Producing a Profile of the Health of Manitoba Women

Background Report

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centres of excellence *for* WOMEN'S HEALTH

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THE PRAIRIE WOMEN'S HEALTH CENTRE OF EXCELLENCE (PWHCE) is one of the Centres of Excellence for Women's Health, funded by the Women's Health Contribution Program of Health Canada. The PWHCE supports new knowledge and research on women's health issues; and provides policy advice, analysis and information to governments, health agencies and non-governmental organizations. The views expressed herein do not necessarily represent the official policy of Health Canada.

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Abstract

Prairie Women's Health Centre of Excellence (PWHCE) was commissioned by Manitoba Health to conduct a feasibility study for a *Manitoba Women's Health Profile,* in keeping with the provincial *Women's Health Strategy* (2001). The goals were to review profiles and surveillance reports from other jurisdictions, and the response to them; and to recommend elements to be included in a *Profile* for Manitoba.

PWHCE struck an expert committee to advise on evidence from other jurisdictions, and the feasibility and usefulness of data sets with relevant data on Manitoba women. (It is valuable to note that the profiles and surveillance reports reviewed have been extremely popular, and requested by a variety of users. Equally important, there are plans in each jurisdiction to proceed with next steps and updates.) Even while agencies such as the World Health Organization are proposing to consider as many as 1000 indicators of women's health for an international surveillance project, PWHCE and the Advisory Committee have considered which indicators can provide a pragmatic, cost-effective understanding of the health of women who live in Manitoba.

The *Manitoba Women's Health Profile* proposed here would include a broad definition of health and be based on a population health framework, recognizing both medical and non-medical determinants of health. A *Manitoba Women's Health Profile* should include, wherever possible, data which reflect the diversity of Manitoba women including differences in income, Aboriginal ancestry, age, disability, geographic location, migration and racism.

The possibility for this *Profile* to be developed concurrently with a report by the Manitoba Centre for Health Policy on gender differences in health status and health services utilization (and now with an offer for collaboration from Health Canada), creates a wonderful opportunity to produce two complementary documents, which together will provide needed information about the health of Manitoba women.

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1. Introduction and History

The Minister of Health and the Minister Responsible for the Status of Women of Manitoba endorsed the Provincial *Women's Health Strategy* in 2000. One of the initiatives in the Strategy was the publication of a Women's Health Profile. Since that time, a number of statistical reports and data on health indicators have been produced in other jurisdictions including Ontario, British Columbia and one by the Women's Health Bureau of Health Canada. Manitoba Health commissioned the Prairie Women's Health Centre of Excellence (PWHCE) to:

- ✓ review similar reports produced in other jurisdictions and the results of those reports; and
- ✓ recommend the elements to be included in a profile of the Health of Manitoba Women, focusing on both information not already available and information which would be useful to Regional Health Authorities and Manitoba Health in the health planning processes.

The PWHCE contracted Lissa Donner to prepare this report and to make recommendations about the potential development and publication of a *Manitoba Women's Health Profile*. PWHCE established a Project Advisory Committee to provide broader expertise (See Appendix 3). Committee members included three researchers in community health sciences, health providers and practitioners, representatives from Manitoba Health, a community health librarian, and a representative from a community agency for women with disabilities.

Section 2 of this Report describes the literature reviewed for this project. It includes information about the experiences of producing women's health indicator or surveillance reports in selected other jurisdictions, and the responses the reports have received.

Section 3 describes the issues involved in selecting indicators of women's health for Manitoba.

Section 4 provides a set of proposed indicators of the health of Manitoba women. These were selected to provide information about women's health in the broadest sense, understanding the importance of providing information about health status, morbidity and mortality, as well as about other important non-medical determinants of women's health. This selection of indicators is consistent with Canada's

international commitment, as a signatory to the 1995 United Nations *Beijing Platform for Action*, which states in part:

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

Even while the World Health Organization is proposing to consider as many as 1000 indicators of women's health for an international surveillance project, the author and Advisory Committee have considered which indicators can provide a pragmatic, cost effective understanding of the health of women who live in Manitoba.

Recommendations for action are included in Section 5.

While this work was in progress, PWHCE learned that the Manitoba Centre for Health Policy (MCHP) will produce a report on gender differences in health, health services utilization and health outcomes, as one of its "deliverables" to Manitoba Health in the next fiscal year. This is an exciting opportunity, welcomed by the PWHCE, as the MCHP and the *Profile* will provide complementary information. Some of the indicators suggested for inclusion in the *Profile*, notably those in Section 4.I.C., 4.I.D., 4.I.E. and 4.I.F. might be better included in the MCHP report. Discussions among PWHCE, MCHP and Manitoba Health are already planned.

PWHCE looks forward to further collaboration with Manitoba Health and the Manitoba Centre for Health Policy on the development of the *Manitoba Women's Health Profile*.

2. The Experiences of Other Jurisdictions

2.1 Reports Reviewed

In the past three to four years, a number of jurisdictions have developed women's health profiles or surveillance reports. The following reports on the health of women in Canada and internationally were reviewed, both in order to understand the issues involved in reporting about women's health (see section 3 below), and in selecting proposed indicators of women's health for a Manitoba *Profile* (see section 4 below).

British Columbia Women's Health Bureau (1999) *Provincial Profile of Women's Health: A Statistical Overview of Health Indicators for Women in British Columbia*, Victoria: British Columbia Ministry of Health and Ministry Responsible for Seniors

British Columbia Women's Health Bureau (2001) *Provincial Profile Of Women's Health: Updated Data On Selected Indicators For Women's Health In British Columbia*, British Columbia Ministry of Health Services

Colman, R. (2003) *A Profile of Women's Health Indicators in Canada*, Prepared for the Women's Health Bureau, Health Canada, Halifax: GPI Atlantic

Colman, R. (2000) W*omen's Health in Atlantic Canada: A Statistical Portrait* Halifax: Maritime Centre of Excellence for Women's Health

Health Canada (2003) *Women's Health Surveillance in Canada*, Ottawa: Minister of Public Works and Government Services Canada

Lin, V., S. Gruszin, C. Ellickson, J. Glover, K. Silburn, G. Wilson, and C. Poljski (2003) *Comparative Evaluation of Indicators for Gender Equity and Health*, Kobe: Women and Health Program, World Health Organization, Centre for Health Development

Misra, D. (2001) *The Women's Health Data Book: A Profile of Women's Health in the United States*, 3rd Edition, Washington, DC: Jacobs Institute of Women's Health and The Henry J. Kaiser Family Foundation

Statistics Canada (2000) *Women in Canada* 2000, Ottawa: Minister of Industry

Statistics Canada (2003) *Women in Canada: Work chapter updates*, Ottawa: Minister of Industry

Stewart, D. E., A.M. Cheung, L. E. Ferris, I. Hyman, M.M. Cohen, and J. I Williams (2002) *Ontario Women's Health Status Report*, Toronto: Ontario Women's Health Council

Women's Health Bureau (1999) *Provincial Profile of Women's Health: A Statistical Overview of Health Indicators for Women in British Columbia*, Victoria: Ministry of Health and Ministry Responsible for Seniors

A complete list of the literature reviewed in the preparation of this report appears at the end of this document.

2.2 Lessons Learned in Other Jurisdictions

Interviews were conducted by telephone with selected individuals with experience in the production and use of similar reports in other Canadian jurisdictions. These were:

- Barbara Clow (Executive Director, Atlantic Centre of Excellence for Women's Health, interviewed about *Women's Health in Atlantic Canada: A Statistical Portrait*);
- Marie DesMeules (Chief, Population Health, Health Canada, interviewed about *Women's Health Surveillance in Canada*);
- Ann Pederson (Associate Manager, Research and Policy, British Columbia Centre of Excellence for Women's Health, interviewed about *Provincial Profile of Women's Health: A Statistical Overview of Health Indicators for Women in British Columbia* and its 2001 updated version).[1]

All of these informants reported that their reports had been popular and well received.

Health Canada's *Women's Health Surveillance* Report met with an overwhelming response. It was published in two formats: a print form (with the complete introductory and concluding chapters and with

[1] It was not possible to obtain an interview with a representative of the Ontario Women's Health Council regarding their report.

summaries only of the chapters on specific issues in women's health) and an electronic form (with the complete text of each section of the Report available on line). This was done because of the length of the document. The print version is now out of stock. Health Canada received extensive media coverage with its publication, and it has also been popular with academics, non-governmental organizations and health professionals.

Health Canada's approach was to invite experts in each of the issues selected to edit that chapter of the Report. This had both advantages (those selected were very knowledgeable about the issue under review) and disadvantages (those selected were less familiar with the use of survey data, much of which had to be prepared for them by the staff of Health Canada). Each chapter was peer reviewed prior to publication.

Health Canada is now working towards the publication of a second report, which would include more information about differences among Provinces and Territories, and among regional health bodies. Funding has not yet been secured for this project.

In the case of British Columbia, there was a change in government shortly after the publication of the *Provincial Profile of Women's Health.* The new government's philosophical approach was quite different and the B.C. Women's Health Bureau was re-organized as part of a new Office of the Special Advisor on Women and Seniors Health. Funding for the Women's Community Health Grants Program was eliminated. However, the *Provincial Profile* remained, and it has remained a useful tool for those pursuing improved health for women. Data in the Ministry of Health's Health Data Warehouse, available to Regional Health Authorities, is now routinely sex-disaggregated. The *Profile* was one important piece of evidence in helping to make this a routine practice.

The Atlantic Centre of Excellence for Women's Health published *Women's Health in Atlantic Canada: A Statistical Portrait* in 2000. They have had a very good response to this document, and have been working with the original contractor (Ron Colman of Atlantic GPI) to produce an updated version. The update will include the detailed references which the Centre chose to exclude from the original *Statistical Portrait*.

The first *Statistical Portrait* had different audiences, with different needs, including policy makers, students and health professionals.

Given this, any future versions will be published in multiple formats including a complete text with references, an abridged version for popular use, and policy fact sheets on specific issues. As well, based on consultations with representatives of the Scottish Executive Office (who have published social inclusion indicators), they recommend including international comparisons wherever possible.

