VOICES FROM THE FRONT LINES:
Models of Women-Centred Care in Manitoba and Saskatchewan

Robin Barnett
Susan White
Tammy Horne
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Administrative Centre:

Prairie Women's Health Centre
of Excellence
56 The Promenade
Winnipeg, MB R3B 3H9
Telephone: (204) 982-6630
Fax: (204) 982-6637
E-mail: pwhce@uwinnipeg.ca

Regina Site:

Prairie Women's Health Centre
of Excellence
University of Regina Extension
CB 109 College Ave. & Scarth St.
Regina, SK S4S 0A2
Telephone: (306) 585-5727
Fax: (306) 585-5825
E-mail: pwhce@uregina.ca

Saskatoon Site:

Prairie Women's Health Centre
of Excellence
University of Saskatchewan
107 Wiggins Road
Saskatoon, SK S7N 5E5
Telephone: (306) 966-8658
Fax: (306) 966-7920
E-mail: pwhce@usask.ca

WEBSITE: www.pwhce.ca

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Robin Barnett, Consultant
1156 Rose Street
Vancouver, BC V5L 4K8
604-255-5363
E: rose2@telus.net

Susan White, M.A.
40 Alloway Ave.
Winnipeg, MB R3G 0Z8
204-775-2105
E: swhite@uwinnipeg.ca

Tammy Horne, Ph.D.
WellQuest Consulting Ltd.
11511 – 125th Street
Edmonton, AB T5M 0N3
780-451-6145
E: tamhorne@web.net

VOICES FROM THE FRONT LINES: Models of Women-Centred Care in Manitoba and Saskatchewan

Executive Summary

INTRODUCTION AND PURPOSE

Women-centred care models emerged because the Canadian health care system has not responded adequately to women's needs. In order to meet women's needs, numerous health centres and programs have developed to deliver services at the community level and within regional health authorities. Women-centred care, a concept with strong roots in the prairie provinces, is formalized in models and clearly labeled frameworks identified as women-centred or gender-sensitive. These include the Women's Health Clinic in Winnipeg, the framework for the regulation of midwives in Manitoba, and services specifically for women who have experienced violence and abuse in both provinces.

This research looked at women-centred care within Saskatchewan and Manitoba and compared findings with other women-centred models. We have not provided a specific definition of women-centred care because there is not yet agreement on meanings. Rather, we found many examples of practices that deepen our understanding of women-centred. Additionally, we gained insight into the philosophies and values that need to be present for women-centred care to flourish. The lack of a common understanding is, in part, because women-centred care is a newer concept for many people. In order to reach a better understanding, we tried to look at health care in practice, rather than theoretical statements from those familiar with women-centred language. Women-centred care is about how we do our business, about processes, and whether or not we look at the particular needs of women differently than men.

BACKGROUND ON MODELS OF WOMEN-CENTRED CARE

Pathfinders for this research were the *Invisible Women: Gender and Health Planning in Manitoba and Saskatchewan and Models for Progress* evaluation framework used to determine the gender-sensitivity of health planning documents in Manitoba and Saskatchewan (Horne, et al., 1999) and the Vancouver/Richmond Health Board's *Framework for Women-Centred Health* (VRHB, 2001)**.** The preparation of both these two models involved scans of the literature and international models. Many of the same models were reviewed for both those projects and they are both still quite up to date. Both frameworks are consistent with and incorporate elements from several other models of women-centred policy,

programming, and gender-based analysis tools, such as the Glasgow women's health project in Scotland (Women's Health Working Group 1996a) and the Pan American Health Organization's gender analysis handbook (Hartigan, et al. 1997). Detailed descriptions of these and other models can be found in the *Invisible Women* report and references in both documents will lead readers to other models and research. The limited resources for this project and the belief that these models are current meant that a full literature scan was not completed for this project.

No one health care service will incorporate everything described in women-centred models because of varying contexts, size of organizations, mandates and resources. However, looking at a wide range of options can assist us in understanding women-centred care. It is our hope that readers can apply what is meaningful to their situations and enhance or develop new services for women.

It is important to note that integrating the concepts and practices of women-centred care may entail changes that go beyond what individuals can accomplish. Training is essential for professionals and staff across the health system. Successful women-centred models may require support in the form of funding and structural changes. Hence, numerous policy issues emanate from this research. Interview participants often describe advocating for policy changes to improve the lives of the women they work with or to expand the type of services they provide. Policies that promote these women-centred approaches need to be put in place.

METHODOLOGY

Integrated Framework for Women-Centred Care

To develop an initial framework to guide the interview process, we integrated the components of the Vancouver/Richmond Health Board's *Framework for Women-Centred Health* with an adaptation of the framework from the *Invisible Women* report. This resulted in 9 elements:

1. The need for respect and safety
2. The importance of empowering women
3. A holistic view of women's health, including a comprehensive range of services and women's patterns or preferences in obtaining health care and health information
4. Involvement and participation of women
5. Women's forms of communication, interaction and decision-making
6. A gender-inclusive approach to data gathering and using of this data in gendered research and evaluation
7. Social justice concerns
8. Gender-sensitive training
9. A team approach in the workplace

Interviews and analysis

Semi-structured interview questions were developed using the above elements. The guide we created from the list above is a working tool, and was not intended to serve as a template. We spoke to 22 people, including medical practitioners (e.g., doctor, nurse, nurse practitioner, midwife), counsellors, social workers, program managers and executive directors, front line workers, community health promotion workers, managers of volunteers, and the director of a regional health authority.

We used the constant comparative method common in qualitative research, where earlier category codes are revised to fit with new information as it arises (Glaser and Strauss, 1967). The thematic categories that emerged from the data were sorted and compared as we proceeded through the analysis. Links from categories to broader themes were discussed among the researchers until we reached consensus. Overall themes and related categories are reported with generous numbers of quotes to illustrate what these meant to women in their own words and to show the extent of the issues.

WHAT WE LEARNED

This section offers an overview of some of the major social and demographic patterns in women's lives in Manitoba and Saskatchewan. We then move into the details of our findings.

We noted that many participants did not use language such as 'women-centred', 'gender' or 'social determinants'. However, because someone does not use the term 'women-centred' does not necessarily mean that they are not women-centred in their practice. It is important to look at the concepts participants used to understand how they incorporate elements of women-centred care in their practice. Themes of women-centred care emerged and participants described the efforts, successes, and challenges they face. Themes revolved around how to address the realities of women's lives, as perceived and described by the service providers we interviewed.

This section begins with a discussion of the social and economic context of women's lives. Participants highlighted:

- Women's roles and responsibilities
- Low income and poverty issues
- Racism and colonialism
- Gender differences
- Abuse and violence against women
- Rural and northern issues

Next we present the broader philosophies, both explicit and implicit, that guided interview participants' responses to women's lives. These formed the following themes: holistic, spiritual, feminist, and First Nations' rights. We describe the "cornerstones" of women-centred care. These are the conditions under which women-centred care is possible. Themes about delivering comprehensive services to women reflect the interview participants' understanding of women's patterns and preferences for care and acknowledge women's ways of communication and interaction.

The discussion about knowledge development touches on evaluation and research; it considers research needs and capabilities to carry it out. Workplace environment is also important and participants provided ample discussion about what conditions are important for workers to be able to deliver women-centred care. Finally, a section about social justice links back to where we began, with women's lives. All of the themes are interconnected. While it is not a component of women-centred care per se, adequate funding is important to facilitating and delivering women-centred care.

CONCLUSIONS

This overview of women-centred care in Manitoba and Saskatchewan parallels the Vancouver/Richmond Framework and the framework from *Invisible Women*. These frameworks flow from other models of women-centred planning and service provision such as the Women's Health Working Group, Glasgow, Healthy City Project in Scotland. Our work provides validation of these working frameworks, and adds to them by fleshing out specific elements of women-centred care.

Some of the elements we found such as empowerment, respect, and safety are also present in the models underlying our working framework. Others such as Aboriginal spirituality and self-determination, integrated service delivery, a common women-centred philosophy in the workplace, staff mental health and safety arose here for the first time. Our working guide is particularly enhanced, and our understanding deepened, by evidence of how the workplace supports women-centred care. This is done by including Aboriginal perspectives, and utilizing the cornerstones of women-centred care found below. We can surmise that it is not enough to provide certain types of services that are merely "directed to women".

Our research demonstrates that all-encompassing women-centred care is comprised of the elements listed below.

The "cornerstones" of women-centred care are:

- **A focus on women**
- **Involvement and participation of women**
- **Empowerment**
- **Respect and safety**

Comprehensive services that reflect women's patterns and preferences for care and acknowledge women's ways of communication and interaction:

- **Address the complexities of women's lives**
- **Are inclusive of diversity**
- **Have integrated service delivery**
- **Respond to women's forms of communication and interaction**
- **Provide information and education**

Gender-sensitive knowledge development requires:

- **Evaluation**
- **Research**

A women-centred workplace must have:

- **A collaborative work environment**
- **A women-centred philosophy shared in common**
- **Service providers as consultants with expertise in women's health**
- **Good communication and concern for staff mental health and safety**
- **Gender and inclusiveness training**

Women can use this integrated guide to validate their own experiences and requests for changes in service delivery. Ongoing public and organizational processes can also engage in scrutiny of this document to develop tools and methods to implement women-centred care in their sites.

In the course of conducting our research it became evident that public policy in health governance and government needs to catch up with what practitioners are doing. Gender-sensitive approaches should be embedded within policies. Policy makers could indeed expand policy parameters so practitioners implement their visions of women-centred care thereby allowing them to reach and benefit more women. Women-centred health policy is supported by what the participants told us: that they have better outcomes in meeting women's needs because women were part of the process.

Finally, many participants articulated a need to base women-centred practice by conducting more research and having more evidence. However, they told us that funding has often been lacking, particularly for expansion of programs to further meet women's needs based on research. Evaluation of women-centred care practices is critical for policy makers so that future policies can be built upon what has been learned. Research that takes a gendered approach and uses data to describe the context of women's lives, rather than solely counting the number of clients, is crucial for all concerned. Currently practitioners are working with resources that are stretched to the limits. Adequate resources are required to enable service providers to provide care based in women's lives that responds to women's realities.

VOICES FROM THE FRONT LINES:
Women-Centred Care in Manitoba and Saskatchewan

PART 1 INTRODUCTION

Women-centred approaches in health care have emerged because of the historical lack of response by the Canadian health care system to women's needs. Over the years, numerous health centres and programs have developed to deliver services based on women's needs both in communities and within regional health authorities. Women-centred care, a concept with strong roots in the prairie provinces, is formalized in models and clearly labeled frameworks identified as women-centred or gender-sensitive. These include the Women's Health Clinic in Winnipeg, the framework for regulation of midwives in Manitoba, and services specifically for women who have experienced violence and abuse in both provinces.

While many practitioners are already sensitive to women and women's needs, they may not embrace a women-centred perspective or identify the work they do specifically as women-centred. Aboriginal-centred models in particular, such as the Medicine Wheel model, have much to contribute to a discussion of women-centred care (see more below).

The purpose of this research was to enable us to take a closer look at what is called women-centred care within Manitoba and Saskatchewan and to compare our findings with other models within Canada and internationally. While we would hope to provide a specific and a concise definition of women-centred care, there is not yet agreement on meanings. Rather, we found many examples of practices that deepen our understanding of what "women-centred" can mean. Additionally, we gained insight into the philosophies and values that need to be present for women-centred care to flourish. The lack of a common understanding is, in part, because women-centred care is a newer concept for many people. In order to reach a better understanding, we tried to look at health care in practice, rather than theoretical statements from those familiar with women-centred language. Women-centred care is about how we do business, about processes, and whether or not we look at the particular needs of women differently than men.

The purpose of this research was to enable us to take a closer look at women-centred care within Manitoba and Saskatchewan and to compare our findings with other models within Canada and internationally.

The concept of gender is incorporated in women-centred models of care. Gender allows us to consider the differences between women and men. Gender includes how we are expected to think and act as

women and men because of the way society is constructed (i.e., our socially determined roles and relationships), and not because of our biological sex alone (See Greaves et al. 1999, for a detailed discussion of the distinction between sex and gender in the context of the health system). Gender interacts with sex, sexual orientation, self-defined gender identity and how we express masculinity and femininity. Generally speaking, women-centred services have been effective in providing quality care because they acknowledge both the complexity of women's lives and the differential impact of the determinants of health for women and men.

A. OUR RESEARCH GROUP

Our team came together to build upon our work in three complementary areas of women-centred health, and to try to integrate our perspectives. Tammy Horne is a community-based researcher and planning and evaluation consultant who was one of the authors of *Invisible Women: Gender and Health Planning in Manitoba and Saskatchewan and Models for Progress* (Horne, Donner and Thurston, 1999). Robin Barnett is a health promotion consultant who worked on the Vancouver/Richmond Health Board's[1] Women's Health Planning Project and who has been coordinating the implementation of *A Framework for Women-Centred Health* within that health authority. Susan White is Assistant Executive Director of the Canadian Women's Health Network and has conducted community consultations for the Prairie Women's Health Centre of Excellence in both Manitoba and Saskatchewan.

[1] As of December 2001, the Vancouver/Richmond Health Board has been amalgamated with other health regions and is now known as the Vancouver Coastal Health Region.

B. BACKGROUND ON MODELS OF WOMEN-CENTRED CARE

The *Invisible Women* evaluation framework was used to determine the gender-sensitivity of health planning documents in Manitoba and Saskatchewan (Horne et al., 1999) and the Vancouver/ Richmond Health Board's *Framework for Women-Centred Health* served as a template (VRHB, 2001)**.** The preparation of these two models both involved scans of the literature and international models. Many of the same models were reviewed for the two projects and they are both still quite up to date. Both of the frameworks are consistent with, and incorporate elements from, several other models of women-centred policy, programming, and gender-based analysis tools, such as the Glasgow women's health project in Scotland (Women's Health Working Group 1996a) and the Pan American Health Organization's gender analysis handbook (Hartigan et al., 1997). Detailed descriptions of these and other models can be found in the *Invisible Women* report and references in both documents will lead readers to other models and research. The limited resources for this project and our belief that these models are current meant that a full literature scan was not redone for this project.

The Vancouver/Richmond Health Board framework was initially developed during a women's health planning project. It was adopted as regional policy of the Board in February of 2000 and was then enhanced and published as a stand-alone guide for the implementation process within services across Vancouver and Richmond (Vancouver/Richmond Health Board 2001 or V/RHB). In addition to consultations with the participants in the planning project, a survey of women-centred programming in selected services and a scan of models of women-centred services was conducted. The guide contains examples of best practices within the region.

The V/RHB framework incorporates the Aboriginal four quadrant or medicine wheel in a diagram. Several Aboriginal medicine wheel models and their relationship to women's health were reviewed for our research (Todd-Dennis, 1996 and Bartlett, 1994).

C. LOOKING AT MANITOBA AND SASKATCHEWAN

We wanted to capture information from key informants who are involved with the provision of quality, women-centred health services. We decided to focus primarily on interviewing people from organizations providing direct service, rather than those focused on policy development such as government health departments or policy research organizations. We felt that people at various levels of authority with direct experience of service delivery could speak from their experience about what works for women and what could be improved. They could also contribute details about the complexities of women-centred care.

Although no one service will incorporate everything … this study of a wide range of options can assist us in understanding women-centred care. Readers can apply what is meaningful to their situations in enhancing or developing new services for women.

