" the client. The care coordinator assesses needs and barriers to access for each woman, and then problem-solves with her. The coordinator can act as a "translator" between the woman and the system, so must understand the culture and language of both. A care coordinator can be in a number of locations (community, clinic, workplace) and can be a professional or peer helper. The report also suggests case conferencing and ongoing communication among providers with shared clients to enhance care coordination.

~ ***Linkage of health and community services:*** These linkages promote both service coordination and a more holistic approach to service. The Committee concluded from the consultations that "one-stop shopping" would be beneficial for women accessing the system. For example, the report suggests that a hospital or health clinic could provide prevention and health promotion, mental health and other specialty services, social services, banking and budget advice, child care and school registration, teen intervention, violence intervention and other services in one location. Staff need to be cross-trained to be familiar with the issues, and the strengths of various types of staff need to be valued (peer educator and medical providers).

~ ***Safe, supportive environments:*** The report emphasizes the importance of environmental influences on women's health and wellness, such as risks associated with care-giving responsibilities, violence at home, exposure to hazardous substances, stress at work, and unsafe communities. The report points out the need for education and advocacy around these issues, especially violence. It recommends that providers identify social and environmental needs of women with complex health care needs, so that health care is integrated with other broader issues.

~ ***Safe, affordable housing:*** The report makes a number of links between housing and health. For example, the Committee notes that women who are trying to live "clean and sober" are more likely to relapse if they return to live in an environment where they used to use drugs. They also point out that women are more prone to violence if they are living in transient or substandard housing situations, and that nutritional eating is difficult for women who do not have access to a stove or refrigerator. The Committee emphasized the need for women-only housing. The report notes that co-ed environments are often under used by women with a history of violence or fear of harassment from men, and that women may not want to "look bad" or speak out in the presence of men.

Goal 4. Promoting Women's Wellness

"To improve and preserve women's health by inviting women, and their providers, to work as partners to prevent disease and improve wellness." (p. 46)

The Committee states that the health care system should first focus on preventing disease and disability, then on early intervention on health problems that do occur, and last on providing acute care. Much of what the report describes for this goal is preventive screening and health education. There is an emphasis on promoting healthy behaviours and lifestyles, although this approach is defined broadly enough to include the behaviours of other people (such as violence and environmental exposures to harmful substances).

~ ***Empowering women to prioritize their health:*** The Committee emphasizes the importance of women learning to value their own health and to realize that placing their health above other responsibilities will benefit both the woman and those for whom she cares. The report also stresses that women not only need to be provided with information, but also to have opportunities to use that information to make decisions together with their health care providers. Opportunities for follow-up (through weekly follow-up behaviour assessments) can provide incentives for women to take more responsibility for their health, and feedback mechanisms (focus groups, community advisory boards, encouragement to women to demand better service if unsatisfied) can be used to make services more responsive to women's needs. The report suggests introducing programs that teach women how to be empowered partners in their health care. It suggests setting up a client resource area with information on a variety of issues including available support groups, specific educational resources or groups for issues such as substance use, violence and safer sex, availablility of complementary therapies, and more "determinants-focussed" issues such as transportation, child care, educational and vocational classes, schools, housing, and legal and social resources. Inter-agency sharing of resource information is also suggested.

~ ***Preventing disease and disability:*** The report focusses on a number of areas for screening or assessment and education and referrals. Minimum recommended areas are general wellness assessments and medical check-ups, cancer and related nutrition issues, reproductive health, HIV, STDs, substance use, violence, mental health, and any issues raised by the client specific to her own lifestyle or community.

~ ***Risk or harm reduction for women who are not ready to give up harmful behaviours:*** Areas of importance include smoking, alcohol abuse, excessive drug use, unsafe sex, being in unsafe areas, eating disorders, and remaining in violent relationships. The report notes that women are often aware that such behaviours are harmful and emphasizes the incremental nature of change, the reality of relapse as part of the behaviour change process, and the importance of being supportive of any change that does occur and not judging women's decisions.

~ ***Emphasis on wellness rather than absence of disease:*** The Committee notes the importance of healthy lifestyle behaviours, positive interpersonal relationships and stress reduction. The report suggests the use of a number of wellness indicators to assessing women's health: feeling vital and full or energy, having good social relationships, having a sense of control over one's life and living conditions, being able to do enjoyable, fulfilling activities, having a sense of purpose in life, experiencing connectedness to a community, maintaining a sense of humour and perspective even in difficult situations, and feeling hopeful and positive about the present and the future.

~ ***Incorporate group education:*** The report recognizes the benefits of ongoing accessible group education programs to which providers can direct clients for ongoing follow-up to

routine care. These groups may be located in health care agencies or in community settings that are more accessible or comfortable for women. Culturally competent peer educators can be an integral part of such groups, as they can share health education messages in ways that are understandable, trustworthy and relevant for clients.

~ ***Begin health education at a young age:*** Schools are the logical setting for health education, but the report cautions that there are some barriers that need to be recognized, including overburdened teachers, school policy, parental opinions, and age appropriateness of material. The report also recognizes that educating parents can have spin-offs in educating children.

~ ***Accessible health education:*** Women can access health education more easily if it is offered in a wide range of locations (health clinics, community settings, and the workplaces). Convenience is also essential, including education as part of a routine office visit.

~ ***Use of peer educators:*** Peer educators can form a bridge to clients who do not feel immediately comfortable or empowered in the health care or social service setting. Women also relate to a peer educator who is similar to themselves—which may increase a woman's confidence that she can learn the same skills. The report notes an example of a community health centre using peer educators in a street outreach program.

~ ***Addressing women with special needs:*** The report recognized the need for both general health education and the special needs of minority populations. For example, all women can benefit from information on nutrition, exercise, sexual health, their rights as clients and how to use the system. However, for immigrant women, providers can develop culturally-relevant educational materials with input from clients. They will also need more training on the workings of the health system and client rights in their new country.

Goal 5. Broadening the Women's Wellness Knowledge Base

> "To improve and preserve women's health by helping practitioners recognize, and incorporate into their practices, the diverse issues that affect women and their health." (p. 46)

The Committee added this goal when they revised their original model, in response to concerns that health care providers are not sufficiently trained to address women's health needs. The report notes that health care practitioners and educators need information about issues affecting women in areas such as leadership and team-building. Informal caregivers, policy-makers and funders also require more education about women's health issues. The report points out that curricula need to be developed in conjunction with the women they are designed to serve.