It is valuable to note that all of these profiles and surveillance reports have been extremely popular, and requested by a variety of users. Equally important, there are plans in each jurisdiction to proceed with next steps and updates.

3. Issues in the Selection of Indicators of Women's Health

The *Manitoba Women's Health Profile* proposed here would include a broad definition of health and be based on a population health framework, recognizing both medical and non-medical determinants of health. The Canadian Institute for Health Information (CIHI) provides the following definition of health indicators:

Health indicators are standardized measures by which to compare health status and health system performance and characteristics among different jurisdictions in Canada. (CIHI, *Health Indicators* *http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=indicators_e*)

In the CIHI definition, the comparison of interest is among different Canadian jurisdictions. Others have used health indicators as a way to measure change over time. In this proposal, indicators are suggested as measures of the differences in health between women and men, and among different groups of women. We propose the *Profile* be structured around 110 indicators of women's health. This is a modest proposal compared with recent WHO proposals for over 1000 indicators (Lin et al. 2003). Other jurisdictions must make also practical decisions based on the original goals and objectives and the availability of data and other resources.

3.1 Developing and Expanding the Evidence Base

A *Manitoba Women's Health Profile* would be an important health surveillance tool. In an ideal world, where policy is based on evidence, surveillance guides intervention. But, before that, existing ideas about health and illness also guide surveillance, since we look for the issues which we have already identified as problematic. For example, most research about occupational health hazards has been done using groups of men. Therefore, there is limited evidence about the similarities and the differences in women's and men's occupational health.

One of the challenges in determining what indicators should be included in a profile of women's health, is to do so in such a way as to allow us to discover new information about women's health and to develop our understanding of the ways in which gender influences health. This is difficult since data gathering and analyses are expensive. In selecting indicators to be included, it may seem to be most rational to focus on that which we already know to be true. However, as Sari Tudiver has noted:

Traditional health indicators, based exclusively on sex-disaggregated data, do not adequately reflect the interrelations between biological processes, social roles, socio-economic context, the health care system and health outcomes. Various types of statistical analysis, such as multivariate analysis, incorporate some considerations of social roles and other aspects of gender, but the challenge is to develop indicators that reflect the complex interconnections among health determinants and health outcomes, including key differences in health and well-being between women and men, boys and girls. (Tudiver p. 75)

Women's groups, women's health advocates and researchers outside of government are essential to broadening the definition of what is "true" about women's health. They identify new and emerging issues, help to identify areas where surveillance lags behind the experiences of individual women and service providers, provide important perspectives based on those experiences, lobby for new research initiatives, conduct research themselves and finally, develop policy recommendations based on those findings.

The emphasis in the selection of the proposed indicators in Section 4 below has been on using existing knowledge about the determinants of women's health, women's health status and gender differences in health. Additionally, some of the proposed indicators have been included in this spirit of open enquiry about gender differences in health.

It is also important to acknowledge that all of these indicators, whether based on quantifiable data (such as the numbers of women living on low incomes) or qualitative data (such as women's reported self-rated health) lack the richness in-depth interviews and personal stories can provide.

3.2 Finding the Right Balance Between Medical and Non Medical Indicators

Given our existing knowledge about the importance of non-medical determinants of women's health, a Manitoba *Profile* should include a balance of information about both the medical and the non-medical determinants of health.

A Manitoba *Profile* would be enriched by access to Manitoba Health's administrative data, which includes data about all physician visits and hospitalizations among Manitobans. However, this would have to be supplemented by data from other sources, which would provide information about the social and economic contexts of women's lives and about women's own perceptions of their health. Especially exciting would be the opportunity to link the Manitoba Health data with data about Manitoba women from the 1996-97 National Population Health Survey, and to supplement this with information from Manitoba's Pharmacare data. Such a Profile would place Manitoba in a leadership position, well ahead of the other women's health indicators reports considered here.

It is important to note the current limitations of the Manitoba Health administrative data (hospital separations and physician visits). These are:

- data about services provided by other caregivers are not included (data for midwives are held in a separate set);
- data from physicians outside of the fee-for-service system (such as those on salaries at community clinics and hospitals) may be incomplete; and
- First Nations status is assigned through self-declaration and is therefore incompletely captured.

Furthermore, we could not include indicators of women's access to dental and other non-insured services, as there are no similar data repositories. These would have provided valuable, additional indicators of women's health, especially for poor women, whose access to uninsured services are restricted. Data held by individual RHAs (such as emergency room visits) could add to the richness of a *Profile*.

3.3 Availability of Sex Disaggregated Data

In recommending which indicators to include in a profile of women's health, the selection is limited to information which has been collected in a way that allows data about women and men to be analyzed separately. This is true for both the medical and the non-medical indicators of health. While the presentation of sex-disaggregated data is now becoming a more common practice, it is not always routinely done.

For example, data about wealth in Canada (as opposed to income) has been collected by Statistics Canada only at the household level, not at the individual level. While there are valid reasons for looking at household wealth, it does assume that household wealth is equally available to all within the household. Additionally, since divorce and separation result in immediate declines in women's standards of living (which has a negative impact on health), understanding women's own wealth would be useful.

The reporting of health information at the household level is also problematic because it is assumed that the person responding to the survey (usually a woman) is able to respond knowledgeably about all family members. It masks gender inequities within households and closes the door to learning about those "family secrets" sometimes not discussed among family members - issues like abortion, mental health problems and family violence - which are important in understanding community health.

A second problem occurs when data which have been collected for males and females separately are published in a way that either combines male and female data, or when sex-adjusted data only are published. There are valid reasons for presenting data in these ways, but to do so to the exclusion of presenting sex-disaggregated data makes gender differences invisible. A recent example of this is the Statistics Canada publication *Access to Health Care Services* (2001). This report draws on data from the Canadian Community Health Survey, in which information about the sex of respondents was collected. All data presented in the Report were sex adjusted, despite the availability of the data by sex, existing knowledge about gender differences in health care utilization, and Canada's commitments under the *Beijing Platform for Action*[2].

[2] For example, Strategic Objective H3 commits those governments which signed the *Platform for Action* to "generate and disseminate gender-disaggregated data and information for planning and evaluation." Article 206 under this objective calls on national statistical services to disaggregate data by sex, age and other socio-demographic indicators.

3.4 Sex as a Proxy for Gender

This proposal to publish a Manitoba *Women's Health Profile* is based on existing knowledge about the importance of gender as a determinant of health, the ways in which gender interacts with other determinants to influence the health of women and the desire to learn more about these issues in order to improve health and health care delivery. However, where available data are disaggregated by sex, and in using them, we assume that sex is a good proxy measure of gender. As Vivienne Walters noted

...gender refers to a complex web of changing roles and relations, and the use of sex as a proxy for gender will yield a very limited understanding of the way gender and health are linked. We need to develop other measures that are based on a much finer appreciation of how women's and men's lives are structured by gender, and these in turn can be reflected in women's health surveillance and other policy initiatives..

...changes in job security, family structure, income levels, dependence on benefits and availability of public services are al key aspects of gender relations. They shape expectations of men's and women's roles and the resources that are available to them to meet these expectations. When sex is used in the analysis of health data it serves as a proxy for gender, and these are some of the unwritten, unspecified elements of gender relations. The problem we face is that such a single measure cannot hope to capture the complexity of gender or the ways in which gender relations change over time and give rise to or exacerbate health problems. (Walters pages 2 and 5)

While acknowledging this limitation, is it important to proceed with the data available to us, and continue to work to develop research methods which enable us to understand gender in a deeper way.

It is also important to recognize the limitations of indicators in understanding women's health. As Tudiver has stated:

There are limits to structured surveillance tools, including well-defined indicators. Surveys and indicators must be augmented and informed by qualitative research to reveal the context behind the limited answers available through traditional indicators. Other sources must be critically mined for evidence on sex, gender and diversity to answer policy-relevant questions: "Why did this trend or pattern occur?"

"What are the short and long-term implications for the health of women and men and for particular subgroups?" "What specific policies and interventions are likely to be most effective in achieving improved health outcomes and reducing health inequalities?" A gender lens can be applied to historical reviews of trends and policies, other theoretical and analytic work, biomedical and social research, policy research and evaluation, risk assessments, environmental scans and health technology assessments to achieve a more comprehensive understanding of an issue and to further refine indicators for women's health surveillance. (Tudiver p. 76)

3.5 Diversity Among Women and Vulnerable Populations of Women

A *Manitoba Women's Health Profile* should include, wherever possible, data which reflects the diversity of Manitoba women. Important issues to consider include: income, Aboriginal ancestry, age (especially the situations of young women and senior women), disability, migration and the effects of racism on visible minority women.

However, our ability to do this with existing data is limited. This points to the need for more in-depth studies, using both qualitative and quantitative data. The potential MCHP report, on gender differences in health status and health services utilization, would allow for more exploration of these issues. MCHP has the capacity (when the necessary approvals have been received) to link Manitoba Health data about health services utilization, with data from the 1996-97 National Population Health Survey (NPHS). NPHS data include self-reported information about ethnicity, disability and Aboriginal ancestry, as well as self-reported health status and measures of well-being.

Information about Aboriginal women is especially important in any report about the health of Manitoba women. Therefore, we recommend that the *Profile* include a separate chapter on the health of Aboriginal women, to be developed in consultation with Aboriginal experts and others with expertise in the health of Aboriginal women. Other research has suggested that indicators of Aboriginal health should include health-seeking behaviours, positive coping strategies and individual and community resilience (Tudiver 2003).

When using Manitoba Health data about hospitalizations and physician visits, it is possible to include information about one group of Aboriginal Manitobans: those First Nations people, who, through self-declaration, have advised Manitoba Health that they are residents with Treaty Status. While these data do not reflect the experience of all First Nations Manitobans, nor of all Aboriginal Manitobans, it is recommended that they be included wherever possible. Information about mortality among First Nations Manitobans is available from Manitoba Vital Statistics only for those people who live on reserves.

Geographic diversity is also important in the lives of Manitoba women. Therefore, wherever possible it is recommended that data be disaggregated by Regional Health Authority (RHA). Data from both Manitoba Health and the Canadian Community Health Survey can be presented by RHA. In some cases, because of small numbers, this will not be possible. In these cases, it would be useful to follow Manitoba Health's practice of disaggregating the data into three regional groups (Winnipeg, Rural South and North). This would capture some of the differences between rural and urban women.