We chose a purposeful sample of organizations to maximize diversity in terms of culture, age, location (rural/northern or urban), sexual orientation, Manitoba - or Saskatchewan - based, type of service delivered, etc. We particularly recognized that research in the prairies must include Aboriginal perspectives and we made a special effort to speak with various Aboriginal program contacts for that reason. Participants came from organizations working to improve the health of women particularly, or of both women and men but with a large clientele of women.

The concept of health was defined broadly in terms of population health. Thus, we interviewed people providing health services at both primary and secondary levels, provincial services, as well as those working in a wide range of other organizations concerned with family and child welfare, services for abused women, street workers, incarcerated women, immigrants and refugees. Other participants were working in the areas of mental health services, youth services, and gay and lesbian health services.

D. FINDINGS

This research provides valuable contributions to the area of women-centred care, in particular because of the workplace information we gathered and because of the significant voice of Aboriginal workers who were part the sample. Many of the themes presented here are echoed in the other women-centred models we reviewed. This report synthesizes information from a wide range of health and community services and paints a broad overview picture of women-centred care from many perspectives. We are able to put emphasis on factors that run through most organizations and are essential to women-centred care. We describe these as the 'cornerstones' of women-centred care. Other key factors emerge on how to deliver comprehensive services, build knowledge, and have a workplace supportive of women-centred care. Although no one service will incorporate everything because of restrictions due to varying contexts, size of organizations, mandates and resources, but this study of a wide range of options can assist us in understanding women-centred care. Readers can apply what is meaningful to their situations in enhancing or developing new services for women.

E. IMPLICATIONS

Integrating the concepts and practices of women-centred care may entail changes that go beyond what individuals can accomplish. Training is essential for professionals and staff across the health system. Successful women-centred models may require support in the form of funding and structural changes. Consequently, numerous policy issues come into play when evaluating health care from a women-centred care perspective. Interview participants often describe advocating for policy changes to improve the lives of the women they work with or to expand the type of services they provide. Policies that promote women-centred approaches need to be in place. Those policies will allow planners, practitioners, and women to grapple with implementation in various arenas across the continuum of care. Our research only gathers information from the practitioners. All of the stakeholders, including individuals, practitioners, and community groups must be involved in developing women-centred tools for the two provinces or individual health authorities. While engaging all perspectives in joint public processes is beyond the scope of this project, it is an obvious step toward integrating women-centred approaches in policy and organizational structures.

PART 2

METHODOLOGY

A. INTEGRATED FRAMEWORK FOR WOMEN-CENTRED CARE

To develop an initial guide for the interview process, we integrated the components of the Vancouver/Richmond Health Board's *Framework for Women-Centred Health* with an adaptation of the framework from the *Invisible Women* report.
This resulted in 9 elements:

1. The need for respect and safety
2. The importance of empowering women
3. A holistic view of women's health, including a comprehensive range of services and women's patterns or preferences in obtaining health care and health information
4. Involvement and participation of women
5. Women's forms of communication, interaction and decision-making
6. A gender-inclusive approach to data gathering and using of this data in gendered research and evaluation
7. Social justice concerns
8. Gender-sensitive training
9. A team approach in the workplace

Semi-structured interview questions were developed using these elements. The guide we created from the list above is a working tool that does not convey the kind of comprehensive diagrammatic representation that the Vancouver/Richmond diagram includes, particularly the integration of the Medicine Wheel (See Appendix 3 and 4). Nor does it include the details within the broad categories of the *Invisible Women* evaluation framework

B. QUESTIONNAIRE

The interview questions used broader language than the wording in the framework in order to avoid leading questions or close off discussion about issues that may not have arisen in the V/RHB or *Invisible Women* frameworks. The guide was intended to steer the interview process, not to serve as a template.

The following topics were covered in the questions: types of care provided; approaches to and philosophies regarding care; efforts taken to make women comfortable; dealing with stressful issues; how to improve programming for women and the resources needed to do so; efforts to make programs accessible; what kinds of information and education are provided; teamwork among staff; research and data collection processes; types of advocacy

done; staff training issues; ways organizations connect women with each other and with other resources; how organizations view women-centred care and visions for the best models of women-centred care (See Appendix 1 for the questionnaire).

C. INTERVIEW PROCESS

Potential interviewees were selected from a variety of organizations. Organizations were initially identified using a grid that plotted organizational types as one coordinate and the diversity of communities they worked with as the other coordinate. This visual method assured that the sample chosen would be inclusive of many of the types of agencies and populations we wished to include.

Letters were sent to the CEOs or Executive Directors, or in some cases program managers, of these organizations inviting them to participate or nominate a person to be interviewed. In some cases the person receiving the letter agreed to be interviewed, otherwise they approached particular staff members, had someone identified by a staff group, or an interested person volunteered. In situations where initial contacts approached felt they or their organization were not suited to the project, they often made suggestions and referred us to others.

In all, 22 people, from 21 different organizations, were interviewed. All but two were individual interviews; in one case two staff members from different programs in one agency chose to be interviewed together. Six people were interviewed in person, the other 16 by long distance telephone. The interviews averaged just under 1.5 hours each.

Most people interviewed were staff members, and one was a key volunteer from a small health professional organization without paid staff. We spoke to medical practitioners (e.g., doctor, nurse, nurse practitioner, midwife), counsellors, social workers, program managers and executive directors, front line workers, community health promotion workers, managers of volunteers, and the director of a regional health authority.

One organization was a representative political body; all the others primarily offered direct services. Most were local organizations, but a number were provincial in scope. One was a federal organization serving primarily the prairies. There was a stronger focus on community-based organizations so that research reflected diverse populations being served, as well as a provincial medical service. Community based services included urban clinics, resource centers, shelters, healing centres, mental health services and northern services.

While the provincial distribution of organizations represented by the participants was carefully considered and tracked, we did not conduct the same number of interviews from both Manitoba and Saskatchewan. The provinces are very similar demographically and in other ways (see below). As a research team, we felt that the two provinces could be treated as a single region. Instead, participants were recruited based on interest in and familiarity with concepts of women-centred care, willingness to participate, and from organizations that were serving populations most common in their provinces (e.g. rural communities in Saskatchewan, where they are more populous, and recent immigrant communities in Manitoba, where they are larger).

D. ANALYSIS

All 22 interviews were taped, for transcription purposes only, with the permission of the participants. Transcripts were then produced from the tapes.

Completed transcripts were coded into categories by one researcher. Elements from our integrated framework based on *Invisible Women* and V/RHB frameworks were used as guiding hypotheses for analysis, but we let codes arise from the data and were open to information that did not fit within these categories. The other two researchers checked the codes and noted agreements and disagreements with the first researcher's codes. The first researcher then revised some codes and combined codes into broader themes, checking again with the other two researchers for areas of consensus and difference. All three researchers then reached agreement on the final codes and themes.

We used the constant comparative method common in qualitative research (Glaser and Strauss, 1967). This involves revising earlier category codes to fit with new information as it surfaced. That is, emerging categories were sorted and compared as we proceeded through the analysis, and links from categories to broader themes were discussed among the researchers until we reached consensus. In this paper, overall themes and related categories are reported with a generous number of quotes to illustrate what these concepts meant to women in their own words, and to show the breadth and depth of the issues.

PART 3

WHAT WE LEARNED

Who are the women of Manitoba and Saskatchewan?[2]

Manitoba and Saskatchewan are very similar in many ways. Both provinces have slightly over 1 million people each and have very similar demographic patterns. Manitoba and Saskatchewan together represent 7.3% of the population of Canada, with more younger and older people than Canada as a whole. According to 1996 Census data, women make up slightly over half of the population of both provinces. There are higher proportions of women over age 65, and especially over age 80, than in the rest of Canada. Women live longer than men and while the ratio of women to men has declined, it is estimated that in 2001 there are almost 40% more women than men age 65-84 and 2.25 times more age 85 and over (PWHCE, 2001).

Women in both provinces are more likely than other Canadians to live in rural areas, with Saskatchewan being more rural than Manitoba. While 22% of the total Canadian population lives outside of cities, 28% of Manitobans and 37% of Saskatchewan residents are rural dwellers (PWHCE, 2001). These rural, mostly agriculture-based, communities are concentrated in the south. Women of the north live in widely scattered communities, largely in either resource extraction-based towns (e.g. mining and forestry) or First Nations' reserve communities.

The distribution of women living in urban and rural areas is different for Manitoba and Saskatchewan. Manitoba's main urban centre is Winnipeg, which contains 60% of the population or 684,800 people. The greater industrial base in Manitoba's economy that is concentrated in Winnipeg is partly responsible for the larger urban population. The location of urban industries such as light manufacturing and food processing employ many women. Saskatchewan's population is in general more widely distributed, reflecting populous rural agricultural communities. The urban population revolves around the two poles of Regina and Saskatoon, cities of 198,000 and 230,000 people respectively. Whether they live in urban or rural communities, Manitoban and Saskatchewan women, like elsewhere in Canada, are most likely to be employed in the service sector, and are 80% of those employed in health care occupations (Willson and Howard, 2000).

A distinctive feature of Manitoba and Saskatchewan is the high proportion of

[2] This section greatly relies on Lissa Donner's advice and research assistance.

Aboriginal[3] people compared with the rest of Canada. Less than 3% of Canada's population is Aboriginal, but according to the 1996 Census, 12% of Manitoban and Saskatchewan residents are Aboriginal. As a result, 30% of all Aboriginal people in Canada live in the two provinces (PWHCE, 2001). These are split mostly between urban populations, which are proportionately very large compared to elsewhere in Canada, and reserve populations, the latter located both in the south and the north.

Aboriginal women's health status is the poorest of all women in the region, just as it is elsewhere in Canada. A recent report on Aboriginal women's health in Canada from the Centres of Excellence for Women's Health (Dion Stout, 2001) details a shorter life expectancy; a substantially higher mortality rate, especially from injury and violence; a much higher suicide rate; extremely high rates of family and child abuse; a grossly disproportionate incarceration rate; higher rates of sexually transmitted diseases including HIV/AIDS; high rates of long term disability; rapid increases in diabetes; higher than average rates of death from ischemic heart disease and stroke; and a very high rate of cervical cancer deaths. The report links these conditions to the high levels of poverty in Aboriginal communities and concludes, "These women bear the burden of ill-health, premature death and marginalization to a degree unimaginable to much of the country's population... [A product of] forces of racism, prejudice and a colonialist legacy" (Dion Stout, 2001:16-17).

Virtually every health and social service struggles to better serve the large Aboriginal population, and Aboriginal people themselves, often led by women, continue to build innovative new services. The two provinces are also the site of major federal and provincial government efforts to transfer services, including health-related services, to First Nations', Metis, and other Aboriginal communities in response to demands both for better service and for self-determination and control.

Most of Manitoba and Saskatchewan's non-Aboriginal women come from families who immigrated to the region not many generations ago, mostly from Western and Eastern Europe (although there are also relatively old east and south Asian and Black populations). Although English is widely spoken, there are long-established and sizeable French-speaking populations whose culture remains vibrant. While Manitoba and Saskatchewan have fewer recent immigrants than Canada as a whole, immigrant and refugee communities continue to grow, with a stronger presence in Manitoba. According to the 1996 Census, immigrants and refugees make up 17% of Canadians, 12% of Manitobans and 5% of Saskatchewan residents, with the average yearly intake around 3,800 to Manitoba and 1,800 to Saskatchewan. Over 50% of immigrants and refugees are women. Changes in the countries of origin of new immigrants transforms the cultural compositions of both prairie provinces (PWHCE, 2001).

The two provinces have similar political histories, generally alternating between NDP and Conservative provincial governments, and both have currently NDP provincial governments[4]. Keeping in mind the demographic patterns of the area, it can still be said that the two prairie provinces have much the same challenges in improving women's health as other parts of Canada. Efforts to improve women's health status and provide services better suited to women's needs are played out against the backdrop of budget restrictions and

[3] 'Aboriginal' is a term referring to First Nations people, or 'Registered Indians', 'non-status Indians', Metis and Inuit, as used for instance in Dion Stout, Kipling and Stout, 2001.

[4] This is not to say that there are not specific historical differences within this general similarity that are important to note in order to understand health care delivery systems (Willson and Howard, 2000).

cutbacks, media reports about waiting lists, and nursing shortages.

Introduction to the Interview Data

Many participants did not use language such as 'women-centred', 'gender' or 'social determinants'. However, because someone does not use the term 'women-centred' does not necessarily reflect on the women-centredness of their practice. For this reason, we looked at how participants incorporated elements of women-centred care in their practice, even if they used different language to describe what they do.

The themes presented in the following sections emerged from the telling of the efforts, successes, and challenges of using woman-centred approaches to care. The themes generally show how to address the realities of women's lives, as perceived and described by service providers we interviewed.

The discussion begins with the social and economic context of women's lives. Participants highlighted:

- Women's roles and responsibilities
- Low income and poverty issues
- Racism and colonialism
- Gender differences
- Abuse and violence against women
- Rural and northern living

Next we present the broader philosophies (explicit or implicit) that guide interview participants' responses to women's lives: holistic, spirituality, feminism, and First Nations' rights. Then we describe the "cornerstones" of women-centred care. Women-centred care is possible when there is:

- A focus on women
- Involvement and participation of women
- Empowerment
- Respect and safety

The themes about delivering comprehensive services to women reflect the participants' understanding of women's patterns and preferences for care, and acknowledge women's ways of communication and interaction. Women-centred care should:

- Address the complexities of women's lives
- Be inclusive
- Be integrated into service delivery
- Respond to women's forms of communication and interaction
- Include information and education

The discussion about knowledge development touches on evaluation and research as well as the need for research and the capabilities to carry it out.

The organizational structure and environment of health care centres are important to the delivery of women-centred care. Participants identified the following qualities as significant in the delivery of women-centred care:

- Collaborative work environment
- Women-centred philosophy shared in common
- Service providers as consultants with expertise in women's health
- Good communication and concern for staff mental health and safety
- Gender and inclusiveness training

Finally, a social justice approach links us back to where we began, with women's lives. All of the variables we measured are interconnected. While it is not a component of women-centred care *per se*, adequate funding is important for facilitating and delivering women-centred care.