~ ***Women's wellness research to build the knowledge base:*** The report identifies a number of gaps in the knowledge base for women's health, including the impact of racism, sexism, "ableism," violence, gender roles, sexuality and poverty on women's health and health care. The report notes that most health research has been performed with Caucasian men. Women need to be seen not as "men with different reproductive systems, but as people whose bodies may react differently to everything from medications to diet to surgery" (p. 80). The report also suggests more research is needed in areas such as barriers to accessing health services (in particular for different cultures and in non-institutional settings), and alternative treatments.

~ ***Incorporating woman-centred principles into education of practitioners:*** Women want practitioners to move away from an illness and disease focus to a more holistic focus on overall wellness. Normal processes (such as childbirth and menopause) have been medicalized. The report points out that the training of health care providers (especially physicians) is hierarchical, and that students learn to accept this approach when dealing with their clients. Individual practitioners are trained to believe they need to know everything, making collaboration difficult. It is also difficult to move from one profession to another without completing a new training program, as experience is not recognized in credentialing practitioners. The report briefly describes a master's level nurse practitioner program at the University of California (San Francisco) which focusses on diversity across the life cycle and covers psychosocial and cultural as well as biomedical theories of women's health. Clinical practice experiences focus on diversity and environmental aspects of women's health and illness, and students work in community-based settings (such as women's health clinics) that focus on women and families. The program has a flat governance structure that has a rotating leader and that includes students.

~ ***Diversity training:*** The Committee emphasizes that providers must accept that there is no "generic woman," and that more education is needed about psychosocial issues such as racism, sexism, violence, gender roles, poverty and health beliefs. Diversity must be understood and integrated into health care delivery (age, culture, occupational and employment status, education level, geography, sexual orientation, religious beliefs). There need to be opportunities for providers to better understand and question their own cultural biases. The report suggests that providers and professional associations can become involved with organizations that work on diversity issues. The report mentions a University of California medical program where students hear guest lectures from diverse non-medical providers such as acupuncturists, nurse midwives and nurse practitioners. The report recommends that medical students' training include sexual assault and domestic violence, dying, cultural sensitivity and competence, alternatives to Western medicine, broad social issues that affect health, various types of prejudice and discrimination (racism, sexism, homophobia), and substance abuse. A multi-disciplinary approach is also suggested, and providers are encouraged to attend professional development activities for other professions or read their journals.

~***Building interpersonal skills:*** The Committee states that "in an ideal system health care practitioners will be working in teams and interdisciplinary groups that include the individual and her family." The report emphasizes the importance of respect for and communication with both clients and other types of providers. Follow-up among providers after referrals is critical for coordinated care. Cultural sensitivity and a recognition of broad social context issues is essential, as are team-building and leadership skills. Providers also need to be able to address their own health issues, which helps providers to be sensitive to clients (there is an example of a support group for staff and volunteers addressing body image and food issues). The report also suggests customer service training for providers, education of providers by clients, and lessening "us versus them" distinctions between providers and clients. Learning to listen to clients' stories and identify the important issues is a skill that providers could work to develop.

~ ***Training informal care providers:*** Family caregivers need education and support for their caring role as part of a well-integrated, comprehensive and holistic approach to health care. There also needs to be recognition of how care-giving impacts health of caregivers, most of whom are women. The report suggests training in psychosocial and cultural issues for volunteers and administrative staff working in health care settings.

~ ***Education of funders and policy-makers on women's health issues:*** Funders and policy-makers often are not aware of the types of services required to meet women's health needs. Organizations seeking funding have little time to provide this education, and tend to design their proposals to meet narrow funding categories which work against comprehensive approaches. Participants in the consultations feared that meeting funders' and policy-makers' priorities may compromise women's health care if women's needs are different from those priorities. The report suggests that providers can use reports to funders as an opportunity to teach them about women's health issues.

At present, this model is not being implemented in an integrated manner on a system wide basis, but parts of it are being implemented within various program components of the public health system. The model presents a template for women's health care where none existed before. The Women's Advisory Committee that led the model's development no longer exists, though there is still a Coordinator of Women's Services, strong advocates of women's wellness issues inside the public health system, and a number of issue specific advisory groups. These include groups for lesbian health, disability issues, and breast cancer.[12]

[12]Monico-Klein, personal communication, 1999.

2. WOMEN'S HEALTH WORKING GROUP, GLASGOW HEALTHY CITY PROJECT

This ongoing women's health initiative is focussed on linking health and social issues, changing existing organizations through internal and external action, working with a diverse range of organizations, maintaining a strong community perspective, and linking with the broader women's movement.

The major goal of this project is to "replace the medical model with a social one as the dominant framework for health care and health promotion."[13] The project began in 1983 with a women's health fair which covered social policy and influences on health and health issues such as nutrition, exercise and fertility. Out of the participation in the health fair grew a broad women's health campaign focussed on a women's health centre (which did not open until 1995). The initiative became known as the Women's Health Working Group of the Glasgow Health City Project of the World Health Organization. The multisectoral partnership that was formalized, and still exists, consists of regional and district governments that serve the Glasgow area, the health authority, universities in Glasgow and many voluntary organizations and community groups.

The Group provides a forum for women to discuss health issues and to identify practical ways of establishing systems to promote women's health. The Group holds membership in the steering group of the Healthy City Project, and has links to senior and elected officials from the partner organizations. For example, when the regional council identified women and health as two of its priorities, additional structures for

[13]Laughlin, 1998, p. 221.

promoting women's health were formed through both political and administrative routes, and eventually influenced the development of similar structures in the district authority.

However, there was still resistance to the Group's efforts from many decision-makers. In response, the Group developed a women's health policy framework in 1991/92 in consultation with the Project partners, women's groups and individual women. The policy emphasized both increased gender sensitivity in existing services, additional services specific to women, and was explicit about links between inequality and poor health, and the gender differences in causes and outcomes of health problems.

a. Policy Objectives and Strategies

The Group's present policy objectives and examples of key strategies are:[14]

