

GENDER-INCLUSIVE HEALTH PLANNING

A Guide for Health Authorities in British Columbia



**BRITISH
COLUMBIA**

Ministry of Health Services

Women's Health Bureau

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INTRODUCTION

How does being a woman or a man affect your health? Can we meet the health needs of women and men through the same services or do we need to tailor services to the unique needs of women and men? Sometimes? Always? When? What are the costs and benefits of creating a gender-inclusive health care system?

Current data indicates that women and men differ in important ways when it comes to health status and health service utilization, particularly if one looks at patterns from a lifespan perspective. For example, on average, women in Canada outlive men by six years and the death rate is higher among men than women in all age categories, particularly during young adulthood (Health Canada, 1999). Men aged 20 to 44 are more likely to die from motor vehicle accidents or suicide while women in the same age group are more likely to die from cancer, primarily breast cancer, the causes of which remain largely unknown (Health Canada, 1999).

Research is also raising questions about the assumptions we hold about patterns and causes of female and male morbidity and mortality (e.g., McDonough and Walters, 2001). The well-worn adage *men die quicker, but women are sicker* is probably too simple to describe similarities and differences in patterns of health and illness among men and women.

Recognizing that there are known and still-to-be-determined differences in the health profiles of women and men should lead us to question whether we should approach health planning in a way that takes these differences into consideration in designing services, allocating resources and setting strategic priorities.

Yet planners do not always take these differences into account when developing or evaluating programs and policies. This lack of attention to gender analysis in health planning may result in oversights, errors, inconsistencies and simplifications (Reid, forthcoming). By making health planning gender-inclusive so that we deliberately explore and consider the possible differential needs, concerns and consequences of health plans for men and women, we can make health programs and services more relevant and appropriate to both women and men in B.C.

The purpose of this tool is to assist communities in improving women's health in B.C. by introducing gender-inclusive health planning to staff and volunteers of local health authorities (HAs). It is a brief overview of gender-inclusive health planning concepts and initiatives currently underway in B.C.

HAs across B.C. are already doing many things to improve women's health. These initiatives include establishing unique smoking cessation programs for women, increasing access to cervical and breast cancer screening programs, introducing sexual assault services in local hospitals, offering home and community care for families, establishing advisory committees on women's health and increasing access to the whole range of reproductive health services. Gender-inclusive health planning, which incorporates sex and gender, is one more way that HAs can improve women's health in this province.

Development of this Resource Tool

This resource tool was developed as an initiative of the Women's Health Bureau (WHB), Ministry of Health Services, with the assistance of the B.C. Centre of Excellence for Women's Health. The WHB has been working on ways to support HAs to improve women's health since their inception in the mid-1990s. For example, the bureau has developed health goals for B.C. women, surveyed HAs on their women's health activities, prepared three provincial profiles of women's health (the most recent in June, 2001) and supported women's health initiatives by funding numerous projects dealing with mid-life health. In addition, the WHB has sponsored networking opportunities for staff and volunteers of HAs to learn about one another's experiences working on women's health. Finally, the bureau has served as secretariat for the minister's advisory council on women's health, a volunteer committee devoted to supporting women's health throughout B.C. through information gathering, policy advice and education.

These steps are all part of gender-inclusive health planning. Many resources are already available to help local efforts toward gender-inclusive health planning (see <http://www.hlth.gov.bc.ca>) and this tool is one more, offering introduction and rationale for considering gender when planning for health.

This tool was developed on the basis of literature and discussions with individuals engaged in gender-based analysis within the health field. As well, input from key informant interviews from two HAs in B.C., the Health Association of B.C. (HABC), B.C. Women's Hospital and several non-governmental organizations interested in women's health (e.g., Heart and Stroke Foundation of B.C. and Yukon) was also used. In addition, Ministry of Health Services staff responsible for regionalization and those who reviewed health service plans provided examples of women's health initiatives throughout the province.

Context of Tool Development

This tool was initially written to support requirements for developing integrated health service plans prepared by the Ministry of Health Services¹ in March, 2000. The ministry is currently reviewing the accountability framework and reporting relationship that exists between itself and the province's HAs. Special attention is being paid to an assessment of the current roles/responsibilities and mechanisms within regional programs regarding HAs, as specified in the ministry's accountability framework document released in 1998.

This review has identified a strategy the ministry can fully implement into its accountability framework. It is anticipated that changes will eventually be made to the ministry's planning requirements as a result of this review. The ministry, however, cannot stop or delay the health service plan process, or the budget cycle for 2001/02, while it evaluates potential options for change. Current health service plan instructions and processes should therefore be considered a bridging course of action.