A. THE SOCIAL AND ECONOMIC CONTEXT OF WOMEN'S LIVES

As we will see in the next few sections, women face multiple sources of inequality, such as abuse, poverty, racism, and sexism

every day. The difficulties of dealing with social prejudices and unequal structures profoundly affect women's personal lives:

People struggle with some heavy shit in their lives. How are they going to get through it, find ways to deal with it? So it doesn't just focus on the individual and not talk about the health determinants. ...It really is a fine balance between the individual and the individual in her social context, how she makes sense of it. (Program coordinator, community clinic-MB)

1. Women's roles and responsibilities

Societal expectations of both women and men influence the roles and relationships that play out in their individual lives. In particular, we heard how women's family and care-giving responsibilities affect their health and lead to the requirement for childcare or child-friendly services:

I think that they [workers] could make sure that they are recognizing the barriers, like childcare, and understanding the relationship between women and their children as caregivers. I think that women got the short end of the stick when it comes to the work ethic. In some ways all women don't have time to take care of themselves. So we need to look at ways of honoring the strengths that we do have, and caregiving for ourselves, because we caregive for everybody else, our children, our partners, our parents, our this, our that, our communities. (Clinical Director, child and family welfare agency-MB)

Some interview participants pointed out the importance of recognizing how women's family relationships, particularly those with spouses or partners, affect their lives:

Even the women who do have partners, a lot of times the men aren't working, or it's really hard for them because of their self-esteem-- to see their wife go out to work, to be in the situation where they might have to look after the children or be placed in what they would consider a role that they don't necessarily like. So a lot of stress comes from jealousy. A lot of the husbands, while the women are going to university or are at work, are calling their wives 3 times a day. And then many [women] are single parents. (Women's program coordinator, First Nations' organization-SK)

The importance of family relationships is magnified for Aboriginal people in particular because of the devastating history of generations of parents and children being separated by the residential school system, including women who are middle-aged adults today. A related element of that history is the loss of thousands of children[5] from Aboriginal communities who were 'apprehended' (taken away from their parents) by state and welfare agencies to be either put in foster care or adopted:

One of the messages that comes loud and clear from the women themselves is they want to deal with issues,... they want to deal with issues around grief....A lot of women, that's a constant and awful grief that they carry with them, that they have lost their children. (Director, corrections-SK)

Thus, agencies serving Aboriginal constituencies have taken the lead in trying to make lots of room for children:

Many of the women have children - theirs or their grandchildren. We make our place friendly for children and are patient about that. We have a separate alcove in the waiting room with interactive toys and books for kids. Some of the exam rooms have toys and women can choose to have kids in the examining room with them. When it's time to do the pelvic exam, in my mind it's up to the woman how she wants to handle that, and we just work around the kids. It gets to be a challenge sometimes, but

[5] We also note that other women also routinely experience the loss of children. Women with mental illness often have had children taken away as was noted in an interview with a mental health worker in Manitoba.

*most of the time it's OK. If I don't make an issue of it, and the mum doesn't, then the child doesn't see it as an issue. (*Nurse, northern community health resource centre-MB)

Family can also have particular meaning in immigrant and refugee cultural communities:

... For me, from some of these cultural perspectives, family is where it begins. Because family is what they see more, from that context you can then think about the broader. You begin from the individual to the family, and then you could go to the broader, such as the workplace. Fewer women are working outside for money, especially from the ... community. Most of them were housewives. Here they begin working outside the home, or going to school, so maybe family is really where you should begin and then of course from there go out to society. (Health educator, immigrant community-MB)

The role of children and family is of critical importance in this discussion about women-centred care. Some interviewees were critical of women-only services which did not have adequate childcare facilities or that did not also serve the children. Comprehensive and integrated services make women's lives easier since they are the ones who often are the family caregivers. The important point for women-centred health is that family and child health initiatives need to view women's health concerns as equal in importance to those of children and other family members (i.e., not view women as mainly caretakers and guardians of the health of other family members).

2. Low income and poverty issues

Many agency contacts we interviewed were working primarily with women living on low incomes, and therefore were dealing with issues related to poverty. Women living on low incomes often are the ones who need public or not-for-profit health and social services the most because they cannot pay privately. They often must struggle to meet day-to-day needs for adequate nutrition and housing.

...since most of the people we work with are poor, and can't eat properly. Because on social assistance, you can't afford a proper diet, and that can be a serious problem. (Program manager, mental health agency-MB)

The gay community here is small, but it is big at the same time. We have a large gay community, but the ones who access this community [service] are those who are poor and underprivileged. Those who are gay and have money do not usually access our services. (Gay and lesbian health worker-SK)

... housing - like that is one of the basics. If you don't have housing, a lot of the other things just don't matter. (Nurse, community health centre-SK)

3. Racism and colonialism

The search for alternative models includes recognition of colonialism and racism. Aboriginal women and others interviewed discussed the effects of racism and colonialism both on women with whom they work, and on the service-delivery workers:

If you are not addressing the issues of poverty, sexism, materialism, and the concerns around our value system, as well as racism, discrimination and the impact this has had over the years on the Aboriginal population, if we are not looking at these things, then we are not going to make a difference. It is just going to be very superficial. (Street workers advocate-SK)

Racism, one participant argues, makes it impossible, especially for Aboriginal people but also for anyone else, to be fully healthy in a society of unhealthy social relationships:

And we say that it is not wellness in yourself or in your community but in your world. So if you live in a racist, sexist society, that is an extension of your world with no job, no anything, all of that is layers and layers of health and wellness. How can you be healthy living in a racist world in "colonized" Canada? …You can't be healthy and well in the social relationships that we have now. It's not possible. (Clinical director, child and family welfare agency – MB)

The specific challenges and initiatives they mentioned include: serving large highly marginalized urban Aboriginal populations, especially youth; efforts to build Aboriginal-controlled institutions; and the move towards transfer of services under self-government processes. Aboriginal workers also discussed the struggles and frustrations of trying to change white-dominated institutions:

I think that people have to have a fundamental understanding of colonization, not how it impacted Aboriginal people, but how it impacted upon them as colonizers. Because we are still doing the same thing. We never go there. And a part of that is racism. People cannot not have been impacted on by racism. It is impossible to say, "I am not racist." People think that if you are not in a white pointed hat, that makes you not a racist. People are so unaware of their biases. To me, being unaware of your biases, and your privilege, is the other thing that makes it racist. And they are virtually unaware of all this. So that when they come in contact with Aboriginal people as care givers, you can only come from a fundamentally wrong place. You can't help it. (Clinical director, child and family welfare agency-MB)

4. Gender differences

A number of participants alluded to the need to acknowledge gender differences and recognize that women experience issues differently from the men in their communities. Also heterosexual women experience issues differently than lesbian, bi-sexual, and transgendered people:

What we're trying to do is deal with cross-cultural issues in a more holistic way as part of our women-centered approach. We're talking about immigrants, we need to deal with them, and that's a very good thing. But we're not talking about women immigrants. It's the same thing with Aboriginal women. There was a whole thing about how Aboriginal women weren't seen as different from Aboriginal men because the whole race was oppressed. (Mental health worker, community clinic-MB)

I think what we found here, and I've never worked in a men's facility, so I really can't make any direct comparison, but what I find, and what I hear my staff saying here is, that women's experiences are different. (Director, federal organization-SK)

5. Abuse and violence against women

Violence and abuse generate innumerable long-term repercussions for health including pelvic pain, mental health issues, disordered eating, self-abuse (such as slashing) and substance abuse. Recognizing this is an important step in working with women:

We acknowledge sexual abuse, and the years that I was asking [about] that in the Healthiest Baby program I could not believe it- for every person that said "no" we had nine or ten that said "yes." The ones who said "no" in the beginning, quite of few of those women later on said that they had in fact been sexually abused. (Nurse, community health centre-SK)

A lot of times their self-worth is not there anymore because they have been abused for such a long period of time. And often times when you look at abuse, it is a generational thing. (Rural women's shelter-SK)

It is important to listen to these voices and the many ways abuse affects the women they work with. Past or present abuse can

affect the way women respond to health professionals, for example, during pelvic exams (Tudiver et al. 2001). The people we interviewed pointed out that professionals have not always been aware of, or sensitive to, women's experiences of abuse and as a result have treated them inappropriately:

It is also something that I ask when women come in for a Pap test or contraceptives, because that has a huge impact on what might be acceptable or would really alert me to be slow when doing the Pap test and show them the speculum. I always pass it over to them so that they can examine it, and try and make the situation as comfortable as possible for them. (Nurse, community health centre-SK)

It's too often you hear of someone, "They have a bipolar mood disorder." You talk to them for a little while longer and they were sexually abused when they were 13. You think, "Did the abuse cause the mood disorder? Are these related?" But it happens really often. It's not just that, it's depression, personality problems, and psychiatrists aren't dealing with these issues by and large. (Program manager, mental health agency-MB)

And then there is the frustration of the inability of women to have their voices heard about these issues:

The issues that the women like to address, like family violence, incest, sexual abuse, that sort of thing, the perpetrators at times are leaders [in their communities], so the leaders are really opposed to looking at those issues. (Women's program coordinator, First Nation's organization-SK)

6. Rural and northern living

Isolation and availability of services were issues outside of urban areas. This affects the access to service:

It is tougher in the rural communities when people are isolated by distance. The north is really poorly served here. (Program coordinator, sexual assault services-SK)
Rural and northern isolated areas are lumped together. The North is 'very unique' but that is not articulated enough. (Nurse, northern community health centre-MB)

This northern manager saw the 'lumping together' of rural and northern living issues as a danger because governments are combining program planning and funding for rural and northern areas, without recognizing the huge differences between the two. She pointed particularly to distances that need to be covered to deliver services in the north, distances that are greater even than in southern rural areas.

B. PHILOSOPHIES

Many participants either mentioned various philosophies and values that underpin their strategies and practices for care, or gave the interviewers printed agency materials. Philosophies articulated are categorized in this report as holistic, spiritual, humanist, feminist, and First Nations' rights. Some interviewees expressed philosophies without using these terms. They were more implicit.

All responses have common threads such as mention of the concepts of respect, dignity of individuals, wellness and well-being. Some mention social change. Many refer to accepted definitions of health from the World Health Organization and United Nations. But there is not one consistent philosophy described. In the next section we look at the cornerstones of women-centred care where we do find common values and practices.

1. Holistic

Holistic philosophies were reflected in comments about the need to recognize balance among different aspects of well being, and health as being something positive (rather then simply the absence of disease). Health is seen as occurring within a broader context that incorporates the determinants of health:

We work from appreciating and incorporating the social context of women's lives. There is an acknowledgment of the health determinants within that context. So where is the influence of the cultural background and socio-economic background, abilities or disabilities, sexual orientation? We see the client in a holistic way. (Mental health worker, community clinic-MB)

Holistic healing, or dealing with the mind/body split. Holistic healing takes into account the mental, physical, emotional and spiritual. …. So spiritual healing, and healing with the body and mind, that holistic approach is what women are looking for. (Program coordinator, urban women's shelter-SK)

2. Spirituality

For Aboriginal women the spiritual focus was central.

But really, when you are looking at anything Aboriginal, the basis of Aboriginal culture is a spiritual foundation. What I think is that everything starts from the spiritual base, and that's what makes us fundamentally different than European based cultures. We come from Nations that have this fundamental belief, and still are connected there, that we are fundamentally related to everything that's alive. We are a part of the whole. We are not at the top. It is very hierarchical in the Western construct. In our context, people call it circular, but the notions of hierarchy are nonexistent. The only thing that is higher is the Creator. And it is not even a higher or lower thing. I think that people are really drawn to that thing, and are healed by those understandings and that sense of belonging to things that have life. (Clinical director, child and family welfare agency -MB)

3. Feminism

While feminism is mentioned numerous times there are different emphases on what aspects of feminism are important, as illustrated in the diverse quotes that follow:

Feminism is where we acquire some of our philosophies for the agency… Being a pro-choice agency is a feminist principle. Gender-based programming is one of the pillars or mandates of our agency. It is not the only one. So we do have other things to consider. (Health educator, immigrant community-MB)

[Our service] operates within a holistic, feminist framework. The staff member will share responsibility and accountability in a consensus building environment where each women's wisdom, experience, and difference is respected. (Program coordinator, urban women's shelter-SK)

Feminism is about more than how you do your work; it's about how you do your life, and how you think about things. That's a little bit different than most philosophies. You figure out how you're supposed to do your job and then you go home and live your life. But it works a lot better if you have it integrated into your life. (Mental health worker, community clinic-MB)

4. First Nations' rights

First Nations people are distinguished from other Aboriginal people, as well as non-Aboriginal people, by having collective rights, including rights to health services, flowing from treaties signed between their Nations and the Crown. Some participants spoke about First Nations' rights as a guiding principle as well as women's rights:

I guess our philosophy statement is that first and foremost we are based on treaty because we are not an Aboriginal organization, we are a First Nations organization, and being based on treaties we focus on collective rights as opposed to individual rights. So we like to say that we are working as First Nations women for the betterment of all our people, which includes our men and our little boys and our grand parents. So there is the distinction that, yes we are women and there are individual rights within that collective that we must work for and we must be recognized, but

overall we work for healthy communities, which include, of course, men. (Women's program coordinator, First Nation's organization-SK)

C. THE CORNERSTONES OF WOMEN-CENTRED CARE

The following four factors were common amongst the participants' descriptions of their services and can be seen as the most essential components of women-centred care.

1. A focus on women

Interview participants varied in the degree to which they considered their agencies as being consciously women-centred, versus focusing on women by default because more women than men make use of the services. Yet this results in a common focus on women. Some participants also noted the similarities between being women-centred and being Aboriginal-centred:

> Participants described better outcomes in meeting women's needs because women were part of the process.

'Woman-friendly' to me is still having women marginalized, but making it nicer for them to be marginalized. 'Women-centred' is programming that is women based, women's health care based. (Women's program coordinator, First Nation's organization-SK)

...You are providing services based on a woman's expressed needs. (Director, regional health district-SK)

I am so used to thinking of our health centre as being Aboriginal-centred, that it is very difficult for me to... quite frankly 95 or 96% of our clientele who walk in these doors are women. I very seldom see men in here. We knew that would happen, but we never said we were woman-centred because we are not. Our focus is Aboriginal, yet within that it is women we see. (Nurse, community health centre-SK)

Sometimes I find that models for Aboriginal people and for women can be very similar because of past experiences or whatever. (Director, corrections-SK)

2. Involvement and participation of women

Participants described many ways that women were involved in both services and decision-making around services. This is more than a philosophical argument for public participation; services are improved when women have input. Participants described better outcomes in meeting women's needs because women were part of the process.

Both the *National Forum on Health* (1997) and *National Voluntary Organizations* (1999) underscore the need to change health services so women who use the health system can be involved in decision-making. Participants pointed out that involvement and participation needs to be inclusive of diverse groups of women, including women who are:

- Aboriginal;
- Francophone;
- from cultural backgrounds other than North American or Western European;
- rural;
- single parents;
- lesbians;
- abuse survivors;
- living with disabilities;
- living on low incomes;
- have low literacy skills; and
- from a range of age groups.

Participants also noted that women's meaningful participation could take a variety of forms, such as:

- equitable representation on boards and advisory committees;
- involvement as collaborators in all phases of planning and evaluation;
- input and feedback channels for individual women who are users of the health system;
- public meetings; and
- formal research methods such as surveys and focus groups.

The following are examples of possibilities for involvement and participation given by participants.