POLICY OBJECTIVE	STRATEGIES
1. To increase awareness and understanding of the factors which affect the health and well-being of all women in Glasgow	P providing staff awareness initiatives P ensuring data collection identifies women's health needs P disaggregating data by sex, race and disability P developing indicators of women's well-being
2. To shape general policy development, planning and service delivery to improve the health and well-being of women	P systematic use of women's health data in policy development and service delivery P assessing services for sensitivity to women's needs P developing, piloting and mainstreaming programs that are responsive to women's needs P providing women-specific services as appropriate P communicating to women and women's groups how they can access relevant data and services
3. To ensure that there are structures within organizations which take account of the factors affecting the health and well-being of all women	P a structure to coordinate and monitor implementation of women's health policy throughout the organization P mechanisms for consultation with women and accounting for their views in decision-making P mechanisms for participation of women in decisions about service delivery P an occupational health strategy to address needs of women as employees
4. To ensure that the key issues identified by women are addressed as priorities	P recognizing and addressing barriers to services (particularly for black and ethnic minority women, women with disabilities and lesbians) P identifying ways of improving mental and emotional health and well-being, reproductive health, safety in home, workplace and community P providing support for formal and informal caregivers while challenging expectations that women are the primary caregivers P ensure that actions taken on specific issues such as reducing poverty, improving the physical and social environment and reducing the incidence of specific diseases, recognizes women's health needs and experiences

b. Policy Priorities

Priority policy areas identified in an original 1992 policy document, and still in place, are:[15]

- P improving mental and emotional health;
- P providing support for women as carers;
- P improving reproductive health;
- P reducing the incidence of disease; and
- P improving women's safety in the home and workplace.

[14] Women's Health Working Group, 1996a.

[15] Women's Health Working Group, 1992.

The Group has undertaken several projects designed to provide data related to the policy priorities. For example, their quantitative needs assessment document covers statistics on morbidity, mortality, lifestyle behaviour, broad social indicators and health utilization. However, it also addresses:

- social indicators specific to women such as income gaps between women and men, housing overcrowding, homelessness and work-family role combinations (numbers of employed mothers with children);
- relationships between material deprivation and poor health;
- informal care-giving; and
- violence and safety (domestic violence, rape, safety at work and in the community, sexual harassment).

The report also contains specific sections for black and ethnic minority women and women with disabilities. Each section concludes with suggestions for further research and/or actions.[16]

The Group also is tracking progress in implementing the policy priorities. The 1996 Phase 2 documents presents 30 indicators of outputs and organizational change outcomes regarding:

- organizational progress (various committees and a monitoring group in place);
- making services more woman-sensitive (housing department services for women fleeing violence at home, mainstreaming of model well-woman services into health clinics, safe transportation measures, physical activity opportunities);
- publications/resource materials (the "Women Count" needs assessment document, print and video resources for the public);
- making links with communities and groups of women with a focus on participation and consultation (community seminars on the women's health policy, health fairs and conferences, seminars for organizations in government restructuring);
- Centre for Women's Health as a model project, which contributes to best practice development among providers and provides direct service to women (information, drop-in, counselling, training and resources for Centre staff and other interested organizations, inter-agency collaborations such as Scotland's first lesbian health service); and
- violence against women (zero tolerance public awareness/education campaign, training material and courses for providers, reports on needs of priority groups).

The Phase 2 document does not cover outcomes for women themselves, but given the Project's emphasis on sex-disagreggated and woman-specific data on a range of issues, they could be used as baselines to examine changes in the health and social conditions of women over time. Users' perceptions of and satisfaction with services are also being assessed.

The health authority adopted the above policy, made women's health a priority, established an internal working group on women's health, hired an implementation coordinator and a women's health consultant within public health who work with a small women's health team, and developed and evaluated a model well-women clinic in a disadvantaged community. The health authority also has adopted the working group's document on indicators for evaluating the policy.[17]

The internal working group has developed policy priorities that overlap with and add to the Group's five original priorities. These are summarized by Laughlin (1998) as:

[16]Women's Health Needs Assessment Sub-Group, 1994.

[17]Women's Health Working Group, 1996a.

POLICY PRIORITY	SUMMARY
1. Awareness raising	P About the origins and aims of the policy and its implications, among Boards, managers and practitioners
2. Information for and about women	P sex-disagreggated data (baselines for evaluating achievement in the areas prioritized by the policy) P information on gender as a health determinant, and related guidelines for working groups P mini-magazines presenting women's experiences, in their own words, about various behavioural (smoking) and social (housing) determinants of health
3. The Centre for Women's Health	P responds to women's unmet health promotion needs (through information, counselling, and support for self-help) P provides training for professional staff and women's groups on gender issues, a women's health perspective and service development P develops ways of transferring good practice into mainstream service delivery P child care is provided P though funded through the health authority, its management Board includes voluntary groups representing the issues and groups of women that have been prioritized in the women's health policy
4. Model well-women services	P community clinics in low income areas, which combines clinical services with counselling, self-help support and health education—the most effective elements of one pilot site were transferred to other communities P nine of 22 existing community clinics are implementing the model well-women's services as part of their own services
5. Mental health strategy	P focusses on mental health promotion in consultation with various mental health practitioners (screening for post-natal depression) P survey data disaggregated by sex have consistently shown that women rate their mental and emotional well-being as their first priority

POLICY PRIORITY	SUMMARY
6. Domestic violence	P recognition of violence as reflecting power imbalance between women and men and as a key indicator of gender inequality. Initiatives mainly focus on staff training to recognize and address violence (in emergency care, family planning, well-woman services, obstetrics, primary care)—the project has noted the difficulty of translating changes in knowledge and attitudes into changes in practice behaviour P the health Board contributes to a Zero Tolerance campaign in the community
7. Women and heart disease	P initial focus has been a gender audit of data on diagnosis, referral, treatment, rehabilitation and outcomes—results are being used to improve services for women (as more men than women have been using rehabilitation programs, the health authority is looking at how to attract women) P public health education about women and heart disease is being done through the community newsletter which presents health issues in women's own words
8. The health of women staff	P a staff survey on stress had a section specific to women and presented analyses of all the questions by sex P the survey found that women in particular were in jobs with little influence and few professional development opportunities as well as struggles with balancing work and home P a multi-department committee has been reviewing literature to develop guidelines for promoting equality for women and providing support to caregivers—these guidelines will apply to organizations with which the health authority works with (contracted service providers)

POLICY PRIORITY	SUMMARY
9. Provider roles	P recognition that providers need to take their own initiatives in being more gender-sensitive (in addition to policy directions from higher levels) P the focus has been on training events (violence) and interactive women's health events where staff can discuss concerns
10. Support for purchasing	P the women's health policy is written in all service arrangements with providers from whom the health authority purchases services, and gender guidelines have been given to those in a position to make purchasing decisions—however, compliance is a problem as not all those involved understand or accept a social model of health, and most organizations are not required to monitor policy-related indicators as part of their contracts (other than those services specifically seen as women's health) P next steps are to develop data collection systems for domestic violence and guidelines for promotion of women's mental health

Laughlin (1998) has integrated the various aspects of the Glasgow initiative into a broader framework with the following elements:

~ ***Investing in women's health:*** as a priority to overcome effects of disadvantage and discrimination.