Ron Colman has stressed the importance of incorporating these factors into an understanding of women's health:

In short there is an element of gender-based "social exclusion" that underlies and goes beyond income issues. For groups that are disadvantaged in other ways – as Aboriginals, refugees and recent immigrants, visible minorities, people with disabilities – gender discrimination may exacerbate other social and economic biases, deepening exclusion and vulnerability. The synergy of these different forms of exclusion requires further study, including the degree to which gender reinforces other forms of discrimination…
there is a tendency in an inventory of indicators such as this to examine various measures of women's health as if they stood alone. The concept of exclusion warns against this, and recognizes the need for a comprehensive and holistic health promotion strategy that acknowledges the full range of socio-economic and cultural determinants of health and the synergistic interaction between them. The good news in this approach is that reducing disadvantage and exclusion in even one area may produce positive spin-off benefits across a wide range of linked dimensions. (Colman pp 127-128)

4. Proposed Indicators of Women's Health

We propose the following indicators for inclusion in a *Manitoba Women's Health Profile*. Wherever possible, we recommend the use of existing data to produce a *Profile* which, as a stand alone document, would provide a well-rounded picture of the health of Manitoba women, while using scarce resources to produce new information. Data which are currently available at no cost are indicated with (NC). In most cases, we have not recommended using time series data because this will influence the cost. In other cases Manitoba Health is cited as the data source. It will be up to the department to determine what costs will be involved to use these indicators.

Statistics Canada owns much of the data proposed for inclusion in this *Profile*. The Manitoba Bureau of Statistics is the designated contact between the Provincial government and Statistics Canada. It is hoped that they would be actively involved in the development of the data request to Statistics Canada and in the negotiation of the costs involved.

The proposed indicators are organized as follows:

I Women's Health Status
- A. Quality of Life and Well Being
- B. Mortality
- C. Health Equity and Inequities
- D. Health Related Conditions
- E. Women's Use of Health Services
- F. Women's Use of Prescription Drugs

II Socio-Economic Determinants of Women's Health
- A. Income and Wealth
- B. Paid Employment
- C. Occupational Health
- D. Unpaid Work
- E. Education

III Violence Against Women

IV Women's Sexual and Reproductive Health

V Health Behaviours and Lifestyle Determinants of Health

VI The Health of Aboriginal Women

VII Women in Health Care Leadership

I Women's Health Status

A. Quality of Life and Well Being

1. Self Rated Health by Age (NC)
   Source: Statistics Canada, *Health Indicators*, data available by RHA

2. Self Esteem by Age (NC)
   Source: Statistics Canada, *Health Indicators*, data available by RHA

3. Distress, Personal Stress and Chronic Stress
   Source: use scales developed by Heather McLean et al (2003) in "Multiple Roles and Women's Mental Health" in Health Canada, *Women's Health Surveillance Report* and adapt for Manitoba using 1996-97 NPHS data. (1996-97 was when Manitoba "bought in", allowing a larger provincial sample).

   MacLean et al found "staggeringly high" levels of distress, personal stress and chronic stress among mothers, regardless of marital status or employment. (MacLean 2003 p. 6) (See Appendix 1, pg 53.)

4. Social Support (NC)

   Statistics Canada's *Health Indicators* includes a measure of social support by region and sex drawn from the 2000-01 *Canadian Population Health Survey*. These data are not, unfortunately, available for Manitoba. Statistics Canada published social support data only for provinces in which survey respondents answered the "social support" module in all health regions. Therefore, any Manitoba data to be included would have to be from the earlier 1996-97 *National Population Health Survey*, which included a larger sample from Manitoba, but which does not include data by RHA.

   Women have traditionally reported higher levels of social support than men. In 1996/97, 86.6% of women and 80.0% of men reported high levels of social support. (Colman p. 96)

5. Pain or Discomfort that Affects Activities, by Age (NC)
Source: Statistics Canada, *Health Indicators*, data available by RHA

6. Prevalence of Disabilities by Age
Source: Statistics Canada, Participation and Active Living Survey, 2001

National data shows that women are significantly more likely to report disabilities involving impaired mobility or agility, vision, psychological impairment and pain, while men are more likely to report disabilities involving learning and speech. There was no gender difference in reported impairments of memory. In analyzing these data DesMeules et al noted:

Data from this recent survey indicate that 13.3% of women and 11.5% of men (all ages combined) report a disability. However, the higher prevalence of reported disability among women is observed only in those aged 25 and over. Disability is reported more often among boys younger than 14 than among girls of the same age. Important patterns by sex include the higher proportion of severe disability among women, and the corresponding higher proportion of mild disability among men. (DesMeules et al 2003b p. 2)

7. Manitobans with Disabilities - Social Demographic Characteristics by Sex and Age
Source: Statistics Canada, CCHS

Use method developed by DesMeules et al (2003b p. 14) to simultaneously examine the frequency of disability among women and men, by age group, marital status, family structure, income, employment, tangible social support and positive social interactions. (See Appendix 1, pg 54.)

8. Free Time and Personal Time
Source: *Overview of the Time Use of Canadians in 1998*, Statistics Canada Catalogue No. 12F0080XIE (NC) There may be a cost for Manitoba-only data.

Available hours per day available for recreation, relaxation and sleep, for women and men, by age, marital status and parental status.

Adequate free time and personal care time are essential elements of relaxation and a buffer against stress. But women's double work burden may well be eroding that buffer and contributing to a significant increase in female stress levels in the last 15 years. While the 1990s saw no marked change in women's free time and personal care, longer-term trends indicate an erosion of free time for women, particularly for working mothers. According to Statistics Canada, full-time working mothers now put in a 74-hour work week when paid and unpaid work are both counted. (Colman p. 81)

Published data from the General Social Survey of Canada show reported free time by age, sex, employment and parental status. Full-time employed mothers, whether married or single parents, reported the least amount of free time compared to other groups in the population.

9. Time Stress

Percentage of the population by age, sex, employment status, marital status and parental status, reporting high levels of time stress.

Source: *Overview of the Time Use of Canadians in 1998*, Statistics Canada Catalogue No. 12F0080XIE (NC). There may be a cost for Manitoba-only data.

Participants in the 1992 and 1998 General Social Surveys were asked a series of 10 questions about their perception of time. Their responses were used to create a measure of time-stress. Those who agreed with seven or more of the questions were considered to have high levels of time-stress. Examples of the questions include: "Do you consider yourself a workaholic?" "Do you worry that you don't spend enough time with your family and friends?" and "Do you feel that you're constantly under stress trying to accomplish more than you can handle?"

The reported results showed that in every age group, women were at greater risk of high "time stress" than men and that for both women and men, rates of time stress increased from 1992 to 1998.

Age	Men		Women	
	1992	1998	1992	1998
	%			
15 +	12	16	16	21
15-24	7	10	18	22
25-34	16	25	23	29
35-44	16	23	22	27
45-54	16	20	18	22
55-64	- -	8	9	14
65+	- -	- -	- -	- -

The highest rates of time stress were reported by full-time employed mothers. Among both married employed mothers and single parent employed mothers, 38% were reported to have high "time stress". Source: Statistics Canada, *The Daily*, November 9, 1999

B. Mortality

1. Mortality Rates by Major Diagnostic Groups, Age, Sex and RHA (NC)

Source: Currently produced by Manitoba Health using data from Manitoba Vital Statistics

2. Sex/Biology Specific Causes of Death

Source: Use method developed by DesMeules et al (2003a p.12) and apply to Manitoba Vital Statistics Data

DesMeules et al (2003a) found an age standardized mortality rate of 40.6% among women for sex/biology specific causes of death compared to 29.6% for men. (See Appendix 1.)

3. Life Expectancy at Birth (NC)

Source: Statistics Canada, *Health Indicators*, data available by RHA

4. Health Adjusted Life Expectancy
Source: Vital Statistics

Canadian women have a longer health-adjusted life expectancy than men, although the sex gap is less pronounced than that of life expectancy. This is in part explained by the higher prevalence of a number of disabling chronic conditions among Canadian women (see the Second Report on the Health of Canadians); therefore, health expectancy is another useful, gender-sensitive indicator of women's health. As infectious diseases have declined as a major cause of death over the past century, people now survive to older ages, when susceptibility to chronic diseases is greater and functional limitations are more common. Therefore, this indicator has gained significant recognition in population health in recent years. (DesMeules et al 2003a p.2)

Use method developed by DesMeules et al (2003a p. 14) and apply to Manitoba (See Appendix 1, pg 55.)

C. Health Equity and Inequities

1. Differences in Health Services Utilization Among Manitoba Women by Income Quintile
Source: Manitoba Health holds the utilization data. Use income quintiles by postal code methodology developed by MCHP.
CancerCare Manitoba holds the cancer data.

We recommend that the charts included in *Women, Income and Health in Manitoba* (Donner 2000) be updated and refined, to show patterns of hospitalization and physician visits by income quintile in Manitoba, as one measure of inequities in health. Donner (2000) showed an association between income and health services utilization among Manitoba women for pregnancy, labour and delivery (low income associated with high utilization), no association for conditions of the genitourinary system and breast, a reverse trend for screening procedures (screening mammograms and Pap smears) and an

association for all other conditions, similar to that for pregnancy, labour and delivery. (See Appendix 1, pg 56.)

We suggest that data be presented for the following health conditions:

- Pregnancy, labour and delivery
- Conditions of the breast and genitourinary system
- Screening procedures (screening mammograms and Pap smears)
- Cardiovascular disease
- Diabetes
- Cancer
- Unintentional injuries
- Self-inflicted injuries
- Assault
- All other conditions

D. Health Related Conditions

1. Cardiovascular Disease

- Cardiovascular Diseases Among Women, by RHA And First Nations Status
- Deaths From Cardiovascular Diseases Among Women by RHA And First Nations Status

Source: Manitoba Health (prevalence), Manitoba Vital Statistics (mortality)

Recent Canadian research (Grace 2003 and Porcellato 2003) has shown differences in treatment for cardiovascular conditions between women and men in Ontario. It would be useful for the *Profile* to include an indicator to measures differences in treatment between women and men. This indicator would best be developed by Manitoba Health or MCHP in consultation with cardiologists in Manitoba, the PWHCE and other experts in women's health.