¹ Note: In June 2001, the former Ministry of Health and Ministry Responsible for Seniors was split into two new ministries – the Ministry of Health Services and the Ministry of Health Planning. The Women's Health Bureau was placed in the Ministry of Health Services.

Possible changes in accountability processes and requirements between HAs and the ministry mean that some aspects of the planning framework included in this tool may change in the near future. The principles of gender-inclusive health planning, and planning in general, will not change despite possible changes in the detailed reporting requirements from the ministry. We therefore consider the planning framework used in this guide as an example of how to think about planning, rather than as a template for developing plans that fully meet the ministry's requirements.

A Note About the Examples

Many examples in this document stem directly from actions of HAs around the province. Wherever possible, these case examples are identified so that follow-up with the appropriate people can take place if there is an interest in further information.

GENDER-INCLUSIVE HEALTH PLANNING

Defining Sex and Gender

What is sex? What is gender?

It is useful to distinguish between sex and gender because each captures different aspects of the similarities and differences between women and men. Sex is commonly understood to refer to biological characteristics that vary and yield distinctly male or female persons. Such characteristics include anatomy (e.g., body size and conformation) and physiology (e.g., hormonal activity, organ functioning) (adapted from Health Canada, 1999). Gender refers to the array of socially and culturally determined roles, personality traits, attitudes, behaviours, values, relative power and influence that society applies to the two sexes (adapted from Health Canada, 1999).

Using sex as a variable in research or planning allows comparative investigations of potential differences associated with biological characteristics.

“Without seeking sex-linked data and disaggregating all data for potential sex differences, it will remain difficult to generalize research findings and treatment options to both women and men with equal confidence and safety,” (Greaves et al., 1999: 2).

Gender refers to what it means at any given point in time, in a given culture, to be a “woman” or a “man.” The specific content of gender varies historically and culturally; gender norms and values differ from place to place and time to time. Gender also involves cultural identity and generational position, as these are elements that may lead to variations in the content of gender. Ultimately, “gender is an evolving and relational variable, which often reflects power differences between groups of people” (Greaves et al. 1999: 2).

Gender-based analysis is an evidence-based “process whereby policies or programs are assessed to determine their actual or potential differential impact on women and men,” (Health Canada 1999: 35). Applied to health planning, we refer to this process as gender-inclusive health planning.

Defining Women’s Health

Our interviews with HA staff in B.C. indicated that the debate over what constitutes women’s health continues. Similarly, research with HAs in Saskatchewan and Manitoba indicated that the majority continued to consider women’s health only in the context of women’s roles as mothers and caregivers (Horne et al. 1999).

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 context of their lives as well as their biology, (U.N. Platform for Action, para. 89, Beijing, 1995)

Historically, women's health has consisted of those conditions or diseases that only affected women, including those associated with childbearing or women's unique anatomy. Today, however, most women's health advocates would argue that women's health encompasses more than reproductive health care. Women themselves report that they want services and care providers to recognize the importance of the subjective experience of health and illness, to be aware of the determinants of health not simply disease, to emphasize prevention and health promotion in addition to treatment of illness and to see health holistically, encompassing spiritual, physical, mental, sexual and social well-being (e.g., Thurston et al. 1998).

Other Important Differences

Women and men are not all the same. Young women, older women, women with disabilities, lesbians, bisexuals, transgendered people, Aboriginal women, women of colour and women who are immigrants or refugees may each differ in their health needs and access to care. Sex and gender are not the only meaningful forms of social difference that affect health. The disadvantages and benefits associated with sex and gender in Canadian society may not be the same for all men or all women because of the effects of these other forms of difference. Therefore, understanding additional actual or potential impacts of diversity on health needs, or access to services, must be considered as part of gender-inclusive health planning.

At one time, equality was understood to mean giving women and men the same opportunities, services or programs on the assumption that this would yield the same results. Today it is recognized that sometimes, different treatments will be necessary for women or men in order to achieve the same results.

Rationale: The World is Gendered

Why do gender-inclusive health planning? Because when it comes to health, sex and gender matter. Research is increasingly alerting us to the ways that sex and gender interact to "create health conditions, situations and problems that are unique, more prevalent, more serious, or have different risk factors or interventions," for women and men (Greaves et al., 1999: 3). Future research will clarify these differences further, making a one-size-fits-all approach to health planning possibly ineffective or even detrimental for women, men or both.

Why women's health? Women have different health needs than men and from each other. Women occupy a unique place in relation to the health system — 80 per cent of health care workers are women and women offer the majority of informal, unpaid care to family members. Tailoring the health care system to meet the particular needs of women (and men) should lead to better use of resources.