Involvement of current or former clients in decision making

I think that one of the things that are fundamental to the work we do here is that you involve those that you are working with in deciding what services they need and how those can best be provided. I think that is really critical, and it is one of the building blocks of our work here. In order to provide the best possible service, you need to be as informed as possible. Who better to teach you that than the people you are working with? They understand the issues, know what the realities are, and know what works and does not work. (Street workers' advocate-SK)

Women have been involved in many levels of decision-making:

I think in the employment [program], they have a participant [who is a current or former client] on the hiring committee when they hire new staff. That's been for quite a long time now. It's usually somebody that's they feel is in a position to be an active participant in the hiring committee. (Program manager, mental health agency-MB)

Community control

Having staff working under community guidance or leadership has implications for resource allocations and planning:

We [staff] have been very responsive to their needs [community advisory committee] and what they are telling us. Since I came on with the primary care program two years ago, they direct my activities in that they felt that reproductive health was the number one issue and they really wanted me spending most of my time doing that. Another thing that they felt was a real issue was diabetes. So those are two areas that I spend most of my time and energy on. (Nurse, northern community health centre-MB)

There was an early group, a group of elders and other concerned people. They really steered our development… picked a place where we would be, had a great bit of input into the building and the structure. We have a vision that they have outlined. (Director, corrections-SK)

Individual control over the care one receives

Women-centred care is inconsistent with top-down decisions by professionals, and requires having women as full partners in their health care:

We try to help women be knowledgeable about their body, the process of birth, and to choose options and work towards the kind of birth that they want. (Midwife-SK)

Everything we do is based on allowing the person ownership of their health. In other words, there are not secret things written in their files. They are allowed to read what is written, to talk about what is in their file, and go through their file and look at whatever they want. (Director, sexual health program-SK)

Yet choices and control over care are also affected by cultural differences:

We have found that with many communities, even if it is concerning the woman, you know there are two situations. There is the situation whereby the man does not mind being with the woman, but then, if that decision has to be made it has to be made in consultation with him; he has to be involved, they won't come to that decision alone. But there is also a situation whereby the man makes all the decisions. (Health educator, immigrant community-MB)

Volunteers

One of the most-often mentioned ways of being involved was volunteering, though not without very distinct approaches and manifestations such as the involvement of former clients. Volunteering also assumes one has the resources to participate:

We have a social worker actually who is responsible for the whole volunteer program. She interviews people who want to be volunteers here, and they go through a very heavy screening process because we are dealing with safety issues. Also, because we are a feminist agency, we have to be careful that we do not get volunteers here who want to convert everyone to a particular brand of religion, for example. So people have to go through a screening process and a two-day intense workshop on child sexual abuse. Sometimes at the end of this, people might screen themselves out because they don't want to be here. After the workshop, the volunteer is asked where she might like to work in the organization. The volunteer is supervised and we meet with her on a regular basis. We also have Volunteer Appreciation events and pass certificates out as a way of thanking people for their contributions. So we are developing a very thorough program related to recruiting, training, and using volunteers. (Program coordinator, urban women's shelter-SK)

The volunteer programs are really important. Even if they never volunteer to actually do the work, at least they gained those skills. There's that ripple effect with their friends. And also the volunteer speakers program which again gives women that opportunity to speak to groups and be part of spreading the word. (Physician, community clinic-MB)

Supporting involvement and participation

Barriers to participation need to be addressed by assisting women with child care and transportation, providing opportunities for women to communicate in their preferred language, having flexibility in available times and places to participate, and compensating women for their time through honoraria and coverage of out-of-pocket expenses. As some women may not be comfortable appearing in public or otherwise identifying themselves, it is also essential to provide opportunities for anonymous verbal and written input. Formal research methods such as surveys and focus groups need to feed findings back to those who participate in the consultations to ensure accuracy in summarizing their ideas and concerns, and to actually use the findings in developing and improving, implementing, and evaluating health initiatives (Horne et al., 1999).

Several concerns about women's ability to volunteer, in terms of childcare, poverty, and scheduling were noted.

We don't have volunteers, but if we have women who have been involved in the program and want to help with the kitchen or with childcare we will pay them. (Nurse, community health centre-SK)

The people that did come were on social assistance and weren't really interested in volunteering. (Worker, northern crisis centre-SK)

I think if we were truly going to try and involve people, we would have to look at accommodating schedules of people who are coming in as volunteers. (Physician, community clinic-MB)

While we recognize the many positive benefits of volunteering (learning new skills,

developing social connections, making a difference in the community), we also would caution against an over-reliance on volunteers to make up for shortages in public support for health and other services. Over use of volunteers, as well as rising expectations of informal caregivers in the home, is one more way in which funders privatize the delivery of services onto individuals, particularly women, to save costs to government. The gendered implications of this are covered in Scott et al., 2000.

3. Empowerment

Health status improves when people have a greater sense of control over their life situations. Important themes of women's empowerment are:

- a core sense of self, the ability to take action based on that sense of self;
- a sense of control over one's life; and
- being connected with others (Sheilds, 1995).

While facilitating women to develop knowledge and skills, it is often important to provide them with the support to change their lives to improve their individual and community well-being, and to connect with others (V/RHB, 2001). Empowerment includes providing a range of choices for women who use health services and defining women's health broadly enough that the social contexts of their lives can be addressed (Horne et al., 1999). One participant felt that equalizing the power relationship between women and health care providers is essential for empowerment.

Giving priority to women's health, and working toward gender equity, and respect for diversity in formal initiatives at the organizational level also contributes to the empowerment of women, both as providers and as users of health services. Organizations can also support empowerment by giving women control over their health records and opportunities to advocate for changes to services or in their broader communities.

Empowerment requires recognizing people's strengths rather than only their deficits, and creating environments where people can build upon and use these strengths to gain a greater sense of control over their lives. Women who feel individually empowered are more likely to participate and take action in their community.

One participant described a liberation model:

All the language that we have-- 'at-risk,' 'disadvantaged'-- people don't see themselves that way. As soon as we start using that language, people have to see themselves in that way. If I say that I work with 'at risk students' and you are a student there, you have to see yourself in that light. We need to change all of that. That is not a liberation model of working with people. People focus on people's deficits rather than anything else they might bring to the table. (Clinical director, child and family welfare agency -MB)

Building capacity

The women we interviewed recognized the importance of women learning skills they can use in their own lives:

I want to make sure they leave here better equipped than when they came so that they have more background information as to what is out there and how they can access all of that. (Rural women's shelter-SK)

Give women the skills that they can then use elsewhere in their lives. (Physician, community clinic-MB)

People have gone back to their own communities, their own ethno-cultural communities to take up that work in whatever capacity they can. (Program coordinator, community clinic-MB)

Mentoring is one way to build capacity:

What we found is that people with more developed skills are often very helpful to those with less developed skills, and it works

well. (Program manager, mental health agency-MB)

Culture and empowerment

For some women, empowerment comes from a sense of cultural identity and knowing your people's history:

I did a series of retreats last year here at the facility and I took the staff on retreats and I also took the women here, the residents, on retreats. I was asking them,"What do we do well here?" And one of the strongest statements that came through to me from the women was, when we are here we find we get a sense of identity. That to me is very powerful. A lot of these women, maybe all their lives, have been ashamed of being Aboriginal, or maybe really not understood what that meant. When they come here, we've been able to help them to find themselves. I don't know that there is any specific program here that does that. Maybe it is all the programs together; plus, you know, about half our staff here are Aboriginal so all of that, the mix, I think makes a difference. (Director, corrections-SK)

4. Respect and safety

The social contexts of women's lives influence both their health and their ability to access health initiatives (e.g., health care, and health promotion). Especially important is the quality of interpersonal interaction between women and their health service providers, particularly women feeling respected, having their experiences validated, and being actively involved in making decisions about their own health needs. Women's experiences of respect and safety also depend on such factors as how privacy and confidentiality are handled (e.g., how records are kept and used), and whether women feel physically safe in the service environment. Sensitivity to women's greater experience of poverty and violence (relationship violence and sexual assault) relative to men is integral to both emotional and physical safety as is sensitivity to experiences of racism, homophobia, and marginalization because of disabilities and language, and respect and safety for women from diverse backgrounds and communities. Women also need to know that providers will refer them to other gender-sensitive providers and agencies as needed. Women who do not feel respected and safe are likely not to access services and could end up seriously ill, at risk or isolated as a result.

Validation

We really try to look at what we do, to be really respectful of the kind of struggles women have, and how they make sense of their lives. We may see those [coping strategies] as unhealthy ways of coping, but they <u>are</u> ways of coping and how do you work with that? (Program coordinator, community clinic-MB)

[Staff] basically asked, "What is going on in your life? Why are you here? What led you here?" And a lot of this relates to the attitude too. If you are talking to people as if they are victims, you are talking down to them; that is very disrespectful. This is something you need to be very careful about. One of the things we have certainly recognized is the incredible strengths and gifts these people have. They are survivors and they have much to offer. (Street workers advocate-SK)

Hearing women's voices

Here it doesn't matter who you are or what your background is, women are to be treated with respect and dignity, their voices are to be heard, and they have to be taken into account when making decisions that will affect them. (Director, national women's organization-SK)

They say that we are the fire keepers, the women and children of the First Nations' community. By giving the women voice, by having First Nations' women's groups on every reserve, the women would be able to speak. They would be able to speak for their children; they would be able to speak for themselves. And that would improve the health and health care. (Women's program

coordinator, First Nation's organization-SK)

Comfortable

Comfort supports the ability of women to feel respected:

The women's groups are a trusting and open place. It is geared at being comfortable; there is no constant lecturing but rather open discussion. It is informal and more "you are here, you are noticed and you are important." In comparison, when you are at a lecture or conference with a large number of people, you are not individualized. At our women's group you are. We believe in women-centred care where the woman knows what she needs. (Program coordinator, urban women's shelter-SK)

We try and make things more comfortable for people having to wait. Like [program name], where there are teenagers coming into the drop-in, we try to make it more friendly by having movies and popcorn in the waiting room. We try to keep them informed about where they are on the list and how long it might be until they get in. If it's going to be a while, they can go and get some coffee and come back and we will keep your place for you. (Physician, community clinic-MB)

Another way to help women feel welcome and supported within the service is to create a comfortable physical environment:

Our facility is fashioned to be very calming - the color schemes, the layout, etc. We try to make it very non-institutional and non-clinic, so that it is more relaxing than walking into a doctor's office. (Director, provincial screening program-SK)

We try to make the place look a little more womanly, pictures on the walls, plants….so that they see themselves reflected somehow. -- the choice of pictures, how the place is designed. Because of how women have been treated by the medical system, we have all learned a lot about how to have the least intimidation factor in the health facility. It's still has to be perceived as clean and professional though. People want to know that they're coming somewhere where they're treated with respect. (Mental health worker, community clinic-MB &program coordinator, community clinic-MB)

Safety is both physical and emotional

Often women's concerns are described as being about their safety and the safety of their children. The interview participants not only spoke of women's physical safety but also spoke at length about their emotional safety, particularly around being able to trust others and to share personal information:

I think that safety is probably a huge characteristic for any kind of programming around women. Women have to feel safe before they will participate in just about anything. I think there has to be an opportunity for women to have their own voices within that context. They have to be able to have some opportunity for ownership of their environment. (Director, national women's organization-SK)

I think when you use the phrase 'women-centred,' you are talking in terms of the emotional, physical, spiritual safety. (Street workers advocate-SK)

We educate people about triggers for survivors of sexual abuse, such as candles, clothing and color of clothing. The colors black and red are big triggers for women who are cult survivors. So none of the women here wear those colours to work. We also try not to wear any perfume or scent here. Many women are allergic to that. So we educate people about triggers in order for the women to be safe. (Program coordinator, urban women's shelter-SK)

Our policy as an agency is that we see clients, particularly in this program, alone at some point in the counseling session. So even if they are joined by their male partners, or anyone else who comes with them, even if it is of a supportive nature, we still see them alone. The primary client is

the woman, but the men are welcome to be part of the session. (Program coordinator, community clinic-MB)

Confidentiality is an important issue with safety concerns, as noted by several participants:

In our women's health centre we have specific security measures in place so that women can come and have treatment without fear of threat by a boyfriend, partner, or spouse. We assure confidentiality and anonymity through a variety of mechanisms which I wouldn't even talk about because we want to keep them confidential. But we do have those things in place and pay a great deal of attention to that. (Director, regional health district-SK)

Many women feel unsafe with workers because of child protection issues as well. A punitive rather than supportive system was described, yet visions of how support could be provided were offered:

I think that there are people that struggle with mental illness, severe mental illness, who can parent but who may need on-going help all the time. Even if that's the case, even if somebody needed an aid three hours a day, several times a week, for eighteen years, I still believe that it's cheaper to the system than putting that child in foster care. It certainly would be better for the relationships of those children with their parents, and the parents with their children. It would be building healthier communities, I think, by doing things in that way. But we don't have a system that's very child friendly. (Program manager, mental health agency-MB)

And women also fear being labeled with a stereotype and having that follow them through the system:

One of the things that I think we do well is we look at the woman as a whole woman. Women are not only treated as battered women when they are in the shelter. The staff recognize her other skills and abilities and look at her whole being; they don't label her. The same is true with our residence women. Yes they have mental health issues, but they also have children and are productive people to the extent that they are capable of being. So we look at them as a whole being and not just as one facet of their character. (Director, national women's organization-SK)

Often mental health issues happen and you get labelled in the system as a 'problem patient'. (Physician, community clinic-MB)

How staff works with women is critical to women feeling safe

Frequently issues of safety are revealed in requests for and assumptions about female staff:

The majority of our staff here is female and this is important because many of the young women we work with here have abuse issues. (Street workers advocate-SK)

All our staff here are women, except for a couple of maintenance men and we have our computer technician here who is a male. But on the whole all our staff here are women. So sometimes I think that helps because as women we [staff] have some experiences too, so that helps us to be more sensitive and maybe work together with the residents here in a different manner. (Director, corrections-SK)

While some feel strongly about the need for female staff, others recognize that there are men who can work respectfully with women:

People are given a choice when they call in on whether or not they want to speak to someone who is male or female. They have a choice and are not pressured in any way to see a male counselor. Women also know that they are a priority here and that we will be here for them. (Rural sexual assault centre-SK)

Some of our male staff work with women, and we have a special crew of men in this agency, they are very sensitive, progressive men. One in particular…he's pretty political and I think he would probably call himself a feminist. …I only watch from his actions, the way he treats people, the way he speaks. I think he's probably there, and he's an aware person. There is another young man who just started, lovely, sweet, and respectful. (Program manager, mental health agency-MB)

D. DELIVERING COMPREHENSIVE SERVICES FOR WOMEN

We now will discuss how interview participants describe their practices and list the key factors involved in delivery of services. Many of their comments reflect the need to offer services that are both convenient for women and sensitive to their needs, strengths, identities, and the circumstances of their lives. Additionally, some of the participants alluded to the differences in the ways women and men receive care and what their preferences are:

It means taking into account all of women's lives. The focus is on women who have children to the women who choose not to have children, on women who are heterosexual to the women who are gay, lesbian, bisexual or however they identify, on women who have financial income to women who need financial assistance, etc. I think it is being open to all aspects of women's lives while taking into account that women have less money, are primary care-givers, have multiple responsibilities whether it is for children, parents, or whatever. I think it is taking into account all those things so that when you are developing programming or services, you are aware of these aspects and make some allowances for them. (Program co-ordinator, sexual assault services-SK)

1. Address the complexities of women's lives

Women seek health care in the context and circumstances of their lives. Women-centred models offer a range of choices for obtaining health care and related services (e.g., social services), and for participating in other initiatives such as health promotion programs. One-stop access to a wide range of services can enhance both choice and convenience, as can offering a wide range of services in women's own communities and minimizing wait times. Communities can be geographic or based on other types of similarities (e.g., cultural communities, lesbian communities). Services can also be offered in settings that reach women in their day-to-day environments such as workplaces, homes, malls, drop-ins or schools. Women-centred services respect women's preferences for a variety of providers: nurse practitioners, midwives, and practitioners of complementary therapies and self-help support groups.