2. Diabetes

- Diabetes Among Women, by RHA, Age and First Nations Status
- Complications of Diabetes Among Women by RHA and First Nations Status

Source: Manitoba Health
Data from *Including Gender in Health Planning: A Guide for Regional Health Authorities* could be used or updated information could be provided.

3. Cancers
   - Cancers Among Women, by RHA and First Nations Status
   - Cancers Deaths Among Women, by RHA and First Nations Status
   - Breast Cancers Among Women, by RHA and First Nations Status
   - Breast Cancers Deaths Among Women, by RHA and First Nations Status
   - Cervical Cancers Among Women, by RHA and First Nations Status
   - Cervical Cancers Deaths Among Women, by RHA and First Nations Status
   - Other Gynecological Cancers Among Women, by RHA and First Nations Status
   - Other Gynecological Cancer Deaths Among Women, by RHA and First Nations Status

   Source: Manitoba Health (morbidity), Manitoba Vital Statistics (mortality data)

4. Arthritis/Rheumatism
   Arthritis and Rheumatism Among Women, by RHA and First Nations Status
   Source: CCHS, Note data not disaggregated by First Nations Status. In addition, or alternatively, Manitoba Health might develop a case definition of arthritis that would allow the reporting of arthritis prevalence among Manitoba women. In this case, First Nations data could be disaggregated.

5. Mental Health
   - Depression Among Women by RHA and First Nations Status
     Source: Manitoba Health (if not available, use self-reported information in Health Indicators, but this is not available by First Nations Status)

- Self-Inflicted Injuries Among Women by RHA and First Nations Status
  Suicide Among Women by RHA and First Nations Status
  Source: Manitoba Health, *Injuries in Manitoba* (2004)

Note: MCHP will soon publish a report on the mental health of Manitobans. Since this publication will include sex disaggregated data, the key findings could be usefully incorporated here as additional indicators (e.g. incidences of major mental illness such as schizophrenia among women and post-partum depression)

6. Falls
Source: Manitoba Health, *Injuries in Manitoba* (2004)

Falls are the leading cause of injury deaths and injury hospitalizations among Manitoba women.

- Hospitalizations for Falls by Age, RHA and First Nations Status
- Deaths by Falls by Age, RHA and First Nations Status

E. Women's Use of Health Services

1. Use of Physician and Hospital Services
Source: Manitoba Health

We suggest that the data in "Sex Differences in the Use of Health Care Services" (Mustard et al 1998) be updated. There is a popular belief that women seek medical attention more readily than men. This study showed for Manitobans in 1994-95 that, after removing the costs of sex-specific conditions (including, for women, normal and abnormal reproduction, and for women and men, diseases of the genitourinary system and of the breast) and considering costs for both physicians' services and acute hospital care, that the costs of insured health care services for women were about the same as for men. That is, the female:male ratio went from 1.3 to 1.0.

2. Women's Use of Alternative Health Care Services (NC)
Source: Statistics Canada, *Health Indicators*, data available by RHA

3. Home Care

Manitoba does not have a computerized data system for home care, like the one which provides information about individuals using hospitals and physician services in the province. The strengths and weaknesses of the current system are described in the MCHP publication *Perspectives on Home Care Data Requirements* (Roos 2001b)

Within the limitations of these data, some work has been done on home care use in Manitoba using a payroll based electronic data system. It is estimated that the current payroll based system captures about 90% of home care clients and 80% of home care services. (Roos 2001b p 1).

Data from *A Look at Home Care in Manitoba* (Roos 2001a) show that in 1998-99, 63% of all home care clients were women. At that time, 71% of all home care clients were unattached, that is, neither married nor living with a partner, 75% of clients received long-term home care and 79% were aged 65 years or older. (Roos 2001a p. 4).

Useful indicators about home care use among women in Manitoba would include:

- Number of home care clients by age, sex, marital status and RHA (where numbers permit)
- Rates of home care use by age, sex, marital status and RHA (where numbers permit)
- Number of hours of service by age, sex, marital status and RHA (where numbers permit). Measurement of hours of services may not be possible, but would be a valuable indicator if feasible.

Note: Since most home care recipients are women, and since there are more senior women than senior men, the presentation of utilization rates will be necessary to examine possible gender differences.

New federal funding for home care will, consistent with the recommendations of the Romanow Report, target those in need of short term, post-acute care and those in need of palliative care. The impact of this on older women, who have been the largest users of long-term home care services, should be measured. We recommend that an appropriate indicator be developed in consultation with the MCHP.

Source: Manitoba Health

F. Women's Use of Prescription Drugs

1. Prescription Drug Use by Sex

Source: Manitoba Health, with MCHP

The MCHP Report, *Pharmaceuticals: Focussing on Appropriate Utilization* has shown that Manitoba women use more prescription drugs than Manitoba men, consuming, on average, about one-third more doses daily than men. (Metge et al 2003 p. 21). This Report also presented information about prescription drug use by income, showing that those with the highest incomes used the fewest drugs and had the lowest drug costs, while those with the lowest incomes used the most drugs and had the highest drug costs. (Metge et al 2003 p. 20)

- Most commonly prescribed drugs, by age and sex
- Pharmaceutical use by age, sex and income quintile

II Socio-Economic Determinants of Women's Health

A. Income and Wealth

Women are economically more vulnerable than men, both because of their lower incomes and because social expectations mean that they are more likely to leave paid employment to care for others.

Since socio-economic status is modifiable, the poorer health outcomes and excess use of health care services by low-income

women is as avoidable as that incurred through unhealthy lifestyles. Improving the status of lower socioeconomic groups and closing the income gap between rich and poor can therefore lead to improved health outcomes for disadvantaged women, and substantial cost savings to the health care system. For that reason, declines in low-income rates and improvements in equity are key indicators of women's health.
(Colman p. 5)

1. Labour Force Participation Rates (NC)
Source: Colman R. *A Profile of Women's Health Indicators in Canada* 2003 p. 40

Labour force participation measures the number of people who were either employed or unemployed during the survey period. Unemployed people are defined only as those who were available for work, and were either on temporary layoff, had looked for work in the past four weeks or had a job to start within the next four weeks. It does not include those who have given up looking for work (See 7 below.) Employment and unemployment rates are a function of labour force participation.

In 2001, Manitoba women had a labour force participation rate of 61.5% compared to 74.9% for men.

2. Gender Wage Gap (NC)
Source: Colman, R. *A Profile of Women's Health Indicators in Canada* 2003 p. 8

This measure compares the average hourly wages of women and men and is a key indicator of gender equity.

Colman (p.7) notes that hourly wages are the most accurate and conservative gauge of pay equity, since women work, on average, fewer paid hours per week than do men.

...women are earning substantially less than men even when they have identical work experience, education, job tenure and other characteristics, when they perform the same job duties and when they work in the same occupations and industries for the same weekly hours. "This 'unexplained' component," says Statistics

Canada, "is referred to as an estimate of the gender based labour market discrimination." (Colman p. 7)

In 2001, Manitoba women's hourly wages were 82.2% of that of men.

3. Low Income Rates

Source: Statistics Canada, *Income in Canada 2001* Catalogue No. 75-202-XIE

Women are at higher risk of low income than men. Women's higher burden of poverty in Manitoba was demonstrated in *Women, Income and Health in Manitoba* (Donner 2000 p.7)(see Appendix 1, pg 57). We recommend that these data be updated to show sex-disaggregated low-income rates for all Manitoba women and men, senior women and men, unattached senior women and men, male and female children, two-parent families, children with single mothers and all adult women and men.

Note that Statistics Canada's *Health Indicators*, which includes data by Regional Health Authorities in Manitoba, does not include any sex-disaggregated income data.

We recommend that this be expanded to include information about low income rates among Aboriginal women and men. Statistics Canada, *Aboriginal People in Canada*, 2001 shows that 41.7% of Aboriginal females in Manitoba lived in low-income, compared to 14.8% of all Manitoba women and 36.0% of Aboriginal males.
Source: Statistics Canada, *Aboriginal People in Canada*, 2001 Catalogue No. 97F0011XCB01047 (NC)

This indicator should also be expanded, if possible, to include information about low income rates among women and men with disabilities, using data from Statistics Canada *Participation and Activity Limitation Survey, 2001.* If this information cannot be obtained, the data about the average incomes of Manitoba women and men with disabilities could be used. In 2001, the average income of Manitoba women aged 15 to 64 was $18,558, or 77% that of women without disabilities and 61% that of men with disabilities.
Source: Statistics Canada, *Education, Employment and Income of Adults With and Without Disabilities*, Catalogue No. 89-587, calculated from tables 5.8 and 6.8 (NC)

B. Employment

Women's employment is an important determinant of health, since employment and income are closely linked. On the other hand, the occupational health risks of women's employment are also important as a determinant of women's health and should not be overlooked.

1. Employment by Age and Educational Attainment

Source: *Women in Canada: Work Chapter Updates*, Catalogue No. 89F0133XIE (NC)
Data for Manitoba available from Statistics Canada, *Labour Force Survey*

Show the percentage of Manitoba women employed by age group (15 to 24, 25 to 44, 45 and older) and educational attainment. Published data for Canada in 2002 show that in each group, increased educational attainment is linked to increased employment. It also shows that at each level of educational attainment, women aged 25 to 44 are most likely to be employed.

2. Women's Employment by Age of Youngest Child

Source: Source: *Women in Canada: Work Chapter Updates*, Catalogue No. 89F0133XIE (NC)
Data for Manitoba available from Statistics Canada, *Labour Force Survey*

Published data for Canada show that from 1976 to 2002, there were dramatic increases in the employment of women with children, especially those with young children. In 2002, 65% of women with children under 6 years, and 72% of women with children under the age of 16, were employed. Mothers' employment has increased, contributing to women's increased incomes, but at the same time, contributing to their "time stress" (see I A 9 above).

Show percentage of women (under aged 55 years) employed by age of youngest child (under 3 years, 3 to 5 years, 6 to 15 years, no children under aged 16 years).