~ ***Social model of women's health:*** recognizes social, economic and environmental as well as biological determinants of health, with a particular emphasis on effects of poverty on women's health. The Glasgow initiative also recognizes diversity and inequalities among groups of women (particular emphasis on black and minority ethnic women, women with disabilities and lesbians).

~ ***Consultation and participation:*** recognizes the prime importance of women's views and their limited access to decision-making processes. There is an emphasis on methods of actively involving women in decisions for promoting health.

~ ***Interagency and organizational development:*** focusses on integration in policy and delivery processes and the importance of incorporating gender sensitivity.

~ ***Strategic framework for action:*** including:

P women-sensitive community development to help articulate women's health concerns;
P an intersectoral forum on women's health to identify agendas for change;
P organizational structures and systems to raise awareness of gender inequality and its links to health, disaggregation and monitoring of data by sex, and gender-sensitive planning;
P a model project to evaluate new model projects to attend to urgent health needs; and
P research and development of indicators of women's well-being.

Laughlin notes that this overall framework is not only helpful for the Glasgow project's ongoing work, but also for sharing the Glasgow experience with other cities.

c. Resource Pack

The Glasgow project has published a "resource pack" that organizations can use to make their services more gender-sensitive.[18] It includes:

~ ***Background information about the Glasgow model:*** focussing on social as well as medical determinants of health, various aspects of gender inequality and the relationship between inequality and women's health.

[18]Women's Health Working Group, 1997.

~ ***Organizational review:*** examining what gender-sensitive policies are in place to promote equality while recognizing differences, identifying gaps, strengths, weaknesses, opportunities and threats, allies and sources of power.

~ ***Strategies to prepare an organization for change:*** raising awareness and conducting consultations, including outlining to senior decision-makers the benefits of the social model of health and a gender-sensitive approach for various stakeholders; for operational decision-makers, an emphasis on practical application of policies. Consultation for policy development can be performed in concert with awareness-building or as a separate phase. The guide focusses on consultations within the ranks of senior and middle managers, and with service users and the workforce, including representative and women-only forums. It is also important to acknowledge any limitations of the consultation, and constraints on decision-making.

~ ***Actual policy development and implementation:*** several steps are outlined from developing policy statements through to evaluation. The guide notes that policy statements need to develop from an understanding of the organization's present efforts in promoting gender equality (resource allocation, procedures for consultation, access to services, staff development, disaggregation of data by sex, women in leadership positions, priority of women's health issues), and to build on any existing policies that promote equality. The guide outlines several principles of equal opportunity to be considered when developing a policy:

P easier access (child care, physical access, sign language);
P more diversity (in staffing, in opportunities for users to speak with women similar to themselves);
P quality, relevance and flexibility (improving housing by eliminating dampness, alterations in work patterns to reduce stress);
P anti-discrimination practice (challenging racist comments, stereotypes of women among the staff);
P protection from abuse and harassment (education of male staff working with female clients, support to employees experiencing domestic violence, safe houses for refugees);
P development of full potential (address lack of control over work, give users wide range of choices over services); and
P addressing structural inequality (challenging community care policies based on assumptions that women will take on informal caregiving roles).

Once policy statements are developed, they need to be followed by a strategic plan for implementation, adequate resources and monitoring and evaluation strategies to judge progress.

3. WOMEN'S HEALTH TASK FORCE, PEEL DISTRICT HEALTH COUNCIL

The Peel District Health Council (Ontario) established its Women's Health Task Force in 1990 and began the Peel Women's Health Project in 1992.[19] The Task Force's mandate was to address women's health issues, guide service development and rationalization, and initiate coordinated community action—culminating in a women's health policy framework to guide future service development and health care reform.

The first step in the process was a research project that involved diverse consumer and service provider participation, followed by the participatory development of the framework. The overall approach emphasized determinants of health—with recognition of gender differences.

[19]Women's Health Task Force, 1993, 1994.

This approach was supported by the objective of health equity in Ontario health reform in the early 1990s, in which women were identified as a disadvantaged groups. Ontario's Advisory Council on Women's Issues emphasized viewing women's health in the context of their position in society, and had identified women's concerns about negative and unresponsive treatment from the health care system. When planning the project, the Task Force not only considered provincial government and local community contexts (demographics, service resources and gaps), but also "traditional" attitudes toward both health and women. The group emphasized that collective strategies would have to focus on both individuals and institutions in:

- raising community awareness of the determinants of health;
- promoting the concept and principles of women-centred health services;
- achieving both public and political acknowledgement of social inequality of women (especially immigrants, refugees and women of colour); and
- building local support for systemic changes to reduce sexism, racism and other discriminatory belief structures.

The research consisted of a women's health service inventory, key informant interviews, meetings with community-based women's groups, focus groups with agencies, and community forums. Over 400 people participated in the research. A community conference on women's health followed the research, where 110 providers and consumers examined priority areas and gave direction for future women's health initiatives. Themes from the research that guided framework development were:

- ***Health care model:*** too much emphasis on sickness, not enough on keeping well. The need for attention to both social context and lifestyle choices (consistent with a determinants approach).
- ***Empowerment:*** emphasis on taking responsibility for one's own health. However, the Peel approach was not individualistic, but embedded in an understanding of social context. Research participants noted that disrespect for women's roles can influence women's self-esteem, making it difficult for them to value and assert their own needs. As well, women viewed the health care system as limiting the choices available to them as consumers.
- ***Access to information:*** women do not always know where to get accurate health information. Research participants preferred "one stop shopping" for information on community organizations that could assist when health needs arose.
- ***Coordination:*** women were dissatisfied with having to call several agencies before receiving assistance. They viewed service providers as lacking awareness of other organizations, coalitions and programs, and as providing duplicate services.
- ***Appropriate and accessible services:*** research participants identified numerous barriers related to language, culture, finances, transportation, physical access, child care, literacy, convenience, confidentiality, and discriminatory attitudes. They emphasized the importance of service-provider sensitivity and services based in community settings.
- ***Caregiver stress:*** participants were concerned that the aging population and a move by the Ontario government toward more community-based care would lead to more informal care-giving demands on women. There was also concern about paid caregivers being "burned out" as a result of increased demands coupled with funding constraints.

~ ***Awareness:*** participants wished to see more education of both service providers and the public about women's health issues.