FREQUENTLY ASKED QUESTIONS

Question: *Don't women and men want the same thing from the health care system — effective, appropriate services in a timely manner?*

Answer: Yes and no. Yes, both women and men value services that are effective, appropriate and delivered on time. However, “effective” and “appropriate” mean different things to women and men. We now know that women do not respond in the same way as men to many medical procedures. For example, since women’s arteries are smaller, angioplasty – a procedure to clear blocked arteries – is riskier and less successful for women than men. So, it is important to remember that effective, appropriate services do not mean that women and men should receive the exact same services.

Question: *What about men's health? Why are women treated like a special category of health care users?*

Answer: A gender-inclusive approach to health care planning is an approach that takes into account the unique experiences and needs of both men and women — everyone has “gender”, not just women. When women’s health is emphasized, it is because much more is already known about men’s health, not that men’s health issues are less important. The vast majority of health research has been conducted by men on men and frequently the results are applied to women. This situation has sometimes lead to inappropriate or ineffective interventions for women. Also, since the health care system is not immune to some of the traditional biases against women, it must become more sensitive to the unique needs of women.

Question: *Women live longer than men do, so they must be healthier, right?*

Answer: It is true that women live longer on average than men, but they experience more chronic health conditions and disabilities. In addition, women are more likely to “suffer depression, stress overload (often due to efforts to balance work and family life), chronic conditions such as arthritis and osteoporosis and injuries and death resulting from family violence,” (Federal, Provincial and Territorial Advisory Committee on Population Health, 1999). “Women experience more acute medical problems, are hospitalized at higher rates than men, use more prescriptive medications (International Women’s Health Coalition, 1997), report feeling less healthy and have more restricted activity days,” (Federal, Provincial and Territorial Advisory Committee on Population Health, 1999). Women access the health care system 25 per cent more often than men, even once women’s unique reproductive capacity is accounted for. Thus, while women do live longer than men, there is evidence that they experience a lower quality of health throughout these years.

Question: *What causes women and men to have different experiences of health and illness?*

Answer: As we all know from our everyday experiences, health is not only about our bodies — it is also about our mental, spiritual and emotional well-being. Consequently, where we live, our relationships, the quality of our housing, our stress levels, our workload (in and out of the home) and many other factors all impact our health. Factors that contribute to health are not shared equally between the women and men. Women:

- earn less than men (for full-time, year-round employment);
- comprise the vast majority of lone parents;
- are more likely to experience violence in their own homes at the hands of someone they love;
- comprise the majority of unpaid caregivers for children, the sick and the elderly;
- are still underrepresented in positions of power; and,
- have more roles and responsibilities (such as paid employment, caring for children and other family members, performing household tasks and, since women comprise the majority of volunteers, volunteer tasks as well).

These different experiences lead women to have poorer health outcomes and experience illness more often than men.

Question: *You keep talking about the “unique needs of women”— what does that mean?*

Answer: Obviously, women have different health care needs that relate to our unique reproductive functions (e.g., cervical screening, pregnancy, childbirth, etc.). However, even when women and men share a health concern (such as cancer), their requirements from the health care system may be very different. For example, since women live longer than men, older women are less likely to have a spouse to assist them with personal care and household chores upon leaving the hospital. Younger women are more likely to be caregivers of young children, so may be unable to rest at home. On average, women of all ages are poorer than men, so are less able to afford medications. Transportation to medical appointments and childcare arrangements are also more difficult for women due to lower incomes and multiple responsibilities. Women and men need a health care system that is sensitive to the context of their lives and that does not create barriers to access for individuals of either gender.

Question: *Won't a gender-inclusive health care system cost too much?*

Answer: A gender-inclusive health care system does not necessarily mean spending more money on providing more services. It does mean, however, that services provided need to be appropriate to the needs of the individual. Knowledge of how gender interacts with health, health care and the factors that contribute to health is a powerful tool for reducing the burden of illness and the resulting economic consequence to women, families and society.

OVERVIEW OF GENDER-INCLUSIVE HEALTH PLANNING

Gender-inclusive health planning asks whether system planners have taken into consideration the possible different needs of men and women in developing programs and policies.

Four key elements in gender-inclusive health planning are:

- Decision-Making** Looking at decision-making structures and processes in terms of sensitivity and representation of both sexes.
- Population Profile** Developing a population health profile that disaggregates findings by sex wherever possible, appropriate or meaningful.
- Program Inventory** Conducting an inventory of existing programs and services bearing in mind the population health profile and its attendant sex and gender implications.
- Program Review** Designing or revising programs and services that acknowledge and address sex-related differences in health status, risk, behaviour, need and access.