3. Reasons for Part Time Work by Sex and Age
Source: Source: *Women in Canada: Work Chapter Updates*, Catalogue No. 89F0133XIE (NC)
Data for Manitoba available from Statistics Canada, *Labour Force Survey*

Published data for Canada show that in 2002, women were more likely to work part time than men (27.7% vs. 10.9%), but for different reasons. Women are more likely than men to work part-time because they are caring for children (14.7% vs. 0.9%) and other personal/family responsibilities (5.9% vs. 0.9%).

4. Unemployment Rates by Age and Sex (NC)

As noted above, Statistics Canada's official definition of unemployment excludes those who have given up looking for work ("discouraged searchers"), involuntary part time workers (the "underemployed"), and those who are waiting to start a new job (either starting a new job in more than 4 weeks, or waiting to be recalled to an old job, or waiting to hear from prospective employers). Statistics Canada therefore publishes a "comprehensive measure of unemployment" that includes all of these additional groups and it is recommended that both the traditional measures of unemployment and the comprehensive measure be included. The official measure of unemployment in Canada shows a higher rate for men than for women. Using the comprehensive measure of unemployment, which more accurately captures the extent of non-working among women who wish to work in the paid labour force, results in a reversal of the traditional results (Colman p. 64).

In 2001, the official unemployment rate was 5.0% for men and 4.9% for women. When the extent of unemployment among those who are involuntarily employed part-time is included, the male rate is 6.2% and the female rate is 8.1%. When the comprehensive measure of unemployment is used, the male rate is 7.0% and the female rate is 8.5%.

Source: Colman, R. *A Profile of Women's Health Indicators in Canada* pp 63-64, based on Statistics Canada, *Labour Force Historical Review*, 2001

Other factors, including youth, education and Aboriginal ancestry increase the risk of unemployment. As Ron Colman has noted:

These data on sub-groups of women demonstrate that averages for Canadian women conceal wide disparities by region, age, education, and other characteristics. Indeed the data presented here indicate that the overall male-female gaps are far less wide than gaps based on age, education, and region. (Colman p. 66)

We therefore recommend that these data be expanded to include information about unemployment among Aboriginal women. In Manitoba in 2001, using the official definition of unemployment, 21.2% of Aboriginal men and 16.7% of Aboriginal women were unemployed. In addition to higher rates of unemployment, Aboriginal women were less likely to participate in the labour force. The labour force participation rate was 53.8% for Aboriginal women, compared to 61.4% for all Manitoba women and 67.3% for Aboriginal men.

Source: Statistics Canada, *Aboriginal People in Canada, 2001* Catalogue No. 97F0011XCB01047 (NC)

5. Unionization (NC)

Source: Source: Colman, R. *A Profile of Women's Health Indicators in Canada* 2003 p 51, based on Statistics Canada, *Labour Force Historical Review*, 2001

Unionized workers tend to have higher wages than non-unionized workers. As well, the gender gap in wages is much narrower among unionized workers, compared to non-unionized workers. Data from all of Canada in 2001 showed an earnings gender gap (for hourly wages) of 31% for non-unionized workers and 12% for unionized workers (Colman p.50).

In 2001, 35.7% of employed Manitoba men and 37.7% of employed Manitoba women were covered by collective agreements.

C. Occupational Health

Women's occupational health has traditionally received less attention, and been the subject of less research, than men's occupational health. In part, the invisibility of women's occupational health problems is the result of women's concentration in female-dominated occupations, and social attitudes towards what is seen as women's "natural" work. (Messing 1995)

1. Decision Latitude at Work (NC)

Source: Statistics Canada, *Health Indicators*.

In light of convincing evidence linking work control to health outcomes, the Canadian Institute for Health Information's National Consensus Conference on Population Health Indicators identified and confirmed decision latitude at work as a key non-medical determinant of health. Because women tend to have lower levels of control over their work circumstances, this is also a particularly important determinant of work stress and health for women. Higher levels of decision latitude at work are therefore a positive indicator for women's health. (Colman p. 58)

Data about perceived decision latitude at work is available in Statistics Canada's *Health Indicators*, by sex and by RHA, using data from the 2000/01 Canadian Community Health Survey.

For Manitoba as a whole, 41.4% of women reported low to medium job latitude compared to 28.0% of men.

2. Occupational Injuries (NC)

The best source of data about occupational injuries in Manitoba is the Workers Compensation Board. The WCB records information by age, sex, occupation, industry, type of injury, body parts injured and time lost from work, for all claims, including both those which involve time loss and those which do not involve time loss. Manitoba Labour produces regular reports using these data. Traditionally, men have been more likely to file WCB claims than women.

After reviewing Ontario WCB data and including in their analyses estimates of labour force participation by occupation, industry and sex, Jennifer Payne and Cameron Mustard, writing in the *Ontario Women's Health Status Report* concluded that:

These results point to a substantial similarity in the consequences of men's and women's exposures to physical and biomechanical challenges in the work environment. Combining the industrial sector analysis results with the occupational results leads us to believe that men may not be at higher risk of workplace injury than women. Rather, the distribution of men and women across the labour force is sufficiently different that the overall result is a higher claims rate for men than for women. These results reveal that gender is not a good marker for risk of injury; it is the occupation, or the tasks that make up that occupation, that appears best able to identify workers at risk of injury. (Stewart et al p. 138)

In Manitoba, in 2002, 43% of workers with WCB coverage were women and 28.3% of all WCB claims (for both injuries and occupational diseases) were made by women. Women reported more claims than men only in the service sector (including health care). This is consistent with the Ontario findings described above.

We therefore recommend that the *Profile* include the following information:

- WCB claims rate by age, sex and occupation
- Leading causes of injuries (WCB "Nature of Injury" codes) among women by age and occupation
- A case study of compensated injuries among health care workers in Manitoba

3. Occupational Diseases

Again, the best source of data about occupational diseases in Manitoba is the WCB. Because of the difficulties involved in showing a causal link between occupational exposures and diseases, less is known about the extent of occupational diseases in Manitoba than about occupational injuries. In order for an occupational disease claim to be accepted, the claimant

must prove that employment is the dominant cause of the disease. Those that do not meet this test are not included in the WCB's data set. However, given an understanding of these limitations, it would still be useful to include information about occupational diseases among Manitoba women in this *Profile*.

In 2002, approximately 92% (16,231) of accepted time loss claims were for injuries and approximately 8% (1,380) were for occupational diseases. (Manitoba WCB p. 34)

We recommend that the *Profile* include the following:

- Leading causes of occupational diseases among women by occupation and industry

D Unpaid Work

One of the biggest knowledge gaps is in understanding the impacts of these labour market changes on women's total work burden. We do know that women have significantly higher time stress levels than men, that time stress has been growing, and that stress has adverse effects on health. We also know that the gender division of labour within the household has not changed nearly as markedly as the gender division of labour in the market economy…

any inventory of women's health indicators must track trends in women's unpaid work. This is essential in order that the employment trends described in the previous section not be seen in isolation, and so that potential health impacts can be assessed in the context of women's `total` *work load.* (Colman p 73).

At the same time as women's participation in the paid labour force has increased, the health care services system has shifted care from hospitals to communities, increasing the burden of care on family care givers, the majority of whom are women. All of these factors have contributed to women's "time stress". A *Profile* of women's health should include the total burden of women's work, both paid and unpaid.

There are two available sources of information about the extent of unpaid work in Canada, both from Statistics Canada - the *Census of Canada* and the *General Social Survey*. They measure unpaid work

differently. The GSS provides more detailed information through the use of time diaries and includes information about volunteer work outside of the home.

1. Unpaid Hours of Childcare by Sex (NC)
Source: Census of Canada 2001

This is presented in Census data as hours per week: no hours; less than 5 hours; 5 to 9 hours; 10 to 19 hours; 20 or more hours.

2. Unpaid Hours of Housework by Sex (NC)
Source: Census of Canada

This is presented in Census data as hours per week: no hours; less than 5 hours; 5 to 9 hours; 10 to 19 hours; 20 or more hours.

3. Paid Work, Unpaid Work And Childcare by Sex and Employment Status
Colman (p 77) has noted that the average numbers presented in the Census data mask the differences among groups of women, notably, the high workload of full-time working mothers, both single mothers and those in two parent households. These data are available only from the *General Social Survey of Canada.*

4. Consequences of Caregiving (NC)
Source: Statistics Canada, *2002 General Social Survey, Cycle 16: Aging and Social Support*, Catalogue # 89-593

Data about the personal and employment consequences of caregiving for caregivers are available from the *General Social Survey of Canada*, *2002*. Published data for the prairie provinces show that 20.4% of males and 22.4% of females aged 45 years and over reported providing some informal care to seniors. Women were more at risk for each of the following negative consequences of caregiving: reduced social activities, changed holiday plans, extra expenses, reduced sleep, increased health problems for the caregiver, reduced hours of

work, changed work patterns, lost income, turned down a job and quit job.

E. Education

Higher levels of education, are, like income, linked to improved health status. Health Indicators includes data about the level of education by RHA, but these are not disaggregated by sex.

Levels of Educational Attainment by Sex (NC)

- Without high school graduation
- High school graduation
- Trade certificate or diploma
- College or University

Source: Statistics Canada, *2001 Census of Canada, Education in Canada*

III Violence Against Women

Women are at less risk for assault causing hospitalization or death than men (Manitoba Health, *Injuries in Manitoba: A Ten Year Review* 2004). However, women are at increased risk of both family violence and sexual assault. These are important issues to consider in a profile of women's health.

1. Spousal Violence
   prevalence of spousal violence
   Source: Statistics Canada *General Social Survey 1999*

2. Spousal Homicide
   prevalence of spousal homicide
   Source: Statistics Canada *General Social Survey 1999*

   Note: From 1974 to 2002, Manitoba women were the most likely in Canada to be murdered by their current or past husbands or common-law partners (Colman p. 119)

3. Violence Against Senior Women
   prevalence of violence against senior women
   Source: Statistics Canada *General Social Survey 1999*

4. Sexual Assault
   reported sexual assaults
   Source: Canadian Centre for Justice Statistics, *Crime Statistics in Canada 2002*

IV Women's Sexual and Reproductive Health

A. Pregnancy and Childbirth

1. Pregnancies
Source: Manitoba Health

Number of pregnancies and pregnancy rates for women by age, RHA (of maternal residence) and First Nations Status

2. Induced Abortions
Source: Manitoba Health

Number of induced abortions and abortion rates for women by age, RHA (of maternal residence, where numbers permit) and First Nations Status (where numbers permit)

Note: medication induced abortions cannot be accurately tracked at the present time as there is no clear tariff code.