Each woman is an individual

Interview participants pointed out that women differ in their preferences for types of services. They also indicated that it is not only important to respect diverse cultural backgrounds, but also to recognize that women differ as individuals and that women who share certain cultural backgrounds are not all alike:

Women's lives are complex and varied and you can't assume that because it works for you and your family that it would work for all women. (Physician, community clinic-MB)

Because of the migration of people to Canada from so many parts of the world, we cannot make blanket generalizations about immigrant women:

… It might look different in some ways to different groups of people. South Asians, for example, it may look totally different what woman-centred means than to a group of Aboriginal women or a group of African

Canadian women… One size doesn't fit all. (Clinical director, child and family welfare agency-MB)

… there is a focus on what women want and need, and this can be many different things. There is not a standard pre-natal care program for everybody. Some people will want a lot more help and individual classes and sessions, while other people want to talk about issues, like the woman who was dealing with her mother's death. (Midwife-SK)

Client-centred

Some of the issues raised under a theme of client-centred approaches reinforce themes of control and involvement in decisions that were discussed earlier:

I remember years ago we would sit around and write out patient care plans until our arms fell off. And what we found at the end of it was we weren't always meeting their needs. So somewhere along someone said, "Oh, you should include the patient in this process." (Director, corrections-SK)

Now what we know is that women in particular, and people with mental health problems in particular, are often used to services not paying any attention to what they particularly want or need, but to delivering to them the service determined to be in their best interest. So often when people come to the agency we have to do work with people to help them to realize that they are the determiners of where the service is going and setting the goal, and that the professionals are not going to set that. We'll have an agenda but that they set the goals. So I think that in that way it works well for a woman. But on the other hand, the services are not designed specifically for women. (Program manager, mental health agency-MB)

Early hospital discharge was noted on a number of occasions as an example of what client centred is not! Hospital policies do not take into account needs of individual women.

It is really sad, because here, basically, they are sending you home until you are 6 to 8 centimetres dilated. Now if you are bringing your baby quite quickly, you're having your baby at home or in the ambulance. So I wouldn't consider that at all women-centred or woman-friendly health care. (Women's program coordinator, First Nation's organization-SK)

So there is that whole new movement, you know, having babies and being home within 24 hours. I think that is not very respectful to women. (Mental health worker, community clinic-MB)

Services respond to the context of women's lives

Participants described many services that address the social and economic contexts of women's lives. These included clothing exchanges, exercise programs, free food, parenting programs, residential links, jobs and childcare:

If someone comes in and says they're depressed and wants pills, I don't just give them pills, which I might have done in general practice because it's real easy and quick. We go through their lives and sort out what are the contributing factors to the depression. The pills might help, but we look at what other things are going on in your life and what you can do about those. I give them permission to do something about those things, because often they feel they don't have that. And I offer them other resources like counselling or referrals to other places, or help with finances, because often that's a problem. There are often many things. It could be children. One woman was depressed while her three children were hyperactive with attention deficit disorder and she was a single parent. (Physician, community clinic-MB)

We are almost like a bridge between being in crisis and being able to work in the community. So we have hired women here on contract to do different jobs and give them some confidence. Sometimes this has led women off of social assistance and getting a full time job in the community. A couple years later they might become board members. There is a lot of cross-fertilization here. We currently have a janitorial crew here who are survivors and are on social assistance. We pay them so much money a month to clean the facility we are in now. It is sort of like a worker co-op. (Program coordinator, urban women's shelter-SK)

Services across the lifespan

Serving women of all ages was important to many of the people interviewed. In keeping with a holistic approach, woman-centred models of health services need to go beyond a narrow reproductive focus:

Our age span here is from 19 to 57, so when you think of the needs of a 57 year old woman and the needs of a 19 year old woman, they are substantially different. And sometimes that really challenges us, to provide for the needs of all those age groups. (Director, corrections-SK)

We do not do enough about changing health needs beyond menopause. This will be a need more in the future because of changing demographics. We're meeting needs now on menopause but not on postmenopausal and aging. (Nurse, northern community health centre-MB)

2. Inclusiveness

The themes in this section address aspects of services that make it easier for women when they seek out care and that make care convenient for women. Participants emphasized the need to respect diversity.

Accessible

A place where the services are in one facility for women, a 'one stop shopping' kind of thing. If we had community clinics that were just for women, let's say women community clinics that would be a really nice model. Also, if you would include in there complementary care. So you would have counseling on site, midwifery resources, pharmaceutical resources, complementary care resources - like holistic resources all under one roof would be really wonderful. (Program coordinator, urban women's shelter-SK)

Barriers to being accessible are numerous and often involve lack of funding to develop services, rather than lack of information about the necessity for the service:

There is a whole group of people out there who have been trying with me to set up a gay and lesbian Deaf and Hard of Hearing group. But we need a telewriter and they are about $800, and we do not have the money to put towards it. There is a whole group of deaf women who cannot access this place because a lot of staff here does not know how to sign and a lot of deaf people do not know how to read lips. And if you do know how to sign, there is a whole different trust level within the deaf and hard of hearing community. When you are signing, everyone else knows what they are saying. They cannot whisper it. (Gay and lesbian health worker-SK)

I think there are some, immigrant women for instance, who too often don't know how to use the system because it's very different system from their country of origin. It would be nice to be able to help them understand the system better, how to use it more appropriately for getting their needs met. (Physician, community clinic-MB)

Mobile services are an example of making services available to rural and northern communities:

We have a mobile that travels across rural Saskatchewan. We have an unwritten policy that the mobile will stop at locations where women can access it within a 100 km. (Director, provincial-screening program-SK)

Flexible and creative

Interview participants discussed not only scheduling services to be convenient for women, but also reiterated the need to be sensitive to diversity and to develop services responsive to diverse needs:

We also look at scheduling. Does everything have to take place 9 to5? How can we be more creative in our scheduling of services? (Director, regional health district-SK)

For immigrant women, if we could get into the places where they hang out, it would be much easier to develop a program there that could meet their health needs. For them it's particularly difficult. Especially if you're not very fluent in English, there's all sorts of barriers to making an appointment, to getting there, to getting home, understanding what they said, feeling comfortable in the environment where the discussion and the exam takes place. (Physician, community clinic-MB)

Timely service

Responding to and assisting women in a prompt and timely fashion is important in engaging women, as well as not contributing additional stress to their already full lives:

Even if we cannot provide counseling right when someone walks in, we still set up an appointment and they are dealt with. If someone has more specific things they need to talk about; we refer them elsewhere because we cannot do on-going therapy here. Rather we try to stabilize people here and then move them on. (Gay and lesbian health worker-SK)

Some people feel embarrassed and might not want to even come in the doors, someone might see them. So when people do approach the agency, we try very hard to serve them quickly and respectfully, so that they will come back. (Program manager, mental health agency-MB)

Inclusive of diversity

Again, participants emphasized diversity and making all types of women feel welcome and supported:

We have an incredible diversity of people that come in here. Some of our staff are transgendered, gay, lesbian, from the streets, and everyone comes in through these doors. We have to try and be inclusive. We cannot do it at the expense of anybody else. We struggle with it and have to find a way to work on a consistent basis with everybody with the same type of philosophy and approach - you cannot treat one group of people one way, and one group another way. (Street workers advocate-SK)

Respectful of Aboriginal traditions

We also have an elders lounge; we have a room that is set aside for that. It is their place and they can access it any time. If they need any private counseling, that room is also available to them. (Nurse, community health centre-SK)

It is not enough to introduce a program, and have a few things around, you know, pictures, and even have Aboriginal staff in there, without really understanding what everything is built on, and that is that spiritual basis. So you look at medicine in hospitals, and the spiritual basis is not there, then there is really no Aboriginal program. (Clinical director, child and family welfare agency – MB)

Even within and among Aboriginal people, there is quite a diversity of culture and language,…. So we try to be as sensitive as we can to different cultures and diversity. One of the things that we do here is, with our elders program, we bring in elders from different cultures. (Director, corrections-SK)

3. Integrated service delivery

While integrated service delivery is 'good service'; it is not in and of itself a women-centred concept. Participants often recognized the importance of an integrated service approach and referred to it as they

discussed meeting the particular needs of women. Therefore, the need for integrated services and women-centred care are inter-related and often there is a gendered perspective on integration across the continuum of services:

We have a very unique discharge planning program in our health district, which intersects with the community in home care. And that is certainly part of our organization where the continuum of care is enhanced, in that people are channeled into that upon discharge from an acute care setting site. They then can be followed up appropriately. (Director, regional health district-SK)

His job is to refer the community to our centre and to coordinate activities in the community with no duplication of services that are offered by neighborhood cooperatives. (Nurse, community health centre-SK)

Participants also pointed out problems and barriers encountered in trying to achieve integration:

And yet people are only in the hospital if they are acutely ill; they live in the community. There needs to be better caring for people who need intensive work when they are recovering from a mental health problem, or they need intensive support to help prevent hospital admission. People get admitted to hospital often because they haven't had the services in the community sufficiently to prevent their hospitalization. (Program manager, mental health agency-MB)

Collaboration and partnerships

Some participants discussed the importance of organizations working together on issues that affect women's health:

Now the problem is, these needs may not only be related to our specific mandate, they may go outside the jurisdiction of our work. So it is our responsibility now to go out and find whom we can partner with in providing those requests as they have come from the community. (Health educator, immigrant community-MB)

Intersectoral communication and sharing

I think it is also really important for women's organizations to have the opportunity to get together and share. Otherwise we are all reinventing the wheel and limping along often on limited funds and trying to provide the best services we can. I think we need people who have the opportunity to lift their head, look around, and ask, "What could we be doing better?" or "What are they doing over here?" or "This works really well, so let's incorporate it into what we do." So I think it is important to have the opportunity to share information and share across disciplines. I think people in the medical profession need to work with people working in violence against women issues, and that people in education and justice need to be a part of it. I think we need to cross all kinds of boundaries so that we know – because sometimes we think, 'Oh this so simple, why don't they do that?' We wonder why different groups don't know things. We need to cross those traditional types of boundaries so that we know what is going on. (Program co-ordinator, sexual assault services-SK)

Complementary and traditional therapies

Participants were interested in expanding the range of health services for women to include complementary or alternative and traditional healing approaches:

We think it's important in terms of health care, that the government cover costs for women to access complementary care. Just as they subsidize physical therapy and chiropractic services, they can also subsidize Reiki, aroma massage therapy, and psychodrama. This would be less expensive for the government, yet more effective for healing. (Program coordinator, urban women's shelter-SK)

Community-based

The people interviewed emphasized the importance of being in tune with the communities in which they work:

We are not isolated because we are out in the community and have a lot of connections. (Program coordinator, sexual assault services-SK)

Basically we have to work for our own communities because it never works with outsiders coming in. (Women's program coordinator, First Nation's organization-SK)

Healing

The concept of healing broadens understandings of what health care is. Healing extends to the community and is not limited to services. A holistic view of women's health needs to include an emphasis on health promotion and prevention as well as medical services. Healing is not to be confused with treatment services, but has broader connotations of health and well being through spiritual and emotional activities, empowerment and political action. The health promotion tradition includes not only health education, but takes a broader approach that emphasized strengthening communities, building supportive environments, promoting healthy public policy, empowering people to work together to address the various determinants of health. This broader view is influenced by key documents such as the *Ottawa Charter for Health Promotion* (World Health *Organization, Health and Welfare Canada*, and *Canadian Public Health Association*, 1986). Health promotion encourages inter-agency approaches such as networks, partnerships and communications. Women should have the opportunity to seek and maintain wellness as they define it. Many health services provide "well woman" services to screen for disease and educate women about various issues and concerns across the lifespan:

The whole area of more counseling, resources, and family counselors - again, this ties into the notion of holistic community healing as well… We need to be working with the families and even beyond that. We need to be working with the community. (Street workers advocate-SK)

One of the things we are looking at implementing this year is a 'healing plan', a life plan, where people will look at different areas of their lives and identify for themselves different actions or activities that they would like to undertake. (Director, corrections-SK)

Some people recognized that personal health practices and women's wellness need to be addressed, along with treatment, in the continuum of services. Woman-specific prevention initiatives promoting healthy behaviour include tobacco reduction, physical activity and nutrition:

I would like to see our Healthiest Baby Possible program, or one similar to it, that would visit the woman through her pregnancy and follow her right up to when the child is five. I think that would make a huge impact in the lives of the women that are involved, not only on them but also on their children's lives. (Nurse, community health centre-SK)

Referrals

Making referrals is an area of notable care and attention among the majority of participants. Recognizing the limitations of individual services and the medical model that focuses on disease, referrals are made to link women with other services, but only those services that participant organizations think are appropriate, reliable and trustworthy. Most participants describe profound efforts to make sure that women get the services they require:

When we say the service is 'client-centred,' that means we don't connect anybody anywhere without them first saying they want that connection. … When a woman comes here and asks, "Can you direct me to counseling services?" what we do is give her a range of choices for counseling. Or if

she comes here and says she wants adult upgrading, then we connect her with what is available. So we have quite a bit of resources available, and try and leave the onus on the woman for what it is she is looking for. Then we try to match her up with someone to the best of our ability. (Program coordinator, urban women's shelter-SK)

I often will call ahead when I am referring someone to a program or person to make sure those things are still in existence. When I refer someone, I really try to make sure that the service or program is available, and that I am not just passing them along. That happens so many times to women, particularly when dealing with the government. We try to make sure that when we refer women, we are referring them to something that is actually there and will help them. (Program co-ordinator, sexual assault services-SK)

It is basically by the networking. If I don't know I put them in touch with someone who does know, so it's very informal. The 'moccasin trail' as they call it. Somebody always knows somebody or some way to do something. (Women's program coordinator, First Nation's organization-SK)

4. Responding to women's forms of communication and interaction

In addition to offering a range of choices and providers, woman-centred health service models emphasize positive and supportive communication. Women need to have a variety of opportunities to learn and communicate about issues of interest or concern to them, including support groups, one-to-one counseling and information they can take away and read on their own. It is also important that providers spend adequate time discussing health concerns and questions, are available for follow-up if desired, and will allow women to bring supportive people, such as family or friends, to programs. Women need to be supported in considering a number of options from which they can make decisions about their health and their lives. Rather than directly asking women to make a choice, providers need to encourage women to discuss the context of their decisions, and support them in the decision they ultimately make.

Various activities were described which underscore the need for a gendered approach to communication and interaction. Even if participants were not consciously presenting them as such, some described gender differences in styles of communication and interaction between men and women.

E. COMMUNICATION

Interview participants have observed that the women with whom they work prefer styles of communication that are interactive and informal.

Word of mouth

A lot of it is word of mouth - you can put up posters everywhere, but it seems that word of mouth is the best way to get women involved. (Gay and lesbian health workers-SK)

We also find with First Nation's persons that the written word is not as effective as personal contact. We focus more on the personal contact; we go out to reserves and do talking circles, presentations over lunch, etc. We also work specifically with the community health nurses who can speak in the language of the women. We also do similar things with immigrant women in the city. (Director, provincial screening program-SK)

Women need to talk

We have a 'Speak Out' wall which is a wall that you can write on about anything you want to speak out about. Usually women write something down about their abuse. (Program coordinator, urban women's shelter-SK)

I think that reflects "our" society where women are more able to ask for help (than men do). (Program manager, mental health agency-MB)

Drop-in situations

Services were described that have drop in programs, if not drop-in medical care, and other kinds of informal drop-in opportunities to make the services more available.