These themes illuminated concerns about what was wrong with the health care system. The next stage was to develop the policy framework in order to move toward solutions. This consisted of principles, goals, objectives and action plans developed by the Task Force.

a. Principles

~ ***Comprehensiveness:*** include resources both inside and outside the health sector, across all age groups and based on the holistic nature of women's health.

~ ***Accessibility:*** no barriers based on age, cost, disability, culture, geography, physical design of buildings.

~ ***Empowerment:*** focus on both independence (to make one's own decisions and act on them) and interdependence (positive relationships with others). Advocacy and education roles are important for both women and service providers. Inclusion of women in planning and evaluation of services is needed, particularly among those most vulnerable.

~ ***Necessity and relevance:*** resources proven to be beneficial should be used when there is demonstrated need, and any new approaches need to have protection against risks. Women need to be able to make informed choices about services, and related information needs to be available.

~ ***Safety and support:*** physical, psychological and social safety and support includes confidentiality, a non-judgmental approach, respect for culture and religious beliefs, promotion of positive social context for women's lives.

~ ***Balance:*** in allocation of resources across different types of women and services.

~ ***Coordination:*** among women's health resources, between women's health resources and other human services, among professions and occupations (a multidisciplinary approach, including the experiences of volunteers and those outside the health field).

~ ***Adaptability:*** based on good research and firm knowledge of the biology, psychology and sociology of women's health. Resources should be able to change and adapt to women's concerns to provide highest quality services.

~ ***Affordability:*** highest-quality resources for the least cost. Funds need to be allocated in the context of the overall health of the community. Cost should not be a barrier to access.

~ ***Accountability:*** to service users and potential users, and to funders. Women's health resources exist for the broader social good, not for their own sake.

b. Goals and Objectives

The following goals were developed (with the topics of the objectives in parentheses):

P shift the emphasis in the delivery of health care to the concept of wellness (emphasis on primary prevention and interdependence of health and social environment);
P empower women to assume responsibility for their own health (support groups, supports for increased material resources, consumer parti-cipation in planning, opportunities for infor-med choices);
P raise community awareness of women's health problems and issues (collaboration among agencies on education/awareness pro-

jects for both service providers and the public regarding factors that affect women's health);
- P improve access to information (central system for health information, interagency information packages, innovative distribution in the community);
- P improve the coordination of services (interagency planning, collaborations and mergers among coalition, committees and community action groups, linkages and shared service delivery among institutions, agencies and programs);
- P improve access to appropriate services and supports (address barriers, alternative treatment possibilities, outreach services);
- P reduce caregiver stress (services to reduce informal caregiver burden, response to government policy trends shifting care to informal caregivers, encourage men's participation as informal caregivers).

c. Action Plans

Next, five working groups applied the goals and objectives to specific areas of concern identified by both the Peel research and an earlier report by the Federal, Provincial, Territorial Working Group on Women's Health (1990). The working groups addressed women's wellness (with a subgroup on healthy aging), reproductive health and sexuality, violence against women, healthy parenting, and mental health and addictions. Over 60 people participated in the working groups. The Peel report outlines how each group applied the goals and objectives to their area. A few examples are provided here for illustrative purposes:

~ ***The Women's Wellness Group:*** in addressing the goal to shift emphasis in health care to wellness, the group suggested inter-ministry collaboration to address determinants of health. It used physical activity promotion as a specific example of how decision-makers can work together to create healthy environments that support healthy behaviour (municipal plans to increase green space and walking paths with good lighting and visibility, mandatory physical education past grade nine with a shift away from sports performance and toward total wellness).

~ ***The Violence Against Women Group:*** addressed this same goal by emphasizing that service providers and the local interagency Committee Against Woman Abuse promote simultaneous action in three spheres—personal (focus on needs of individuals subjected to violence), civic (focus on identification of violence, punishment of abusers and compensation of survivors), and ecological (focus on systemic causes). The working group suggested placing greater emphasis on the ecological approach through supporting the activities of the local anti-abuse committee and Women's Action Coalition in public education, political action, workshops and conferences. Audiences would include men's groups, local politicians and health and human service organizations. The working group also suggested advocacy for provincial legislation regarding elder abuse and stalking.

~ ***The Reproductive Health and Sexuality Group:*** in addressing the goal of improved access to appropriate services and supports, the group suggested that a multicultural inter-agency group should take the lead role in working with the health department to develop prenatal classes for multicultural populations as well as a community outreach strategy to provide sexuality information to young people; the district health council should include a survey of sexuality information and service barriers for people with disabilities in its long-term needs assessment; the province and doctors should establish practice guidelines for routine testing for STDs regardless of age or marital status, and include 35- to 45-year-olds in STD education.

~ ***The Mental Health and Addictions Group:*** emphasized that the traditional mental health system tends to pathologize women in isolation from their social environment, which leads to over-prescribing of drugs such as tranquillizers and the risk of addiction without necessarily resolving problems in women's lives. The medical model is expensive and limits women's access to community-based services. In addressing the goal of empowering women to assume responsibility for their health, this group emphasized a client-driven model of mental health services, accountability to clients (mechanisms for feedback and adjustments), and choice of a full range of services (counselling, group support, safe houses). The group also wished to see facilities made available for support groups to continue meeting once their links to formal services end. Other points related to empowerment arose around the goal of shifting to a wellness emphasis—recognizing that women and men have different treatment issues and designing services specifically from a woman-centred perspective, incorporating an analysis of structural conditions and social barriers that prevent good health.

~ ***The Healthy Parenting Group:*** noted that parenting is often not seen as a women's issue because of assumptions that it should be a shared responsibility. However, many women either do not have male partners, have partners who are abusive or do not share parenting responsibilities equitably. The group also points out that parents have multiple needs—physical and practical (financial security, food, shelter, access to child care), psychosocial (validation, self-esteem, friendship and support) and educational (knowledge of child development, safety and behaviour, parenting skills, language skills).

In addressing the goal of improved access to appropriate services and supports, the group called for strategies to "bring services to families rather than families to services," by using locations where people already go, such as schools, churches and other religious centres and recreation centres. The group also suggested free or low-cost drop-ins and support groups, outreach to isolated parents, and more community-based parenting centres. The working group emphasized teen and low income parents in particular.

The combined efforts of the five working groups presented about 125 directions for action. These were prioritized based on strategies common to all or most of the groups, and inclusion of a cross-section of strategies from each group. The final list contains 11 actions. The overall policy emphasis within the actions were community development (through development of the Peel Women's Health Network), and women-centred services and community awareness, involving:

- sharing the research findings and actions with decision-makers;
- developing a women's mental health coalition and initiatives to promote self-esteem;
- developing and sharing information on principles of women-centred service and a related process for reviewing proposals for women's health services;
- coordinating access to women's health information;
- holding another women's health conference; and
- reviewing and updating the plans of action.