3. Teenage Pregnancies
Source: Manitoba Health

Number of teenage pregnancies and teenage pregnancy rates by age, RHA (of maternal residence, where numbers permit) and First Nations status (where numbers permit)

4. Childbirths
Source: Manitoba Health

Number of live births and live birth rates for women by age, RHA (of maternal residence) and First Nations Status. This should include hospital and out-of-hospital births with midwives.

5. Caesarean Deliveries
Source: Manitoba Health

Percentage of births by Caesarian delivery by RHA (of maternal residence) and facility

In all of Canada from 1991 to 2001, the Caesarean delivery rate increased from 18.2% to 21.2% of all births. In 2000-01, 18.5% of births were by Caesarian delivery. Health Canada (2003a pages 169 and 171)

6. Vaginal Births After Caesarean Deliveries (VBAC)
Source: Manitoba Health

Percentage of women who have previously received a Caesarean section who give birth via a vaginal delivery in an acute care hospital by RHA (of maternal residence) and facility.

This is included in Statistics Canada's Health Indicators as a measure of the appropriateness of health care services. The Society of Obstetricians and Gynaecologists of Canada (SOGC) has issued guidelines with recommendations to promote vaginal birth after Caesarean where appropriate.

In 2003, the VBAC rate in Manitoba was 3.27%, compared to 29.9% for all of Canada.
Source: Statistics Canada, *Health Indicators*

7. Induction of Labour
Source: Manitoba Health

Percentage of women whose labour was induced by RHA (of maternal residence) and facility

Induction of labour induction rate occurs when labour is induced by medical or surgical means, before the onset of labour. Induction of labour is an obstetric intervention associated with increased complications compared with spontaneous labour. (Health Canada 2003a p. 29)

In all of Canada, from 1991 to 2001, the rate of medical inductions increased from 12.9% to 19.7% and the rate of surgical inductions increased from 6.35 to 7.7%. In 2000-01, the medical induction rate in Manitoba was 19.4% and the surgical induction rate was 2.7%. (Health Canada 2003a p. 168)

8. Migration for Birthing
Source: Manitoba Health

The issue of lack of providers outside large cities for women giving birth is critical. Information on the extent to which women travel from rural and remote communities to Winnipeg

(and other urban centres) to give birth (and whether it is a high-risk transport) may be available in the forthcoming report of the Manitoba Ministerial Working Group on Maternal and Newborn Health.

9. Midwifery
Source: Manitoba Health

Midwife assisted births by RHA

10 Location of Births (Hospital and Home)
Source: Manitoba Health

11. Post Partum Depression
Source: Manitoba Health and MCHP

This is not available in the MCHP's forthcoming report on mental health, but is an important indicator of women's health, and can be integrated in other work from MCHP.

12. Tobacco Smoking During Pregnancy
Source: Statistics Canada, *Canadian Community Health Survey* (NC). There may be a charge for Manitoba data.

Percentage of women who reported smoking tobacco during pregnancy

13. Alcohol Consumption During Pregnancy
Source: Statistics Canada, *Canadian Community Health Survey* (NC). There may be a charge for Manitoba data.

Percentage of women who reported consuming alcohol during pregnancy, by frequency of drinking

B. Sexual Health

It is important to note that the questions asked in the CCHS, like those in most other population surveys, assumed that respondents were heterosexual. Therefore, no conclusions can be drawn from these data

about the sexual health of lesbian women. It is recommended that this issue be addressed in the Profile, and that these data be supplemented with information from other sources about sexual health issues for lesbian women.

1. Age At Sexual Debut

Age at first intercourse by sex and age at time of survey
Source: Canadian Community Health Survey (NC). There may be a charge for Manitoba data. Note: this will not include First Nations Women.

Hansen et al, writing in the *Women's Health Surveillance Report*, included information from the CCHS on age at first sexual intercourse. However, they noted that:

Age at sexual debut is typically measured as age at first intercourse. In CCHS 1.1, sexual intercourse was not defined for respondents, and this is a common issue in behavioural surveys of sexual activity. Age at first intercourse is important in health terms, as it indicates that an individual may potentially experience pregnancy or a sexually transmitted infection. At the population level, a younger average age at first intercourse results in more sexually active teens and a longer period of sexual activity before a lasting relationship is entered into. However, measuring the first incidence of intercourse unduly suggests that an individual's sexual life commences when they start having penetrative sex. This implied or practical definition of sex also limits our understanding of the sexual activity of gay, lesbian or transgendered women. (Hansen et al p. 1)

They found a significant correlation for both males and females between current age and age at first intercourse. This supports the findings of other research which shows that median age at first intercourse has steadily declined among Canadians (Hansen et al p. 2)

2. Contraceptive Use and Safer Sexual Practices

Contraceptive choices affect the long-term sexual health and fertility of women and men, particularly when contraception is not used correctly or

consistently. For many women, the ability to control their fertility has enhanced their ability to control their lives; however, with this power has come a greater responsibility for contraception in a relationship. Given that the majority of contraceptive methods available are made to be used by women and that the consequences of a contraceptive failure can have a greater impact on the life and health of a woman than on her partner, this is a vital issue in women's health…The context in which men and women make decisions related to contraception has changed with the advent of oral contraception (OC) some 40 years ago and, more recently, with the increased awareness of HIV/AIDS and sexually transmitted infections (STIs). (McMahon et al p. 1)

Given the importance of these issues for women's health, it is unfortunate that the available Manitoba data about contraceptive use appear to be sparse. Data from the CCHS about the use of oral contraceptives are not available for Manitoba, as this was an optional question and Manitoba did not choose to participate. However, if the recommendation (above in I. F.1) to include information about pharmaceutical use by age among Manitoba women in the Profile is accepted, then information would be available about oral contraceptive use.

The 2000/01 CCHS also included an optional question about condom use among those who reported having sexual intercourse, in relationships lasting less than one year. Again, Manitoba data are not available.

The *1998 Canadian Contraception Study* (Fisher et al p. 190, sponsored by Janssen-Ortho Inc.) found that 13% of married women and 26% of unmarried women aged 15 to 44, having sexual intercourse in the previous six months reported that their partners always used condoms.

3. Sexually Transmitted Diseases
Source: Manitoba Health

Sexually transmitted diseases are a common cause of illness with significant health consequences for women. STD infection is a complex health problem, with biological, psychological and social determinants. (Stewart et al p. 47)

Certain sexually transmitted diseases in Manitoba are reportable, and data about these are published by Manitoba Health, most recently in *Reportable Diseases in Manitoba: CDC Unit Annual Review Calendar Year 2001*. (Manitoba Health 2001) These area: gonorrhea, syphilis, Chlamydia, human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS). Unfortunately, human papilloma virus (HPV), which has been linked to cervical cancer in women, is not a reportable disease.

In 2001, *Chlamydia* was the most commonly reported STD in Manitoba, with 3,249 cases reported. About 72% of those cases occurred among women. (Manitoba Health 2001 p. 5)

We recommend that the following indicators (all previously published in *Reportable Diseases in Manitoba*) be included in the *Profile*:

- reported new cases of HIV among by age and sex
- reported new cases of HIV among by sex and mode of transmission
- number of AIDS cases and AIDS deaths by sex
- incidence of Chlamydia by age, sex and RHA

4. Screening for Cervical Cancer (Papanicolaou Smears)

Cervical smears reduce the risk of developing invasive carcinoma of the cervix in women who have been sexually active. The Canadian Task Force on Preventive Health Care concluded that there was fair evidence to include Pap smears in periodic health examinations of sexually active women. (Stewart et al p. 244)

- rate of Pap Smears among women by age, RHA and First Nations Status

Source: Manitoba Health

Note that self-reported data about Pap smears by age, RHA and length of time since last Pap smear are available in Health Indicators. However, data on actual tests, if available from Manitoba Health, would be more accurate.

5. Screening Mammography

The Canadian Task Force on Preventive Health Care concluded that there was good evidence for screening women aged 50–69 years by clinical examination and mammography and that the best available data support screening every one–two years. (Stewart et al p. 244)

- rate of screening mammography among women aged 50 to 69 years , by RHA and First Nations Status

Source: Manitoba Health

Note that self-reported data about screening mammography in the previous two years, by age, RHA and length of time since last mammogram are available in *Health Indicators*. However, data about actual procedures, if available from Manitoba Health, would be more accurate.

V Health Behaviours and Lifestyle Determinants of Health

While these indicators are categorized as "lifestyle" determinants, the connection between income and each of these issues should be noted in the Profile.

A. Tobacco Use (NC)

The facts, as we enter the 21st century...

- *Smoking-related disease continues to be the number one killer of Canadian women.*
- *In Canada, tobacco use is the number one preventable cause of death and disease.*
- *At least half of all women who smoke will die as a result of the effects of tobacco.*
- *Lung cancer, a key smoking-related disease, has surpassed breast cancer as the leading cause of cancer death in women.*
- *Smoking doubles the risk of cardiovascular disease, the leading cause of death in women.*
- *Women are equally, if not more, affected by tobacco than men. We don't yet fully understand the effect of smoking on females due to gaps in biomedical research.*

- *There are troubling trends for the future regarding women and tobacco.*
- *In what seems to be a continuing trend, teen girls are smoking at higher rates than teen boys.* (Greaves and Barr p. 1)

The following proposed indicators are drawn from data already published in Health Canada's *Canadian Tobacco Use Monitoring Survey*. The following chart is an example of the information included in this publication for 2002. While in general, the proportion of the population who smoke has decreased in the last decade, the chart below shows that 15 to 24 year old women are now more likely to smoke than their male counterparts.