Some questions to consider are:

- How does this program or policy affect men and women?
- What have we done to include women in paid and unpaid decision-making positions in our community?
- What structures have been created to make sure that women and men's needs are identified and acted on?
- Are goals inclusive of women's needs?
- What actions have been taken on the basis of current knowledge of men's and women's needs?

Gender-inclusive health planning can be understood as both a *process* and an *outcome*. It is asking questions about the possible or known effects of a program, service, intervention, facility or policy for both men and women and taking an active approach to ensuring that the views of women and men are taken into account in decision-making. While not all programs or policies will necessarily have different effects on men and women, it is important to ask in the planning phase whether there might be any differences, what those might be and whether those differences are relevant.

The organizational vision and mission, as well as any goals and objectives for the future, will then need to be reflective of the sex and gender analysis used in developing the plan.

Components of a Health Service Plan and Gender-inclusive Health Planning

The following have been identified as components of a health service plan for HAs. Items two to 11 should reflect a gender-inclusive analysis.

- 1) Letter of transmittal;
- 2) Health service plan report;
- 3) HA's vision;
- 4) HA's mission;
- 5) A brief summary of the unique characteristics and health care needs of the HA area's population;
- 6) A brief overview of the existing health system, including an analysis of its strengths and weaknesses;
- 7) Priority issues to be addressed in three years, with a brief summary of process used to identify them;
- 8) Goals and objectives that are consistent with these priorities;
- 9) Major strategies for achieving change;
- 10) Evaluation;
- 11) Communications plan; and,
- 12) Budget submission.

The extent to which women's health is a priority in a given HA will become evident from setting of the vision of a healthy community through how to plan evaluating successes. Steps five and six, which ask for a report on the characteristics of the local population and its health needs and to relate that to an inventory of existing services, offer an important opportunity for asking questions in a gender-inclusive manner.

The four elements of gender-inclusive health planning outlined earlier easily align with the components of preparing a health services plan.

DECISION-MAKING STRUCTURES AND PROCESSES

Governance and Management

How is our gender balance? In B.C., gender representation has been ensured to date by the appointment process. Recent data suggests that women occupy half of the volunteer positions in HAs, but a relatively small proportion of senior paid positions.

Governance – HAs' governance structures in B.C. have good gender balance. As of November 2000, regional health boards were 46 per cent women, 54 per cent men; community health councils were 58 per cent women, 42 per cent men; community health services societies were 56 per cent women, 44 per cent men. Aboriginal representatives on the boards are 71 per cent women.

Management – Most senior administrators of HAs (CEOs and chairs) are men (82 per cent men, 18 per cent women). There are increasingly more women in upper management levels, yet the top position remains male-dominated.

Some HAs, for example the Capital Health Region and Northern Interior Health Region, have also designated specific staff to work on women's health.

What is the gender balance among decision makers in your region?

Public Participation

Public participation is a mandated element of health services planning in B.C. HAs are learning through various experiences how to facilitate public participation in health decision-making. Experiences in other jurisdictions suggest that every community has its own unique history and conditions that must be factored into strategies for working with community groups.

In developing policies and programs directed at women's health, consider working with established women's organizations in the community and/or bringing members of such organizations into existing planning structures. Most organizations serving women's interests will be non-profit services and groups. These organizations engage in advocacy, networking, research, education, lobbying and service provision. Women who have an interest in and work for women's health policy may also have paid or volunteer positions in organizations, government departments, health care and education. Many women's organizations require support to participate in planning because of limited personnel and small budgets.

Research suggests a common challenge for Canadian communities working on women's health issues is confronting the organized opposition to abortion services and "by association, to women's organizations which support a policy of access to abortion by women," (Thurston et al., 1998: 3).

Possible mechanisms for incorporating women's views into planning processes include advisory committees, designated staff positions, open board meetings, newsletters, calls for input and creating volunteer opportunities in the organization.

Community consultation is an established practice of B.C.'s HAs. Many HAs actively involve women and women-serving agencies in their planning processes. While more women than men typically volunteer to participate in planning processes, they often don't speak about their own needs, but rather those of their children and the community in general. Women are more likely to participate if they are assisted with day care and transportation to meetings.

Several HAs have designated specific women's health advisory groups to ensure that women's health is considered. The Vancouver/Richmond regional health board, for example, has a women's population health advisory committee (PHAC) that specifically examines women's health issues in the area and contributes to policy and program discussions to promote women's health.

In your HA, what mechanisms are in place to support the public participation of women in planning?