Compared to the detailed work of the working groups, the final action plan is very general. There seems to be an assumption that the structures and processes of the action plan will in turn lead to actions on other recommended strategies. However, we were unable to obtain any further information on activity that has tran-

spired since 1995/96 (the last year covered by the plan) or whether the Women's Health Task Force or Women's Health Network is still active.

4. MODEL OF CARE WORKING GROUP, WOMEN'S HEALTH PROGRAM DESIGN COMMITTEE, CALGARY REGIONAL HEALTH AUTHORITY

The Calgary Regional Health Authority (CRHA) in Alberta has identified women's health as a priority area. The Model of Care Working Group of the Women's Health Program Design Committee, Calgary Regional Health Authority, developed a Women's Health Model in 1997. The aim was to facilitate a common, comprehensive understanding of what is meant by "women's health," and to present a framework to guide planning, service provision and evaluation of health care that is sensitive to women within their social contexts.

The Working Group stated the following assumptions at the beginning of its work:[20]

- a woman is at the centre of her health care, recognizing that she is the expert concerning her own health and is ultimately responsible for it;
- each woman is unique and holistic;
- a woman's health is influenced by the dynamic relationships between all aspects of her being and her environment; and
- the health care system is one of many components of a woman's environment that can affect her health.

The women's health model has three basic key concepts:

- ***Woman:*** is at the centre of the model and is unique, holistic, complex (biological, psychological, developmental, spiritual, social and sexual), and surrounded by and responsive to her environment. Assessments of her experiences, environment and interaction with the health care system influences a woman's health experiences.

- ***Health experience:*** a woman's lived reality of health, or her perception and evaluation of her health status includes dimensions such as clinical indicators, ability to perform roles and adapt to circumstances, and desire to achieve optimal well-being. Health professionals should assess a woman's health experience as part of woman-centred care.

- ***Environment:*** the context, or social and physical environment, in which women live their lives and experience their health includes key aspects such as roles, culture, social support, gender, societal attitudes, economic resources, and the health care system.

The CRHA document concludes with the following principles for the planning and provision of women's health care:[21]

- an ***ethical*** approach to the health care of women;
- the provision of health services and programs that are ***accountable*** to the women we serve, health care professionals and the public, including the measurement and reporting of program outcomes;
- a ***mutually-supportive*** system that fosters the closest possible collaboration between women and their health care providers;

[20] Model of Care Working Group, 1997, p.1.

[21] Model of Care Working Group, 1997, p. 6-7.

- a ***gender-sensitive*** system that promotes the diversity of each woman, including her biological and psychosocial uniqueness, and the social context of her life (culture, roles, responsibilities and economic issues);
- a ***holistic*** approach that recognizes women as unique and complex biological, psychological, social and spiritual beings in continuous and changing interaction with their social and physical environments;
- ***respect*** for all people, and in particular, respect for the expertise each woman has regarding her health by recognizing women at the centre of their care;
- the provision of services that ***empower*** women to be responsible for their health by informing them about choices, options and education about how the system works;
- a ***coordinated and integrated system*** across the continuum of health (prevention, promotion, treatment and education);
- an emphasis on ***education*** for women and their health care professionals that is sensitive to our broad definition of women's health and the determinants of health proposed in the conceptual model;
- a focus on ***research*** that is consistent with a broad definition of women's health and recognizes the paucity of gender-specific science;
- a system that ***advocates*** for the needs of women;
- a system that is both ***flexible and responsive*** to women;
- a system that is ***accessible*** and ensures that services are available without barrier of age, mobility, geography, culture, finance, language or religion.

Within the CRHA, women's health has an administrative leader responsible for implementing this model throughout the system. In addition, the CRHA and the Salvation Army have an agreement to provide resources and staff to the Grace Women's Health Resource Centre which provides ambulatory and primary health care, a resource library, and courses on a range of topics.

5. PROVINCE OF BRITISH COLUMBIA[22]

a. Vancouver-Richmond Health Board

A particularly promising British Columbia model has been developed by the Vancouver-Richmond Health Board. It has a Population Health Advisory Committee on Women's Health made up of community women who advise and assist the Board to:[23]

- identify health needs, concerns and priorities of women;
- develop a comprehensive regional health plan that specifies health needs and priorities of women and provides for relevant programs and services;
- develop recommendations for policy, planning, resource allocation, services and programs, and research to effectively address women's health needs; and
- monitor the development and evaluation of health outcomes that would indicate improved health status of women.

To date, this committee has researched and prioritized women's health issues through reviewing literature and consulting with the community. Current priority areas are poverty, violence against women, access to health services, participation in health, and medicalization of women's lives.

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[22]Other health regions in British Columbia are working on models of woman-centred and/or gender-sensitive planning, but did not have detailed materials ready for release prior to our project deadline.

[23]Women's Health Bureau, 1998.

This advisory committee is also part of the Vancouver-Richmond's Women's Health Planning Project, which focusses on determinants of health and health services across the lifespan. It includes a number of components, such as women's health profiles, a framework for women-centred care, and gender analysis of utilization data,[24] and involves extensive participation by multiple stakeholders.

b. Women's Health Bureau of the Ministry of Health and Ministry Responsible for Seniors

More generally, the Women's Health Bureau has made a number of recommendations for ensuring that women's health is included in health authorities' planning agendas, and that women participate in the planning process. Through literature reviews and consultations with women's groups and key informants in health authorities both in and outside of B.C., the Bureau identified the following four key elements for successfully integrating women's health issues into the health planning process:

~ ***Include women:*** from diverse backgrounds, in advisory, governance and management roles.

~ ***Ensure participation:*** efforts to include women need to be sensitive to women's roles and responsibilities as well as social and economic circumstances.

~ ***Collaborate:*** health authorities and women's organizations need to work together to ensure women's health issues remain on the health agenda.

~ ***Meet information needs:*** accurate, up-to-date information on local and general women's health issues for both health authorities and women's organizations.

The Women's Health Bureau document further outlines what both health authorities and women's organizations can do to achieve the above key elements.

~ ***To include women in the planning process***, the document suggests that health authorities:

P provide opportunities for input at times and places that are accessible to women (forums, focus groups, workshops);
P include women on Boards that are representative of the community;
P establish a women's advisory committee and/or involve women in other advisory committees;
P designate responsibility for women's health to a key contact person with a strong feminist background (Board member, senior staff person—such as in Capital Health Region in Victoria) and inform women's organizations who the contact is; and
P appoint a liaison person (coordination or mediator) between health authorities and women (and their organizations) in the community.