We have a space that is a common area, so if you just want to come in and have a cup of coffee, you can do that. You do not have to come up here only when you have a problem, you can read a book or visit with others. (Gay and lesbian health worker-SK)

Telephone contact

Receiving service via the telephone makes services both more accessible for women who cannot leave their homes for reasons such as caregiving responsibilities, and, as the physician below notes, more efficient:

If women have questions, they are welcome to call us at anytime to get answers. The answers will by provided by someone within the program or external to it. We put women in touch with contacts. (Director, provincial screening program-SK)

I can phone her, or she can phone me when it's convenient for her and we can talk just to check in and see if everything going OK, or do we need to change anything. And then I'll see her face-to-face in a month so that she doesn't have to come, with all that entails– transportation and child care and whatever else she has going on her life. It can be a 15-minute phone call versus a 2-hour ordeal. (Physician, community clinic-MB)

Diverse Languages

Of course communications and interactions are dependent upon common languages and understandings. Many of the participants described situations where they were trying to communicate with diverse cultural communities in the languages with which they are most comfortable. Many also noted insufficient funding to do this adequately:

A number of the staff speak different languages, and you do hear it occasionally … which I do think is very good. Some of the elders that we utilize don't have very good English. They prefer to speak in their own language. There is some translation that goes on. The local elders here, a number of them speak primarily Cree, so we do a fair bit of translation for them. When they're talking about traditions and ceremonies they want to be able to talk in their own language. (Director, corrections-SK)

We have 50 different language groups that we can provide interpretation for, yes. But not to provide the workshops in those 50 different languages, no. Workshops, we can provide right now maybe in 5 different communities. (Health educator, immigrant community-MB)

…At conferences we've provided ASL interpretation. (Program coordinator, community clinic-MB)

F. WOMEN GETTING TOGETHER

Women's interactions are described as relational, that is they are able to understand their own situation by hearing the stories of other women and comparing their own stories with those other stories (Belenky et al., 1986, Miller, 1986). They are able to provide support for each other as commonalties arise.

Groups

I find it empowering for these women when they bring their feelings out and their issues forward, because they sit there and they actually say to each other, "Thank you for being there, I am the only person who speaks about this. People want to, but they are scared." So you could feel the potential in the room. And it's exciting, it's really

great, I know that great things are going to come out of it. (Women's program coordinator, First Nation's organization-SK)

The elders tell us here that the circle itself is healing, just sitting in a circle is healing. You know, you don't have to say anything, just sit. In my experience– I guess I've done most of my work with women– there are women that I know that just come. When they sit in that circle, they start to cry and can't even talk. (Director, corrections-SK)

I think we need generic women's support groups. I don't think issue specific groups do it anymore. More book clubs, but they don't have to read books [laughs]. I think the support women want is life support, not endometriosis support so much, although that's the one [support group] that survived. (Physician, community clinic-MB)

Women-only groups

Women-only groups sometimes happen unintentionally if staff are not aware of gender differences and what draws women to groups. Sometimes they are set up intentionally for safety and comfort reasons:

Like we have had training sessions that are just women only. We actually don't allow men to come in, to provide women a safe environment to talk in. (Health educator, immigrant community-MB)

Participants also described work with groups of women formed around cultural identity, and deaf women's groups.

Information and education

Information and education also need to be sensitive to women's ways of communicating. Health information must be tied to women's needs and interests and be directed to their developmental and life stages. Information also needs to be available in a variety of formats, including verbally through shared stories (e.g., in a peer education setting), through face-to-face outreach to various communities, and by phone contact with trained resource people. Written material in particular needs to be adapted for language and literacy needs. All information needs to be presented in a culturally sensitive manner. Information needs to be available in a timely manner (e.g., in advance of receiving health care), and come from sources credible to the women.

Provide information in appropriate ways

We also have a lot of reading material. We give them packages, but if they can't take it home they can come here to read them. (Worker, northern crisis centre-SK)

We do actually provide individual sessions for women based on their request. And we have resources that they want to borrow, to go and use, to use them for talking to their girls. We do make that possible for them. And then we do have a general session for all. (Health educator, immigrant community-MB)

The information we share should be accessible to promote the ability to understand, to take control over one's own body, the use of plain language, the use of visual materials, different ways of teaching to help people make sense out of it. It's very much a political, social critique. Where is the information we're getting coming from? We augment; we just don't use the information that's from drug companies. We look at research that has been written by other consumer- or client-focused sources. (Program coordinator, community clinic-MB)

Overall there were a variety of information and education vehicles such as clearinghouses, Internet websites, newsletters, resource libraries, self-directed learning television programs and workshops. One example is a conference attended by a participant that acknowledged the principle

of participation of women and had components for both women and providers[6].

G. KNOWLEDGE DEVELOPMENT

Gender-sensitive research and evaluation goes beyond simply looking at differences between males and females on indicators that are presently being tracked by health organizations and/or their funders. Indicators need to be specific to women's health concerns, for example the impacts of abuse on women's lives and their abilities to carry out health promoting behaviours, work and maintain socially supportive relationships. Both statistics (quantitative data) and narrative (qualitative) methods such as interviews and focus groups are important to capture women's voices and to develop quantitative indicators that better reflect the context of women's lives.

Data needs to be presented in user-friendly ways, such as health profiles that contain both quantitative and qualitative results, and reports of main findings of women's health research and evaluation projects. Findings need to be disseminated to the broader public (e.g., through women's organizations and various media) as well as to academic and government audiences.

Knowledge development amongst participant organizations appears to be related to the resources available to any one group and therefore its ability to analyze data and conduct research. Participants described many research projects that were ultimately practical in nature, linked to program or agency development. Many keep data records because of funding requirements, but do not have resources such as time, staff, technology or expertise to analyze the data. Unfortunately many were not keeping data that would reveal the gendered nature of women's lives or their health and health care (see Hedman et al., 1996, Vancouver/Richmond Health Board 2000, Women's Health Bureau, 1999).

1. Evaluation

Evaluation is a type of applied research. However we discuss research and evaluation separately as the comments of participants reflected an understanding of evaluation as focused on types of data needed to enhance service planning and delivery. Research was seen as dealing with broader issues such as gender differences in health status that went beyond the immediate service context. Surveys of consumer satisfaction were the most commonly described type of research, though it is really a form of evaluation. Evaluation activities include participant feedback, cost analysis, auditing, and service use.

Feedback on service planning and delivery

Feedback is one way for women to have a say:

We have a suggestion box and often time – like it is kind of difficult to describe without seeing, but the atmosphere here is quite relaxed. And like I said, when young people feel that it is safe to say something, they will say, "You guys should be doing this." So we take all of that into consideration for sure.
(Director, sexual health program-SK)

The only thing we do is around follow-ups. We check to see if the women are satisfied. We just call them and talk to them.
(Worker, northern crisis centre-SK)

In this case a participant describes an example of cost analysis:

This grant is a participatory action (research) grant. We have asked 12 women to access their medical files over a 12- year period. We are comparing the costs of servicing the women from a traditional health perspective compared to the cost of a community-based service like [ours]. So we would like to see a healing centre like ours

[6] The name of the conference has been omitted for reasons of confidentiality.

funded through health dollars. (Program coordinator, urban women's shelter-SK)

In another case a community clinic linked accreditation activities with indicators for women's health:

We're starting to work towards accreditation where we will have much clearer quality indicators. It will be ready clear what we're trying to do. (Mental health workers, community clinic-MB)

Needs assessments

Some organizations have conducted needs assessments for both funding proposals and for service improvements. When doing health research and evaluation, it is important for researchers to consult with women to set priorities for what questions should be asked, and to involve them in the research process through participatory approaches. Participants identified that it is important for researchers to identify gaps in the knowledge base about particular groups of women (e.g., certain cultures, women with disabilities, lesbians) and work to address these:

Now what we are proposing and what we have a proposal in to just about every organization that you can think of, funding people, is that we want to conduct a comprehensive needs assessment that would, we would hope, take a year long. We have in there that it could happen in six months, where it would be very expensive, it would be very time consuming, it would have to bring on experts. But what it would actually do is give us for the first time, because even government is just pulling numbers out the air, an accurate assessment of exactly what we need to do to combat this issue. And we haven't had any success at all in getting this funded. (Women's program coordinator, First Nation's organization-SK)

We do constant needs assessments. As newcomers continue to come in and they begin to adjust to living in Canada, they begin to learn the language more and more; they can now access the services for themselves. They now know where to go, so the need begins to change. And therefore, our services change. Our program should be designed to cope with the dynamics of this community. As the needs change we should be able to provide a different kind of service according to the needs of the community. (Health educator, immigrant community-MB)

Importance of sex dis-aggregated data and gender analysis

Some of the women we interviewed spoke of keeping data on who was using their services. However, they did not always recognize the importance of dis-aggregating data by sex or other demographics. Data collected through research and evaluation of health services must be presented separately for females and males (i.e., sex-disaggregated data). This is important because it reduces gender bias in research by providing information on men's and women's health separately. This allows us to see and address similarities and differences between men's and women's health. When collecting data, the following should be included:

- vital statistics such as morbidity and mortality;
- service utilization;
- satisfaction with services received;
- social indicators;
- health behaviours and associated factors such as knowledge, attitudes and barriers;
- program outcomes;
- public opinions and preferences concerning health issues;
- community consultations.

It is also important to further break down data by additional categories that reflect diversity (e.g., age and income groups). We recognize that some data can be difficult to collect because the information is sensitive. Thus some aspects of diversity may be easier to document through qualitative consultations rather than large-scale population surveys or health system utilization statistics.

The need for adequate resources for evaluation

Funders may need to be more sensitive to the time and resources needed to collect and analyze data, and provide necessary resources to not only collect the data, but to build gendered information about both women and men:

We are looking at strengthening our database in terms of being clear on the demographics of our clients. (Director, regional health district-SK)

A lot of the compilation of data does not necessarily have a gendered aspect. So bringing gender into our data in order to see how to best serve the needs of women. (Women's program coordinator, First Nation's organization-SK)

The computer system is the pits. It's old, antiquated; it can't give us any data, which is really stupid. It can't even tell us how many people we've seen, let alone who they are or what we've seen them for. It costs money, speaking of challenges. (Physician, community clinic-MB

2. Research

There was interest among the participants, both in doing original research reviewing existing research and in the application of research to practice. Often research was linked to potential programming expansion and outreach. A number of participants were aware of the fact that women were excluded from or under-represented in research studies until the last decade, and also that there are gaps in research on women's health

We would like to do more research, but once again it is due to a lack of funding. Also, there is a cost of having someone out of the organization do the research for us. We would like to have a women's study done on the older women in the community and their health, but again, we do not have the staffing or the money to hire someone to do it. (Gay and lesbian health worker-SK)

We worked with a professor at the university and drafted a questionnaire…. The professor did an analysis on that and we did a position paper and presentation to government. We also posted the information on our website. (Program coordinator, sexual assault services-SK)

We also have to be aware that there is a difference between the assessment of a man and woman, let's say in cardiac care, in that they present differently. We haven't looked enough at this and we don't have enough research, and unfortunately most of the research has been done on men. So that is an area that we have to be very current with and make sure that we are keeping up so that we are not misdiagnosing women with things like hysteria or panic attacks, when in fact they are having a myocardial infraction. (Director, regional health district-SK)

In fact, to enhance skills in doing research we completed recently a six-week workshop series that I coordinated as a staff development piece. (Health educator, immigrant community-MB)

H. A WOMEN-CENTRED WORKPLACE

Women-centred care requires a women-centred workplace. In order for the workplace to provide women-centred care, various things have to be in place for the staff to enable them to support women. Some relate to staffing and others to the work environment and how everyone works together. A collaborative work environment, rather than a 'power over' hierarchical one, follows from an awareness of potential power imbalances between providers and women, and the effects of abuse of power. Models of work should support the health and well being of all types of staff. Mutual empowerment is the goal. Dis-empowered workers have difficulty working with women in mutual association and partnerships. Empowered providers can provide an environment that safe for

everyone, in which women can talk about health issues and their lives.

1. Collaborative work environment

Teamwork

Interview participants recognized both the benefits and challenges to using a team approach. An interdisciplinary team approach brings together different perspectives, from professional to paraprofessional, to lay workers and community volunteers, who together provide a more holistic view of individual and population health. This would include alternative or traditional medicine practitioners:

It is a challenge for us to work together well as a team. But it is very important that we do and that we take the time to shut the doors and say, "We need time as a staff, not only for ourselves, but in order to work better together." It is absolutely necessary that we work as closely as a team as possible, but again, there is certainly a fair amount of independence in the programs as well. (Street workers advocate-SK)

… and in regards to professionals, there is also the barrier of when professionals do not work together as a team and everyone is specialized. This just enhances the mind/body split or community-based/professional-based split. Women are really asking for a team approach…It is a multi-disciplinary team with the consumer as the head of the team. (Program coordinator, urban women's shelter-SK)

Flat organization

Some small agencies are using alternatives to conventional hierarchical ways of organizing services:

I think then the women look at the organization and realize there is not a hierarchy that goes on. Women are much more comfortable in a 'kitchen table' environment as opposed to having the pecking order. So when they see that exchange of relationships that aren't locked by stereotypical roles, I think they feel a lot more comfortable. (Director, national women's organization-SK)

2. Women-Centred philosophy shared in common

Participants described workplaces in which there were common values and philosophy from which staff were able to work together and to provide services. These common beliefs are in turn reflected in information and services to women:

Everyone is pretty much on the same page. I could see that being a problem if everyone was not on the same page, but everyone sort of has the same goal, which is to provide better, safer, and more supportive services. (Program co-ordinator, sexual assault services-SK)

We have strong consistency in our counselling model and our care model. We follow very consistent standards of care both in the clinical and counselling aspects. …So that women are getting the same information from different nurses or workers. (Director, regional health district-SK)

Here it goes beyond your just lucking out in working with us, it's embodied in the agency. So then it's reflected back into the whole fabric of the place, for instance in how we make decisions about what programs to offer. It's not made in isolation; it involves the staff. It doesn't just mean encountering one good caregiver; it has to be all of us working from the same principles. (Program coordinator, community clinic-MB)

Passion

Many spoke of their work in passionate terms. Passion was sometimes driven by a philosophical or political perspective, but more often by caring and compassion:

We get very intimately involved in people's lives and we go way beyond any sense of this as a job or occupation. It is more of a

vocation. We have been very fortunate that the people we have attracted to this agency are people who have certainly made that very personal and professional commitment. They do not see themselves as separate or distant from - we recognize that we have gifts and others have much to offer us as well. (Street workers advocate-SK)

I think they see I will go and help them no matter what so that they get what they really want. I will go the extra mile to help them and they know that. (Worker, northern crisis centre-SK)

3. Service providers as consultants with expertise in women's health

Participants discussed the need for different types of staff working together to offer an approach that recognizes the value of respecting women's own experiences and respects the expertise they develop through these experiences. It is also important that staff have expertise in women's health, broadly defined.