Province	Sex or age group (years)	Population estimate ('000)	Current smokers (%)	Former smokers (%)	Never smoked (%)	Average cigarettes smoked per day[1]
Manitoba	Total	903	21	28	51	15.7
	15-19	82	23	#	72	10.3
	20-24	78	33	11	56	12.3
	25+	743	20	33	48	16.8
	25-44	333	25	24	51	14.3
	45+	410	16	39	45	19.6
	Male (15+)	446	21	31	48	18.3
	15-24	82	27	8*	66	13.1
	25+	364	20	37	44	19.5
	Female (15+)	457	21	25	53	13.3
	15-24	78	30	8*	63	10.2
	25+	379	20	29	51	14.1

* moderate sampling variability, interpret with caution

Source: Tobacco Control Programme, Health Canada Supplementary Tables, CTUMS Annual 2002

The following indicators of women's smoking are proposed:

- Percentage of females 15 years and older who smoke, by age group Percentage of females 15 years and older who have never smoked by age group
- Percentage of females 15 years and older who are former smokers by age group
- Prevalence of smoking over time, females 15 years and older

Source: Tobacco Control Programme, Health Canada

Since *Canadian Tobacco Use Monitoring Survey* does not provide data by Regional Health Authority, the indicators above could be supplemented with data by age, sex and RHA for 2000, the only year for which it is available.

Source: Statistics Canada*, Health Indicators*

B. Leisure Time Physical Activity

Source: Canadian Community Health Survey

The importance of physical activity in the prevention of disease and the promotion of good health is widely recognized. Only 34% of Canadians aged 25 to 55 currently meet Health Canada's current recommendations for physical activity. (Colman p. 150) Manitoba women participating in the CCHS were more likely to be classified as physically inactive than men (54.7% of women compared to 42.7% of men). Women's multiple roles and time stress, described above, contribute to the challenges which women face in making time for leisure time physical activities.

The following indicators are proposed:

- Percentage of women active or moderately active by age
- Percentage of women active or moderately active by RHA
- Percentage of women physically inactive by age
- Percentage of women physically inactive by RHA

Note: since numbers are small, it is not possible to present these data simultaneously by age and RHA.

C. Healthy Body Weights

Source: Canadian Community Health Survey

Healthy body weight is an issue for women's health. Obesity is linked to increased morbidity and mortality. At the same time, women, especially young women are at increased risk for eating disorders.

In 2001, 8.0% of Manitoba women who participated in the CCHS were classified as underweight, 43.5% as having an acceptable weight, 13.6% as having some excess weight and 31.2% as being overweight.

The following indicators are proposed:

- Percentage of women who are underweight by RHA (Body Mass Index <20)
- Percentage of women whose weight is acceptable by RHA (Body Mass Index 20 to 24.9)
- Percentage of women who have some excess weight by RHA (Body Mass Index 25 to 26.9)
- Percentage of women who are overweight by RHA (Body Mass Index 27+)

D. Healthy Dietary Practices

Source: Canadian Community Health Survey

Health Canada recommends that Canadians eat 5 to 10 servings of fruits and vegetables per day. In 2001, of those Manitoba women who participated in the CCHS, only 37% reporting meeting this standard.

The following indicators are proposed:

- Percentage of women who ate 5 to 10 servings of fruits and vegetables per day by age
- Percentage of women who ate 5 to 10 servings of fruits and vegetables per day by RHA

Note: since numbers are small, it is not possible to present these data simultaneously by age and RHA

VI The Health of Aboriginal Women

Aboriginal women bear a high burden of illness in Manitoba. This Profile should recognize that, while at the same time highlighting the ways in which Aboriginal women are actively pursuing good health. We propose that the *Profile* includes a chapter summarizing the health issues faced by Aboriginal women in Manitoba and that this chapter be written in consultation with Aboriginal women.

VII Women in Health Care Leadership

Just as the United Nations Gender Empowerment Index measures the participation of women at senior levels of government, and as professionals and managers, it is recommended that indicators be included in the *Profile* to show the extent of women's leadership in the health care system. The following indicators are proposed:

- Percentage of female senior managers Manitoba Health
  Source: Manitoba Health
- Percentage of female senior managers RHAs
  Source: RHAs
- Percentage of female RHA Board members
  Source: RHAs
- Percentage of women physicians, by area of specialty and RHA
  Source: College of Physicians and Surgeons of Manitoba

Senior managers will be defined in the process of refining the variables for the *Profile*.

5. Summary and Recommendations

The Prairie Women's Health Centre of Excellence recommends that Manitoba Health commission a *Manitoba Women's Health Profile*, including the indicators described in Section 4 above.

Manitoba's *Women's Health Strategy* states that the government intends to develop a *Profile*. This will be in keeping with epidemiological and health planning research already underway in other jurisdictions. National and international examples demonstrate how the publication of such a *Profile* would increase the breadth of knowledge about women's health, by contributing new information and new understandings about women's health and the ways in which gender influences health.

"Traditional health indicators, based exclusively on sex-disaggregated data, do not adequately reflect the interrelations between biological processes, social roles, socio-economic context, the health care system and health outcomes" (Tudiver 2003). A Manitoba *Profile* would be enriched by access to Manitoba Health's administrative data, but would have to be supplemented by data from other sources which would provide information about the social and economic contexts of women's lives and women's own perceptions of their health.

A *Manitoba Women's Health Profile* should include, wherever possible, data which reflect the diversity of Manitoba women including differences in income, Aboriginal ancestry, age, disability, geographic location, migration and racism.

The possibility for this *Profile* to be produced concurrent with a report by the MCHP on gender differences in health status and health services utilization (and now with an offer for collaboration from Health Canada), creates a wonderful opportunity to produce two complementary documents, which together will provide needed information about the health of Manitoba women.

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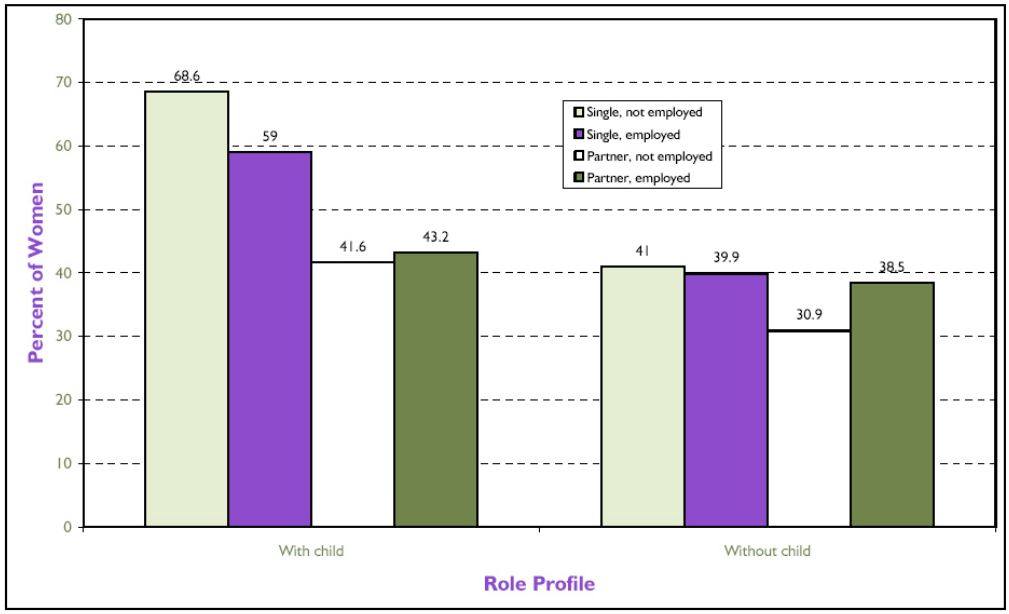
APPENDIX 1

Select Examples of Women's Health Indicators

Distress, Personal Stress and Chronic Stress

Exhibit 3: Percent Reporting High Psychological Distress for Women in Role Profiles, Canada, NPHS, 1998–1999

Exhibit 6: Percent Reporting High Personal Stress for Women in Role Profiles, Canada, NPHS, 1994–1995



From Maclean, H. et al. (2003) p.13 and 14

Social Demographic Characteristics by Sex and Age Among Manitobans with Disabilities

Social demographic characteristics		20-44		45-64		65+	
		Female	Male	Female	Male	Female	Male
Marital status	Married	55.8	49	65.9	73	39.5	75.5
	Separated	11.8	6.8	26	15.6	55.9	19.3
	Single	32.4	44.2	8.1	11.4	4.6	5.2
Family structure	Couple, no dependent child	16.6	19.3	41	39.1	36.6	70.4
	Couple, dependent child	49.2	47.4	24.5	34.2	5.4	4.5
	Single, dependent child	16.8	6.1	7.3	2.4	0.8	0.4
	Single, no dependent child	16	26.2	26	23.5	55.3	22.6
	Other	1.4	1.1	1.3	0.8	2	2.1
Income	Low	20.8	17.2	20.1	18.5	27.3	13
	Lower-mid	25.4	25.5	23.8	21.1	39.4	43.1
	Upper-mid	34	34.2	33.1	35.1	23.5	31.4
	High	19.8	23.2	23	25.3	9.8	12.5
Employed last week	Yes	57.7	68.6	39.5	52.8	3.2	8.2
	No	36.8	25.5	46.4	31.3	83	75.4
	Unable to work	5.5	6	14.1	15.9	13.8	16.4
Tangible social support	None of the time	3.4	4.1	3.9	4.2	4.5	2.8
	Little of the time	8.8	7.6	8.7	6	10.8	4.6
	Some of the time	19.5	15.4	18.9	13.9	15	9.3
	Most of the time	33.2	33.1	32.5	28.8	28.5	25.4
	All of the time	35.1	39.9	36	47.1	41.2	57.9
Positive social interactions	None of the time	1.5	2.2	2.6	3.6	3.7	4
	Little of the time	6.8	7.1	7.7	6.2	10.6	7.1
	Some of the time	18.3	19.1	18	17.2	17.8	17
	Most of the time	35.4	32	32.7	29.5	30.4	24.9
	All of the time	38.1	39.6	38.9	43.6	37.6	47