The document also suggests that women's organizations assign a designated contact to liaise with health authorities and work with the authorities to establish a liaison mechanism. Other suggestions were to appoint a provincial level women's health coordinator and to have university faculty advocate for women's health.

~ ***To ensure women's participation***, the document suggests that health authorities could:

P directly invite women's groups to participate in planning and consultation activities;
P allow oral submissions as input;
P provide financial assistance with travel and child care so women can attend meetings and planning events;

[24] Poole, 1999, personal communication.

- P be aware of women's roles (mother, employee) and accommodate their schedules;
- P have meetings in different communities in the health authority area;
- P provide an honorarium for participation in planning; and
- P provide organizational assistance to help women become involved in planning.

The report also urges women's organizations to be proactive in becoming involved by requesting involvement, making health authorities aware of barriers to participation, offering to facilitate women's participation, and representing the diversity of women's needs.

~ ***To improve collaboration and communication between health authorities and women's organizations***, the document suggests that health authorities:

- P contact each other to share information on best ways to involve women and consider women's issues;
- P demonstrate that they value women's time and input; and
- P encourage Board members to visit and learn about the work of women's organizations, as a way to initiate networking.

Similarly, women's organizations can share information with each other and initiate networking with health authorities, while being realistic about what health authorities can do.

~ ***To meet information needs***, the document suggests that health authorities can inform women's groups of current and planned health authority activities, and invite women's groups to give input into the planning process and/or on specific issues. Women's organizations can inform health authorities of their health-related activities and issues relevant to women in their areas as well as request information on health authority activities and upcoming agenda items. The document also suggests holding a provincial meeting or conference to facilitate networking between health authorities and those who work on women's issues, and to establish a women's resource centre.

6. CHICAGO URBAN WOMEN'S HEALTH AGENDA

In 1993, the Mayor's Task Force on Women's Health was convened, with the Department of Health of the City of Chicago playing the lead role. The 18-member Task Force had representation from public health, the mayor's office, academia, non-profit organizations and corporations and produced the *Urban Women's Health Agenda*.[25] Unlike some of the other models presented in this report, this one did not involve public consultation and involvement. Rather, the Task Force presented factors that influence women's health and recommended types of programs needed to promote women's health. Exemplars of well-evaluated, effective programs were summarized. Because this model is not an example of inclusive planning involving women, it is presented in less detail. However, some of the issues and recommendations may be of interest to readers who could include them as ideas within more inclusive approaches.

The purposes of the Task Force were to:

- P propose effective remedies for health care problems of women and girls;
- P provide a context for cooperation among institutions concerned about women's health (from multiple sectors);
- P propose effective and innovative solutions to systemic, institutional obstacles to adequate provision of health care to women and girls, particularly those most in need, and to identify service gaps;

[25] Sive Group, Inc., 1994.

- P develop innovative, consumer-based model programs that can be replicated across the U.S. by both government and the private sector; and
- P provide leadership for a bold new focus on the health care of women and girls of Chicago and all U.S. cities.

The model is rooted in family and neighbourhood working together with institutions. This "block-square" approach recognizes that:

- P women's health is premised on the understanding that they have both the right to and responsibility to seek accessible, comprehensive health care;
- P health care delivery systems should be decentralized, and promote preventive care and respond to public health issues created by societal problems (domestic violence, rape, and gun violence); and
- P the family and neighbourhood emphasis will eliminate physical and psychological isolation of health care practices which isolate people from these social supports.

a. Thematic Recommendations

Phase 1 of the Health Agenda report made seven "thematic recommendations:"

- ~ ***Improving women's health means improving women's self-esteem:*** the report noted links between self-esteem and substance abuse, eating disorders, and career choices.

- ~ ***The health care system must build on community institutions and inter-generational networks of families and community residents:*** these stakeholders need to participate in policy-making. Programs built on community resources are more likely to address barriers such as lack of money, poor trans-portation, physical disabilities and illiteracy.

- ~ ***Promote collaboration at the systems, institutional and community levels:*** the report notes that such collaboration will have positive effects for women and girls both as people in need of care and as primary caregivers within families. [Later in the report, the assumption that women are expected to be primary caregivers is criticized.]

- ~ ***The number of women in all health careers must be increased:*** the assumption is that achieving equality at the provider level will lead to a health care system that practices equality.

- ~ ***Confront violence in the home, workplace and public settings:*** there is a particular focus on violence involving guns, and recognition that fear of this violence limits women's participation in health promoting activities such as sports and recreation.

- ~ ***Women must have a greater role in medical research and clinical trials:*** there is also recognition that when women have been included, they have been mostly white, middle class women. The report calls for more participation by women of colour and those on low incomes.

- ~ ***A holistic approach must complement primary care:*** there is an emphasis on involvement in one's own treatment and in making treatment sensitive to cultural factors.

Following Phase 1 of the report, completed in 1993, the Task Force reviewed a number of surveys that addressed women's health issues in the U.S. The review noted links between such factors as poverty and abuse and women's physical and mental health as well as limitations in how the health care system addresses women's medical problems. The data also showed that health problems and lack of access to health care was a larger problem among minority women (black women, lesbians).

b. Systemic Obstacles

The Task Force then set out to develop the *Urban Women's Health Agenda*. They first identified three categories of systemic obstacles:

~ ***Those within the medical and health care infrastructure:*** such as few women in decision-making positions, lack of access to resources (birth control, health insurance), little understanding of issues (addiction), ways of operation that limit access for certain groups (clinic hours), lack of positive health education (about body image), provider insensitivity (regarding culture, sexual orientation), inadequate use of non-physician providers and community-based services, lack of training of providers in issues related to women's health.

~ ***Those created by the impact of broader social, legal and economic policies and attitudes:*** such as discrimination, low wages and poor work opportunities and conditions, excessive focus on women's childbearing role, segregated public housing, young women taught not to question male authority, social condoning of male behaviours harmful to females (violence, irresponsible sexual behaviour).

~ ***Catastrophic impact of certain diseases:*** such as heart disease, breast cancer, HIV/AIDS, infant mortality, substance abuse—inadequate attention to how these affect women, little research with women.

Some of these obstacles affect women regardless of their backgrounds, while others have greater effects on women in poverty or on young women. The report also noted systemic problems with a health care system that promotes medical approaches that inhibit women's health.