Roles

Some of those interviewed understood their role as facilitators of women's choices rather than making the choices for them. This often implies equality between women and health workers because of they collaborate together. The role of providers working in teams was also discussed in the context of changing the disincentives to do so. For example, fee-for-service limits the role of nurses, as doctors cannot bill for procedures done by nurses and nurse practitioners cannot bill either:

I see myself more as a consultant to her health and not dictating… My role is to explore that with them so that they understand what their choice is and what their options are. But if anyway she decides she wants to continue smoking, it's her life. I don't need to add grief to her life; she's probably got enough problems anyway. (Physician, community clinic-MB)

Female staff

Interview participants pointed out again in this context that some women often prefer seeing female staff:

The women wanted nurse practitioners because all the doctors in the community were males. They wanted females; they wanted the nurse practitioner to come in. (Nurse, northern community health centre-MB)

So I think having female staff helps. It also changes the 'flavour' of the place, the way people talk, the freedom they have to talk amongst the staff, and that spills over into the way the clients are served. They have commented on that– that it's really nice that it's women here. The culture of the place is much more female oriented. (Physician, community clinic-MB)

Staff reflective of the diversity of women

Some of those interviewed pointed out the importance of having staff that reflects the diversity of the population of women who access their services:

… As you diversify your staff and volunteers, you get a snowball effect of getting new people coming in. (Program coordinator, community clinic-MB)

Our entire centre is staffed by Aboriginal workers and I guess the cultural and spiritual beliefs underline all of the services that we provide. ((Nurse, community health centre-SK))

Expertise in women's health

There were also comments on the need both to have expertise in women's health issues and to share and learn from others:

A women-centered program is one that houses expertise. Expertise for us is on the health care side. It is professional to have an edge on mammography, counseling, family planning, and other things of that nature. It is having a concentration of

professionals who have expertise in a particular area and the focus is on a woman's needs versus the general population. (Director, provincial screening program-SK)

The administration and professional health care workers have the knowledge and expertise of the various components that go into making a woman's health experience or her disease experience, so that we are able to care for her in the most current and sensitive way possible. (Director, regional health district-SK)

I don't set myself up as the expert on everything. I think it's important for people to know I have a body of knowledge. I will share that with you. If they want to bring me stuff to read to educate me, I'm open to that, it's quite okay by me. It takes a lot of time sometimes. They come in with a binder of materials. But it's useful for me too. (Physician, community clinic-MB)

And yet, many participants described situations where there is no time for reflection:

I think that many women working with women are just trying to keep their heads above water. We don't have an opportunity to look around and ask, "What would look better here?" I think we can ask how to do things better, but sometimes we are so busy trying to keep our head above water that we don't have a chance to be a visionary about better ways of providing women's services and programming. (Program coordinator, sexual assault services-SK)

4. Workplace Practices

From interview responses, it is evident that for some agencies there is commitment to creating an open, safe and supportive working environment for staff as is described in the sections that follow.

Staff communication is vital for sharing information

So we communicate and it's all reported in the charts so everyone can see where this woman is at. We have integrated charting so the nutritionist's notes and the counsellor's notes are all chronologically in with our notes. (Physician community clinic-MB)

They worked in a very holistic way and they gave each other feedback. It sounded quite wonderful. ...How they found a way to work in a climate way that was very respectful. (Mental health workers, community clinic-MB)

Staff mental health and safety

Staff mental health and safety was mentioned by a few participants, but since so many workers are women, they face some of the same issues common to women:

Because of this research we did, we have become quite keen on Reiki and teaching women how to give Reiki to themselves. This is a huge stress reducer. The study indicates that women are able to sleep better because of Reiki.…We also do Reiki exchange within the organization. So if I am having a stressful time or a woman is, we can give each other Reiki treatments. And that is as simple as coming up behind me and putting your hands on my shoulders. We are practicing workplace wellness with the staff and the women. (Program coordinator, urban women's shelter-SK)

The other things that we do is when people are coming to the agency we certainly recognize that there are people who have preferences about whether they'll work with women or men and we listen to that and respect that. So that if a woman has

difficulty working with a man, she certainly will not be placed with a male worker, and the same for a man. The other side of that is recognizing the women workers' issues. If they are working with a man and that work becomes uncomfortable for whatever reason, then that would be changed as well, and is recognized as an issue to raise. So in that way there is some acknowledgment of gender differences and preferences. (Program manager, mental health agency-MB)

5. Gender and inclusiveness training

Training is a complex area. Many participants said there was no money for training. Many took opportunities up as they arose. Others were proactive within their agencies and spoke of the challenges both of training in general and with concepts specific to women-centred care. Many were as interested in diversity training as part of, or in addition to, gender or women-centred approaches.

Training initiatives should include how gender inequality can adversely affect women's health and include background on abuse, poverty, discrimination, economic dependency on partners, power imbalances in relationships, and cultural norms of caregiving as women's work. Such training also needs to address diversity among women; for example culture, sexual orientation as well as the prejudices women still face such as racism and homophobia as well as sexism. It cannot simply compare the lives of women and men. Training would help providers to respond more sensitively to women who use their services or programs, e.g., survivors of violence. Gender-sensitive training needs to be an organization-wide commitment involving both management support and staff involvement, and not dependent on the interests of individual managers or staff. Training is most effective if it involves ongoing consultation, educational materials (research and application information) and periodic information sessions or workshops, rather than single one-time workshops. Training will be most sensitive to women's needs if both women staff and women who use the services or programs are involved in developing and implementing the training:

I think the gender-based training is very important and we are very interested in that, and have the support of our CEO on that. (Director, regional health district-SK)

We have two staff members that are trainers and we have offered all the staff women-centred training. It's a ten-day training session and it is in modules, and it really speaks to women's issues. It talks about women's ways of knowing, talks about issues around abuse, sexual abuse, physical abuse, and family violence. (Director, corrections-SK)

We do provide training on diversity issues, not necessarily gender issues per se, but diversity issues is maybe the major thing that we provide training on. (Health educator, immigrant community-MB)

The challenges for training

Training in women-centred care has its challenges. Besides a common lack of funds and resources to deliver training, there is also the challenge of how to train workers in a different way of approaching care, with its unique lessons about women:

Physicians who work here don't have any special training. They come here and learn on the job. Some people learn better than others and are more comfortable than others, personality wise. (Physician, community clinic-MB)

Well, I find that we don't have money for us here to go to training. (Worker, northern crisis centre-SK)

Well I definitely think that sexual abuse is something that everyone should be aware of and you need to be aware of how widespread it is. I think it is also important to be aware of the long-term implications of it. Substance abuse is another poorly

understood and highly judged area. But, I think there are some people that won't be helped with training, and I don't even know what would help them. (Nurse, community health centre-SK)

Change processes in moving to women-centred care

Some people interviewed spoke of the process of moving away from looking at women and men in a gender-neutral way, and toward integrating women-centred care principles in their work with women:

I think that, for me, between woman-friendly and woman-centred, it would be an evolution process. Some say they are gender neutral, apparently which in actuality means that they just don't look at the needs of women. They are looking at the needs of men. It's entrenched in their policies. 'Women-friendly' means that they are starting to look at it, and recognizing indeed for different care models. And then 'women-centred' would have the different care model implemented right in. (Women's program coordinator, First Nation's organization-SK)

I think the staff needs the support to look at their assumptions and then to change them in ways that fit more the organizational assumptions and the sort of women-centred approach to practice. They also need to be able to talk about, 'This is what you want me to do, but I don't know if I can do it.' (Physician, community clinic-MB)

While one might ask, "Concretely, how can we move a service-providing organization towards women-centred care?" none of our participants had a 'how-to' handbook to lay out during our interviews. The specific steps of such a transformational process are important areas of future research.

As well, though not mentioned by the participants in this research, there may also be issues around resistance to gender-based analysis and care that is called "woman-centred". Similar concerns emerged from the interviews conducted with health regions/district managers in the *Invisible Women* project (Horne et al., 1999).

Training students

Some interview participants had structures in place for people to start getting practical and hands-on training in issues related to women-centred care practice as part of their education:

We do a lot of training with professionals in training, or people going through some sort of training programs-- social workers, nursing, medicine. …We've had nurses come from the North. We have nurses who come through for a couple of weeks at a time on rotation. (Program coordinator, community clinic-MB)

Train the trainer

Training can be costly both in terms of funding and human resources. Training some practitioners to in turn do more training is one way to build people's skills and engage them in training:

We are going to look at bias towards everything, including gender, ethnicity, age, sexual orientation. We are going to cover the whole gamut. What will happen is there will be some skill development and training, and hopefully the volunteers that attend will be able to go back and train other volunteers. That is our whole premise for this, or that they will in turn be able to teach the skills to other staff and volunteers. (Program co-ordinator, sexual assault services-SK)

I. A SOCIAL JUSTICE APPROACH

A social justice focus addresses the social determinants of health in particular – income, employment, education, social support and the physical and social environments – and how these play out differently in the lives of women and men and for people of different cultural backgrounds. Social determinants also

interact with other health determinants. For example, smoking, a personal health practice, is more prevalent among women with low incomes; child development outcomes are strongly linked to poverty (V/RHB, 2001 and Horne et al., 1999).

1. Advocacy

A social justice focus includes advocating at the political level for political, cultural, social and economic equality for women and men, as well as making a commitment to gender equity at the level of organizational policy. Advocacy is needed for individuals, for example with income and disability benefits, custody processes, housing, and at the system level.

As discussed in the earlier section on The Social and Economic Context of Women's Lives, participants see women at their agencies whose lives are affected by many societal issues such as gender roles, low income and poverty, racism and colonialism, abuse and violence, rural and northern isolation. The participants we interviewed often respond to these issues by supporting women in advocacy within the health and other systems. They also work more globally on the issues they see in their daily work, sometimes with success, but mostly with frustration. And they often have to deal with funders and government in trying to advocate for women's needs. They made a distinction between advocacy for individuals dealing with systems and advocacy to change policies that perpetuate unresponsive or unjust systems.

Client advocacy

We've talked about having a program to help women who have particular problems within the system to access it better. The system can be played. And there are certainly women who don't play it very well. We've toyed with the idea of setting up some kind of program where women could get the support and the training and the education that might be helpful for them to learn to advocate within the system better. (Physician, community clinic-MB)

… The goal [is] to assist people who deal with mental illness in their lives to begin to develop the skills so that they could do their own advocacy…. This program I believe can work well with men or with women. In the groups that appear, it's usually at least two-thirds women who come to this group. I think that may be true generally in the area of mental health where women are more likely to seek services anyway. (Program manager, mental health agency-MB)

Policy advocacy

I guess part of the challenge for us is that we are finding that the things we need to advocate for are things that have a political will or lack of will attached to them, which makes them that much more challenging. (Director, sexual health program-SK)

We do position papers to the government from time to time. … And those are both related to policy and health. Those are kind of very formal things. (Program coordinator, urban women's shelter-SK)

Well, I am trying to think of how to say this because as you know, we have a registered charitable status and you are not supposed to do advocacy. But is some ways I don't consider informing public discussion necessarily as advocacy. They might be interpreted as advocacy, but other folks might interpret it differently. But definitely we do presentations to the provincial government and send information to the federal government. (Program coordinator, sexual assault services-SK)

Making visible issues that affect women

Interview participants also spoke of the need to raise awareness of issues that many people find uncomfortable to discuss:

I created a binder ... that addresses homophobia. It is a resource manual for teachers, educators, social workers and administration on how to integrate programs into schools. We are trying to change programs like sex education to include sexual orientation, and are trying to change policies in order to make sexual orientation inclusive. We are also trying to make it safer for teachers to be 'out' at school. We work at starting a gay/straight alliance in the school and this is really hard because you have got teachers telling you that gay people are a specialized group. We constantly have to jump through hoops in order to get change to happen. (Gay and lesbian health worker-SK)

I would like a system that is actually able to talk about sexuality without choking on it. (Director, sexual health program-SK)

2. Effective uptake of women's issues by decision makers

The women we interviewed recognize the importance of being heard and being taken seriously by decision makers, and of working with other agencies and professionals to increase their effectiveness.

Credibility within the health system

We used to have not a lot of credibility; I think we have a lot more now. I think that is important because if you're going to make any systemic changes you need some credibility within the system to be able to do that. (Physician, community clinic-MB)

The medical system is a huge industry. So, even our own physicians, when they talk about what they do here, they see it perceived by their colleagues as 'less than'. You may be seen in a certain way in the women's community, as being able to work in a feminist organization. For the physicians it may be seen as a loss of credibility. (Program coordinator, community clinic-MB)

Getting the ear of government

In Saskatchewan we have a pretty good relationship with the government…. We have senior analysts come from those departments and it feels like we have the ear of government. For instance, when we wanted to present a position paper to government on the whole issue of client file confidentiality, it was fairly easy to arrange a meeting. Now whether or not anything ever comes of that, it feels like in Saskatchewan we have a pretty good rapport with government. Federally…we sent information a year ago and I haven't even got an acknowledgement that they received it. So I would say less so with the federal government. (Program co-ordinator, sexual assault services-SK)

I know that as an agency we are too small. Nobody is going to listen to us around that issue. It has to be a concerted community lobby to get that service. (Program manager, mental health agency-MB)

J. THE NEED FOR ADEQUATE RESOURCES

Participants pointed to the need for adequate funding resources in order to provide women-centred care.

Funding

Lack of adequate funding limits the ability of most participants to provide the kind of full range of services in order to meet the needs of women.

If we had more staff we would be able to offer better services for women. We haven't been able to run the women's group or even develop new programming for women because we only have two staff. We do all of our own training and fundraising and everything else, so it is really hard for us to commit those extra hours. We are under-

staffed. So I guess in that sense we would be able to do more. We feel very limited right now. (Director, rural sexual assault centre-SK)

That funder actually was accountable; it had a needs assessment and then we got to go back, and they gave us money. But a lot of times you don't; you have a needs assessment but you don't get. (Program coordinator, community clinic-MB)

Due to our lack of funding, we have stopped doing rural outreach. (Gay and lesbian health worker-SK)

Agency/program promotion

Agencies are often too busy providing services with limited budgets to have time to promote their services to the public:

I am not a public relations or media expert, nor do we have anyone connected with the agency at this point and time that is. We have seen agencies here that spend a good portion of their time, and the Executive Director's time, on marketing and creating a public image. That is something that we don't have the time, resources, and inclination to do. (Street worker's advocate-SK)

We're just too busy to promote it and to encourage it. (Physician, community clinic-MB)

...But we don't necessarily advertise the programs per se either, again because of the lack of number of workers that we could provide to serve people. (Program manager, mental health agency-MB)

CONCLUSIONS

PART 4

Women-centred care, as we found it in Manitoba and Saskatchewan, parallels the Vancouver/Richmond Framework and the framework from *Invisible Women*. We posed our questions in broader terms than the aforementioned frameworks and we used the frameworks to guide analysis, but not to restrict it. The many themes and findings arising from our analysis were much more specific than the framework categories. However, we found as we further organized the specific themes that many of them fit under the broad categories of the framework we initially developed from the V/RHB model and the evaluation framework used in the *Invisible Women* study. This is fitting because the previously developed frameworks were influenced by other models of women-centred planning and service provision, such as the Glasgow project. Our work then provides some validation of the frameworks, but also adds to it by fleshing out more specific elements (as reflected in our themes) of the broader framework categories.

Elements such as empowerment, respect, and safety are also present in the models underlying our working framework. Others such as Aboriginal spirituality and self-determination, integrated service delivery, common women-centred philosophy in the workplace, staff mental health and safety emerged here for the first time. Therefore, we find our initial working framework is particularly enhanced, and our understanding deepened, by evidence of how the workplace supports women-centred care and by inclusion of significant Aboriginal perspectives. Since the cornerstones of women-centred care did recur throughout the interviews, we can surmise that it is not enough to provide certain types of services that are merely 'directed to women'. Respect, safety, empowerment, the involvement and participation of women, and a focus on women must be present to truly label a service 'women-centred care'.