Source: DesMeules et al. (2003b) pg 14

Sex/Biology Specific Causes of Death

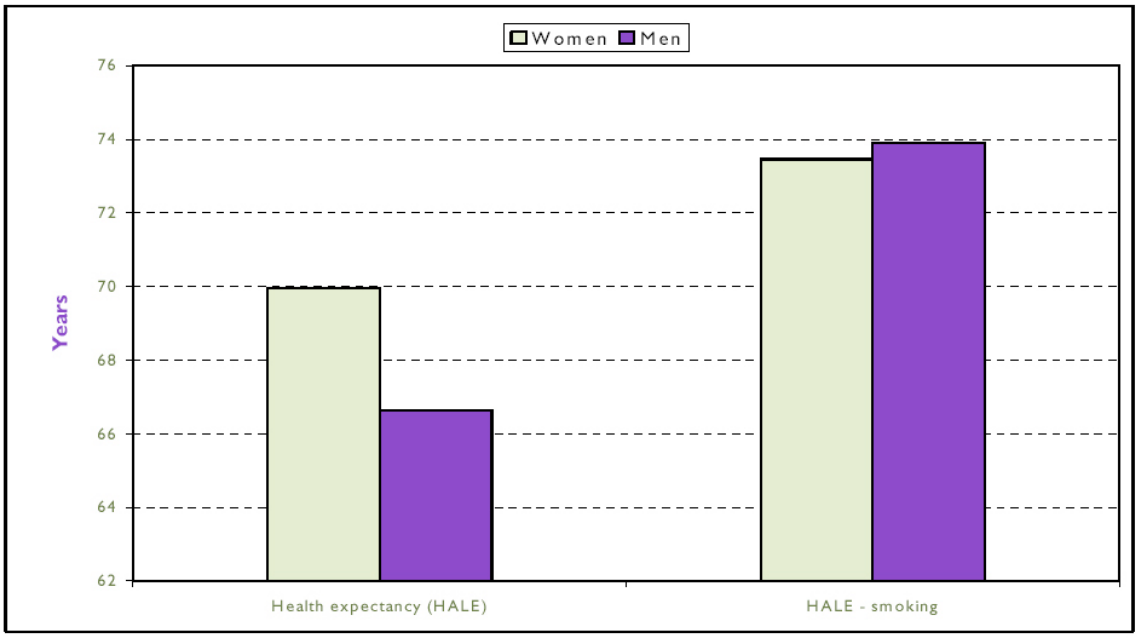
	Deaths	Age-standardized mortality rate (/100,000)
Women		
Cancer of the uterus incl. cervix	3180	5.74
Cancer of the ovary	4147	7.57
Cancer of the female genital	7768	14.06
Cancer of the female breast	14630	26.39
Complications of pregnancy	40	0.1
Total	**29765**	**40.55**
Men		
Cancer of the prostate	10922	27.71
Cancer of the testis	111	0.26
Cancer of the male genital	11121	28.18
Prostatic disease	207	0.55
Excess male perinatal deaths	217	0.42
Total	**22578**	**29.15**

Source: Vital Statistics, Statistics Canada

From DesMeules (2003b) p. 14

Health Adjusted Life Expectancy

Exhibit 10: Health Expectancy at Birth of Canadian Women and Men, 1997–1999

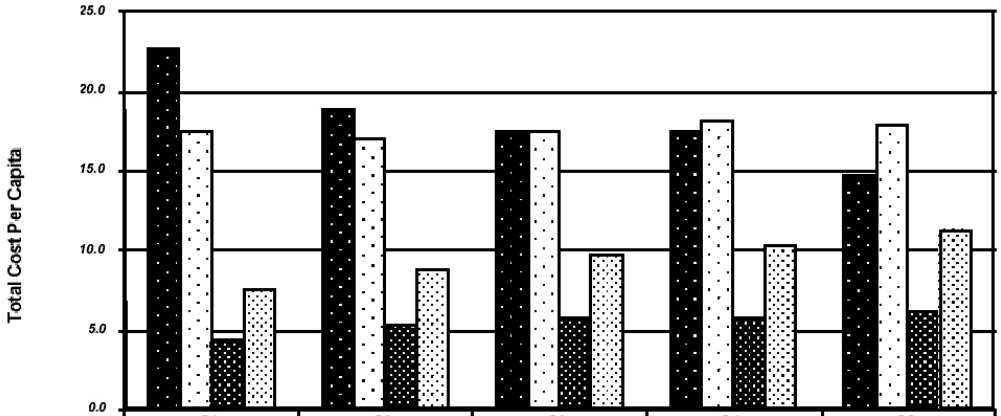


From: DesMeules et al. (2003a) p. 14

Health Equity and Inequities

CHART 3

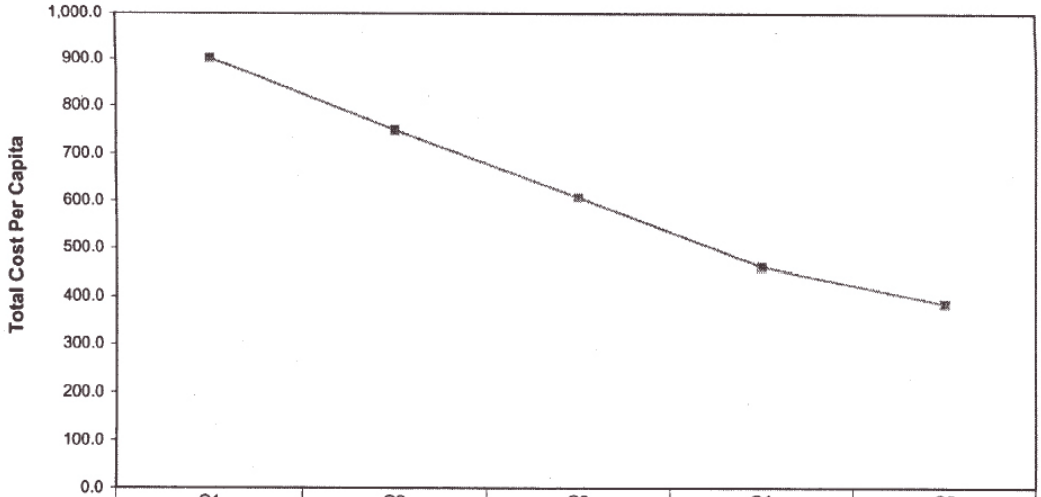
HEALTH CARE EXPENDITURES ON PREGNANCY, LABOUR AND DELIVERY, CONDITIONS OF THE GENITOURINARY SYSTEM, BREAST CONDITIONS AND SCREENING, 1994-95 PER CAPITA COSTS FOR PHYSICIAN SERVICES BY INCOME QUINTILE



	Q1	Q2	Q3	Q4	Q5
Preg, L&D	22.6	18.8	17.5	17.5	14.6
GU	17.4	17.0	17.4	18.2	17.8
Breast	4.4	5.2	5.8	5.7	6.1
Screening	7.5	8.7	9.7	10.2	11.2

CHART 4

HEALTH CARE EXPENDITURES FOR ALL OTHER CONDITIONS, 1994-95, PER CAPITA COSTS FOR ACUTE HOSPITAL CARE BY INCOME QUINTILE



	Q1	Q2	Q3	Q4	Q5
Other	902.3	751.7	611.0	466.0	390.6

From Donner (2000) pp 39, 40

Low Income Rates

	Canada		Manitoba	
	Number	**Percent**	**Number**	**Percent**
All Persons	4,886,000	16.2%	202,000	18,50%
All Females	2,669,000	17.70%	113,000	20.40%
All Males	2,187,000	14.60%	89,000	16.50%
Seniors	646,000	17.70%	32,000	22.00%
Senior Women	487,000	23.50%	24,000	28.30%
Senior Men	159,000	10.00%	9,000	13.60%
Unattached Seniors	519,000	44.0%	25,000	44.20%
Unattached Senior Women	417,000	48.5%	21,000	51.30%
Unattached Senior Men	101,000	31.90%	4,000	25.60%
All Children < 18 yrs.	1,298,000	18.50%	64,000	23.70%
Children in 2-parent families	697,000	12.10%	34,000	15.50%
Children with single mothers	521,000	55.80%	28,000	70.70%
All Adults				
Adult women	2,080,000	17.56%	84,000	1.91%
Adult men	1,508,000	13.27%	55,000	13.52%

From Donner (2000) p.7

APPENDIX 2

Summary of Indicators Recommended for the Manitoba Women's Health Profile

***Note:** These are indicators for which we know there is no cost. Many others could be available from Manitoba Health, see page 14.

		No. of Indicators	Known to have no cost*	Page
Health Status				
A	Quality of Life & Well-being	9	4	15
B	Mortality	4	2	18
C	Health Equity & Inequities	10		19
D	Health Related Conditions	17		20
E	Use of Health Services	5	1	22
F	Use of Prescription Drugs	2		24
Socio-economic				
A	Income & Wealth	2	2	24
B	Employment	6	6	27
C	Occupational Health	5	4	30
D	Unpaid Work	4	3	32
E	Education	4	4	34
Violence		4		35
Sexual & Reproductive Health				
A	Pregnancy & Childbirth	13		36
B	Sexual Health	8		38
Health Behaviours				
A	Tobacco Use	3	3	42
B	Leisure Time Physical Activity	4		44
C	Healthy Body Weights	4		45
D	Healthy Dietary Practices	2		45
Health of Aboriginal Women	A summary of the data above only		--	46
Women in Health Care Leadership		4		46

APPENDIX 3

Advisory Committee Members

The following members of the project Advisory Committee gave generously of their time. The conclusions and recommendations are those of the PWHCE and the author, and do not necessarily reflect the views of Advisory Committee Members.

Laurie Blanchard, Deer Lodge Centre Library
Dale Brownlee, Manitoba Health
Elaine Burland, Manitoba Centre on Health Policy
Pat Gregory, WRHA
Margaret Haworth-Brockman, PWHCE
Patricia Kaufert, Community Health Sciences, University of Manitoba
Shannon MacDonald, M. D.
Pat Martens, Manitoba Centre for Health Policy
Dawn Ridd, Manitoba Health
Sharon Segal, MS Society
Shahin Shooshtari, Manitoba Health
Leonie Stranc, Manitoba Health
Barbara Wiktorowicz, Women's Health Clinic

Thank you as well to Evelyn Shapiro who provided advice on the selection of indicators related to women's use of home care services and to Jocelyn Proulx, who advised on the selection of indicators related to family violence.