They emphasized that three views of women's health need to be considered simultaneously:

- biomedical;
- phenomenological experience of women; and
- consequences of socio-economic, political and environmental factors that affect women's lives and their health.

c. Program Development Criteria

The Task Force, through contacts with women's health advocates across the U.S., identified a range of projects to promote women's health. Organizations responsible for the projects were contacted for information, and the programs were reviewed as to whether they addressed obstacles to women's health and offered solutions. The Task Force developed a set of program development criteria to use as guidelines when developing programs for women and girls:[26]

- develop patient-doctor interaction that is empowering, such that every time a woman goes to a doctor or other health care provider, she comes away feeling more able to care for herself and her family rather than feeling diminished or less in control; and such that women patients are confident that no undocumented assumptions are made by the treating physician (regarding sexual orientation);
- go beyond the biomedical model to look at women as whole persons, including the context of lives, lifestyle and nutrition issues;
- look at the social context of women's experience (at the effects of domestic violence, sexual assault or any other negative family experiences, which affect women's well-being);
- consider the effects of women's multiple

[26] Sive Group, Inc., 1994, p. 24-25.

roles as providers, users, and so often as the single heads of households, who are frequently the sole caregivers for the children in those households;
- include women patients in program planning and decision-making;
- foster inter-institutional linkages among health care agencies, and between health care agencies, educational institutions, public housing authorities and/or community agencies and other institutions which frame women's lives and experiences;
- include both "mind and body" elements (primary health care should mean that when treatment is completed, patients self-esteem is improved as is the patient's physical health);
- note that women are well-served by "buddy system" forms of treatment and counselling and by peer education practices;
- emphasize prevention in health education;
- include flexible and extended scheduling for patient care;
- consider the scope of the program services and the population they serve in order to test useful models of health care for working poor women;
- give incentives to patients who seek, and to providers who deliver, holistic care;
- include legislative, administrative and licensing changes; and
- educate women to the dangers of cigarette smoking and excessive dieting.

d. Program Recommendations

The recommended programs that the Task Force viewed as being consistent with the above criteria fell into the areas of:

- athletic programs for women and girls, with emphasis on low income parents and young teens;
- domestic violence programs (with emphasis on viewing violence as both a health and a gender issue, holding abusers accountable, having more services to protect and support survivors, and training providers in abuse issues, including those specific to culture and sexual orientation);
- hospital involvement in communities (in collaboration with community-based organizations and public health centres);
- lifestyle and nutrition (through both school and parks programs);
- literacy (including graphic images and electronic media);
- medical school curricula (requirements and incentives to work in under-served communities);
- teen parents (assessment of personal and family resources, extensive education and support for parenting and self-care through hospitals and neighbourhood centres);
- treatment of low income patients (multidisciplinary health care teams including a health advocate, training and hiring of neighbourhood residents as lay community health advisors and advocates, positive incentives for patients to seek preventive care such as prenatal); and
- women's and girls' health education (toll-free health line that is confidential and anonymous, and can refer to a range of other services).

The Task Force also provided a summary of additional areas for further review, such as programs specific to particular groups of women (ethnocultural groups, lesbians, women with disabilities, women in the workplace).

e. Policy Recommendations

Policy recommendations made by the Task Force were focussed more on the state rather than the health department level, and were specific to the State of Illinois or the federal U.S. government:

- alternate providers (nurse practitioners and midwives;
- research (breast cancer);
- child abuse prevention through early inter-

vention, child support enforcement;
- P STD and cervical cancer screening;
- P health care reform (universality, comprehensiveness, provider choice and inclusion of women in research);
- P domestic violence (provider training and health care system protocols, research on effective ways to protect survivors, firearm restrictions, enforcement of existing legislation dealing with violence in the home);
- P emergency room care (education and opportunities to use primary care providers rather than emergency rooms);
- P gun violence (legislation, anti-violence curriculum in all schools);
- P health insurance coverage for children and pregnant women (this seems to focus on women primarily as mothers);
- P mammography screening;
- P nutrition and health (focus on equal access to physical activity for girls);
- P compulsory school-based sexuality education in grades 3 to 12;
- P require self-insured group health plans through workplaces to offer same protections as other plans (cannot drop members due to diagnoses or costs);
- P training community health care workers (through job training programs);
- P statewide minimum universal coverage;
- P welfare reform (positive and negative incentives to attend to children's health—this seems more focussed on children than on women's health); and
- P young mother parenting (ensure access to parenting skills education).

f. Conference on Urban Women's Health Issues

In 1996, following publication of the report, the Health and Medicine Policy Research Group in Chicago (a key member of the Task Force) convened a conference on urban women's health issues. The conference was designed to carry forward the work of task forces in Chicago, San Francisco and New York and to generate models, strategies and recommendations for improving the health of urban women. The conference brought together scholars, health care providers, activists, educators and government and health system representatives to develop a framework for understanding and influencing the social, political and economic forces that shape women's lives. Participants identified barriers and successful strategies as part of this process. Much of the discussion was consistent with a health determinants approach (socio-political determinants, healthy communities). Recommendations from the conference fit into five domains:[27]

- ~ ***Develop a more comprehensive framework for addressing women's health:*** include social and economic conditions within the concept of public health, which necessitates interdisciplinary planning, resource allocation and evaluation. Conference participants also emphasized the need to convince decision-makers that women's health is more than reproduction or disease concepts, and to increase public awareness of the need for an active government role in keeping communities healthy (to challenge anti-government attitudes).

- ~ ***Guarantee responsible social and economic policy:*** including an assessment of the impact of policy decisions on women on low incomes. Participants also called for more sophisticated public discourse on issues of immigration and diversity as well as economic alternatives that meet basic needs of all.

[27]Warshaw, Schaps, & McLachlan, 1999.

~ ***Link sectors for coordinated social change:*** develop common agendas, alliances and strategies across sectors with people working on other women's issues outside the traditional health sphere, including an "early warning system" to anticipate and respond to policies being developed that could negatively impact women. The participants also called for increased collaboration among organizations.

~ ***Build capacity of low income communities:*** facilitate and sustain participation of community residents in research, policy development, funding and the provision of services, so that women are engaged in decisions that affect their lives. Lay helpers were mentioned as a way of involving community members in health care. The participants emphasized research capacity in particular (giving grants directly to local communities, disseminating research findings to community residents, and making training and technical assistance available to communities that want to do their own research and needs as-sessments).

~ ***Create accountability within the health care delivery system:*** ensure that private providers are accountable to the public, that diverse populations of women receive equitable treatment, that evaluation is qualitative as well as quantitative, and that community groups are involved in evaluating the system.

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