Our research demonstrates that all-encompassing women-centred care is comprised of the elements listed below.

The "cornerstones" of women-centred care are:

- A focus on women
- Involvement and participation of women
- Empowerment
- Respect and safety

Comprehensive services that reflect women's patterns and preferences for care and acknowledge women's ways of communication and interaction:

- Address the complexities of women's lives
- Are inclusive of diversity
- Have integrated service delivery
- Respond to women's forms of communication and interaction
- Provide information and education

Gender-sensitive knowledge development requires:

- Evaluation
- Research

A women-centred workplace must have:

- A collaborative work environment
- A women-centred philosophy shared in common
- Service providers as consultants with expertise in women's health
- Good communication and concern for staff mental health and safety
- Gender and inclusiveness training

The fact that so many of these elements are consistently present across different models of women-centred approaches and frameworks shows that, in fact, our research is consistent with other conceptualizations of women-centred care. It also demonstrates that women-centred care is a well-established practice even if the language of women-centred care is not widely used in public discourse and media, or is used in a way that is not clearly defined.

Interview participants described both their own service sites and drew upon other examples they know of from across the two provinces. These examples can pave the way for others to assess their own practices and learn ways to enhance practice or build new programs. Women can use the examples to validate their own experiences and requests for changes in service delivery. Ongoing public and organizational processes such as program planning, consultations, evaluations and accreditation can also engage in scrutiny of this document and the elements and develop tools and methods to implement women-centred care in sites of service. In British Columbia, *A Framework for Women-Centred Health* is used as a template in planning new services, in evaluating services, and in developing research proposals. Some health care workers working with youth are adapting this Framework to create a youth model. Others are trying to integrate its concepts within the accreditation manual and processes.

What is evident is that public policy in health governance and government needs to catch up with what practitioners are doing. Policy makers could indeed expand policy parameters so practitioners can take their visions of women-centred care to the levels that would provide greater benefit to the health of women. As we saw, many of these practitioners base their practices the needs of women articulated by women.

We saw many a desire to base women-centred practice in research and evidence, but we also heard that funding has been lacking to do this, as it has been for expansion of programs to further meet women's needs. Evaluation of women-centred care practices is critical for policy makers so that future policies can be built upon what has been learned. Research that takes a gendered approach and uses data to describe the context of women's lives, rather than solely counting numbers of clients, is crucial for all concerned. Currently practitioners are constrained by limited resources. Adequate resources are required to enable services providers to deliver care based in women’s lives that responds to women’s needs.

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APPENDIX 1

Women-Centred Models of Health--Interview Questions

Preamble
Explain:

- The purpose of the research
- What will happen to the information
- The confidentiality protections

Questions:

1. Could you briefly describe services or programs that you provide specifically for women (or mostly for women)? What are some other programs that you provide for both women and men?

2. How would you describe your approach to health and health care?

3. Does your organization purposefully design programs or services to take into consideration the particular needs or life situations of women? How do you make your programs 'woman-friendly'?

4. Would you describe any of your services or programs as 'woman-centred? What does 'woman-centred health programs' mean to you? What are the key characteristics that make them, or would make them, woman-centred?

5. How does your organization ensure that women feel comfortable participating in your programs or services? What does your organization do to help women feel safe in your environment?

6. What does your organization do to help women address any issues in their lives that are stressful for them?

7. What changes or improvements would make the program(s) more effective in promoting women's health? What about new or different program elements beyond what you do now?

8. What would you need to make these improvements and changes possible? What are the barriers?

9. What specifically do you do to ensure that your programs are accessible and effective for the broadest diversity of women (examples)?

10. Does your organization carry out any informational or educational activities? In what venues, formats and languages?

11. Do you encourage and support women program participants to become involved in your organization, e.g., in program planning and delivery, or decision-making? How?

12. To what extent do staff members in your organization work together in teams to provide programs and services? How do they do this?

13. Does your organization carry out research connected to any of your programs? (This could include needs assessment, program evaluation, statistics on service use, satisfaction surveys, and policy development research.) Do the women who participate in your programs have any involvement in these research activities? How are they involved?

14. When you collect data, do you look at the data for women and the data for men separately? Do you look at the data by other factors (age, ethnicity, etc)?

15. Is your organization involved in any advocacy activities to promote improvements in women's health services or for broader social policy changes that would improve the conditions of women's lives?

16. Do you provide training for your staff, board members, or volunteers on gender issues? Do you provide training on diversity issues (e.g., age, ethnicity)? Is there other training or information that you feel is important to woman-centred programming?

17. Do you help women to connect to other women and to other programs or services that would benefit their health? How? What types of programs?

18. Can you recommend to me another example of what you consider to be a really good model of woman-centred health programming in Manitoba (or Saskatchewan as relevant)? Or one that you consider interesting, innovative or taking a quite different approach that you think might be worth looking at?

19. Do you have a mission statement, statement of philosophy, or program description? May I have a copy?

20. Any other comments to add?

APPENDIX 2

Circle of Services

Information
e.g. – Resource Centre
- Info Packages
- Info Sheets/Kits
- Newsletter
- Phone Triage

Action Groups
- Action
- Research
- Policy Analysis & Development
- Networks/Public Meetings
- Women & Health Reform
- New Reproductive & Genetic Technological Network

Counseling
e.g. – weight preoccupation
- Past abuse
- Stress and self care issues
- Youth Dating Violence

Information Sessions, Outreach & Community Presentations
e.g. – Menopause
- Motherhood Stress
- Weight Preoccupation
- Growing Older
- Healthy Relationships

Liaison/Collaboration with other services and sectors

Multiple points of entry

Most appropriate care provide and service

Women encouraged to access information services

Support Groups & Self Help Groups
e.g. – weight/body image
- Endometriosis
- Aging
- Mothers
- Breast implants
- Smoking cessation
- Youth Dating violence

Professional Consultation/Counseling*
e.g. – Medical
- Dietitian
- Health Educator
- Mental Health Practitioner
- Teen Clinic

* Usually limited # of sessions

Medical Care
e.g. – Well Women Care
- STD/AIDS/HIV
- Birth Control & Unplanned Pregnancy
- Teen Clinic

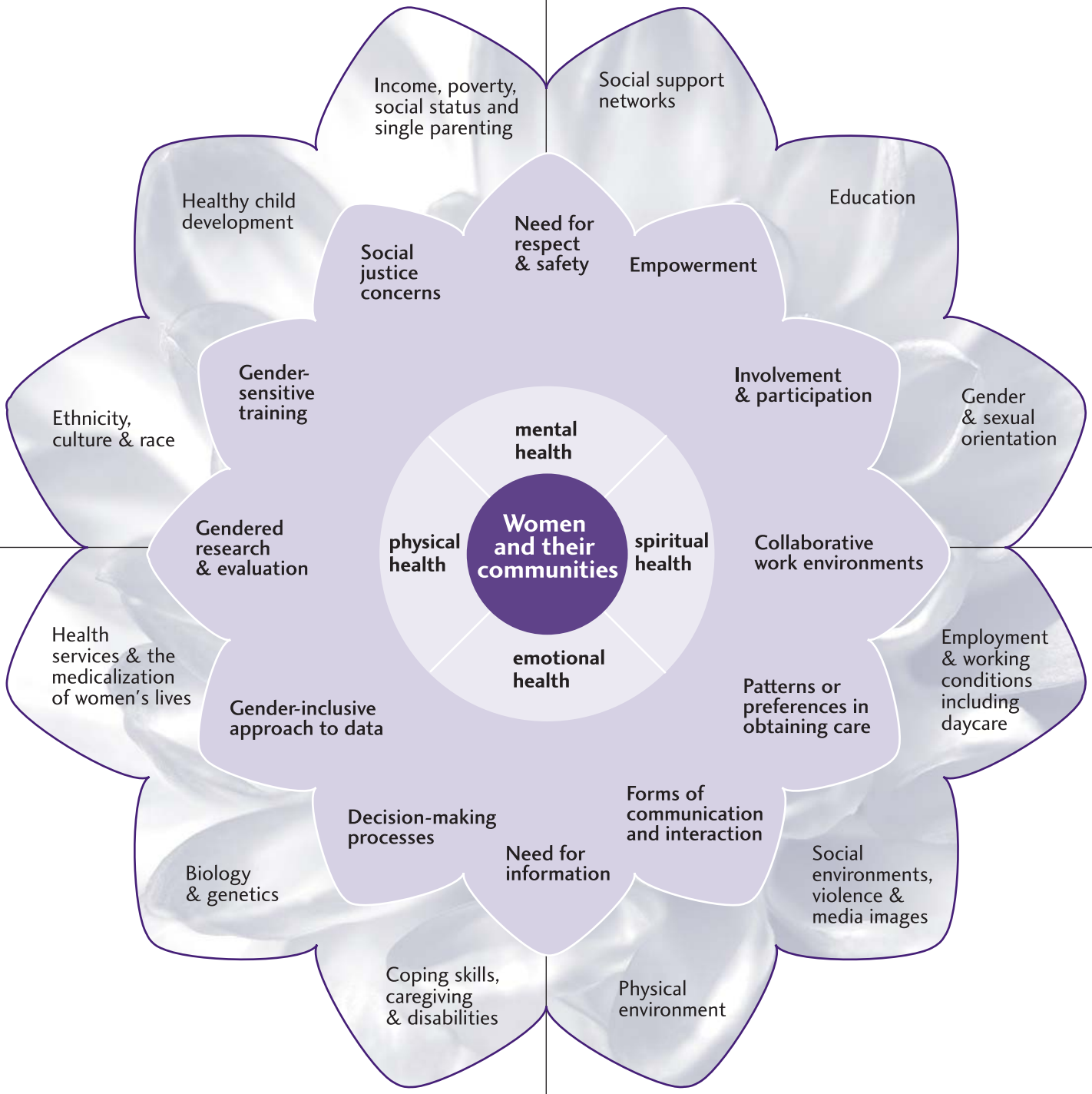
Peer Counseling
e.g. – Birth Control/Unplanned Pregnancy Program
- Teen Clinic

Empowerment
- Individual (skill development, knowledge
- Group (self help, action)
- Community

Input to WHC Programs
- Client Surveys, Program Evaluations
- Membership in Women's Health Clinic
- Participation on Committees and Board
- Advisory Committee
- Volunteering

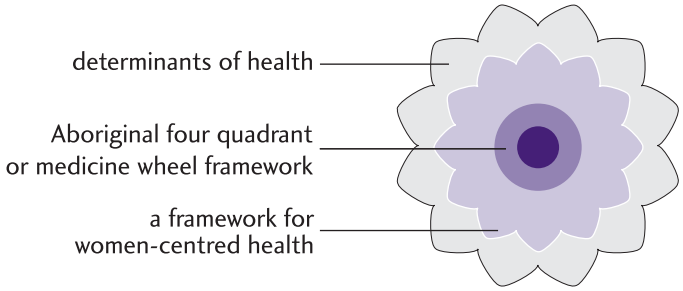
System Change
- Reframing health issues
- Demonstration of best practices & gender sensitive services
- Research & issue identification
- Policy analysis & development
- Community education
- Stakeholder working groups

Note: The services noted above are intended to provide examples and are not an exhaustive listing of WHC services.



A framework for women-centred health

KEY TO CHART



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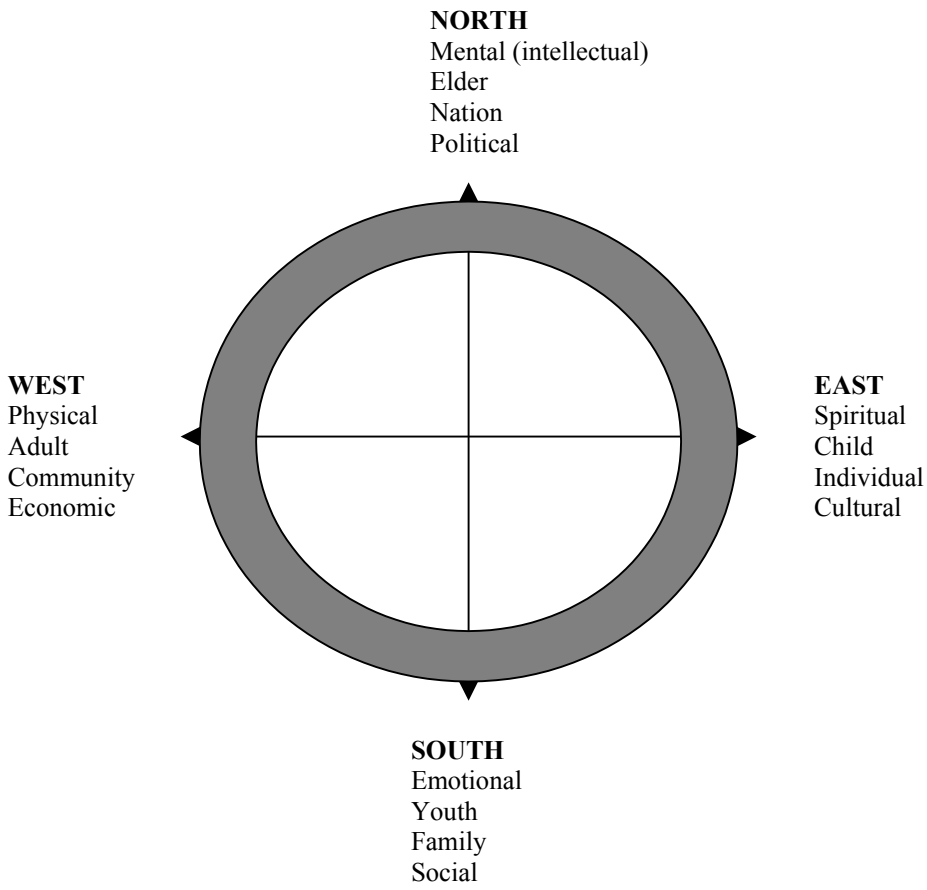
Places to start

Are the differences between women and men reflected in your services, programs, policies and frameworks?

question	YES	NO	SOMEWHAT	UNSURE	action	framework element
Have you considered ways to make your service/program safe for women and girls?						Respect and safety
Do you facilitate women being able to have a sense of control over their lives?						Empowerment
Are women and girls involved in decision making about services and programs?						Involvement & participation
Does your work environment support you to provide programs that support women empowering themselves?						Collaborative work environments
Are you aware of women's preferences in obtaining services or care?						Patterns or preferences in obtaining care
Do you encourage or provide ways for women and girls to meet together and support each other?						Communication and interaction
Do you ask women if information is presented in ways that they find accessible?						Need for information
Do you support women making decisions about health differently than how you support men?						Decision-making processes
Does your service collect data that distinguishes between women and men?						Gender-inclusive approach to data
Are you aware of current research that documents health issues for women that are different from men's?						Gendered research and evaluation
Do you measure all women's experiences by one standard of race, ethnicity, sexual orientation, abilities, income level and age?						Gender-sensitive training
Does your service or agency support providing equality of opportunity and health outcomes for both women and men?						Social justice

APPENDIX 4

Elements of the Medicine Wheel (after Bartlett 1994)



MEDICINE WHEEL MATRIX			
East	**South**	**West**	**North**
Spiritual	Emotional	Physical	Mental
Child	Youth	Adult	Elder
Individual	Family	Community	Nation
Cultural	Social	Economic	Political