Policy and Planning Literacy

It cannot be assumed that all stakeholders in health decision-making share a common understanding of the planning process, of health care terminology or of how gender affects health. Part of the process in developing a sex-specific or gender-inclusive health plan may include educational sessions. As most HAs will be undertaking gender-inclusive health planning for the first time, there is a sense that all participants – staff, board members, health services providers and volunteer participants – are learning the process together and can teach one another about their position with respect to the emerging plan. Research in Alberta with women involved in women's organizations indicated that women understood that policy ranged from that which operates at the organizational level to legislation, yet typically had negative associations with policy (Thurston et al., 1999). Rather than seeing policy as an instrument for change, these women reported that policies were often detrimental to them and their quality of life. Finally, they reported that as women-serving organizations, they were seldom consulted in the development of policy beyond the organizational or community level. This suggests that some women's organizations will want an orientation to participate in planning at the HA level. Not surprisingly, women in smaller centres may have greater access to policy makers than women in larger, urban centres.

Who Participates? Diversity Among Women

The medical care system is often based on assumptions about the "generic woman." Such women are white, middle-class, heterosexual, ambulatory, English speaking and responsible for domestic labour and caring. Such stereotypic views of women have generated research and practices that are biased. Women who do not conform to traditional assumptions are more likely to be marginalized further in the health care system. Recent feminist scholars contend that sexism shares qualities with other "isms" – heterosexism, classism, racism, ageism and ableism.

Developing a Population Profile

To conduct gender-inclusive health planning, data and information is essential. In most instances, the first step in moving towards a women's health plan, or any kind of gender-inclusive health planning, is the development of a population profile that summarizes the size and characteristics of the local population, including health status and health services utilization. A key resource for developing a population profile is data that is broken down by sex (female/male), called sex-disaggregated data.

Sex-disaggregated Data

A study undertaken for the Prairie Women's Health Centre of Excellence indicated that very few HAs in Saskatchewan or Manitoba considered questions of sex and gender in the development of their health plans (see Horne et al., 1999). Major barriers to the development of women-specific plans or programs were lack of technical expertise in conducting gender-inclusive health planning and a lack of sex-disaggregated data (i.e. broken down by sex). At a recent women's health networking event in Richmond, B.C., the importance of having sex-disaggregated data about one's HA area in developing programs and support for women's health was also identified.

To improve access to data on women's health in B.C., the WHB has produced a health profile of selected indicators of women's health – broken down by region – for the past three years. The most recent version was produced in June 2001. Data is reported in relation to provincial health goals. These include data on rates of British Columbians receiving B.C. Benefits, an indicator of poverty, and data on rates of violence and sexual assault, conditions linked to mental health problems.

Some HAs are already using sex-disaggregated data in their health plans. For example, in the 2000 plan for the Northwest Health Region, causes of mortality are separated by sex. This plan also reported on sexual assault, teen pregnancy and screening mammography, all issues of particular interest to women in the region. The Capital Health Region plan identifies 85 per cent of seniors over age 75 who are poor, are women. This fact will contribute to what health services are needed and how much these women are capable of providing themselves. Further, the plan also notes that lone parent families headed by women are more likely to be poor than other families in the region. Finally, the Nisga'a Valley health board reports that over 60 per cent of surgical cases are women, an important factor in determining health service needs for the area. These examples illustrate how sex-disaggregated data provides a concrete portrait of a region's population and contributes to an improved understanding of potential health issues and service needs.

Provincial Sources

In B.C., the Ministry of Health Services supports HAs by providing access to health status data and health services utilization data through PURRFECT and the health data warehouse. PURRFECT is the acronym for Population Utilization Referral Rates for Easy Comparative Tables. The latest version is not broken down by sex, but it is planned that the next version, due out in January 2002, be sex-disaggregated.

All HAs have access to the health data warehouse (HDW) through the Internet (<http://www.hdw.moh.hnet.bc.ca/hdw/>). The HDW has data on many elements of health, including many of the determinants of health. For example, there is data on HIV/AIDS, sexually transmitted disease rates, immunization rates, population/demographics, census data and crime statistics. This data is generally available broken down by sex/gender, age and region. For additional information, email hdw@moh.hnet.bc.ca, or refer to the list of data at the end of this document.

National Sources

Canadian Institute for Health Information (CIHI)

CIHI tracks and reports data on health status and health system performance for the whole country. Provincial and regional breakdowns are available on their Web site (www.cihi.ca) for selected indicators and selected regions (e.g., population size, proportion over age 65 and life expectancy). Some data on women's health, specifically (e.g., hysterectomy rates, rates of pap smears and screening mammography), are available as well as some of the non-medical determinants of health (e.g., education levels, unemployment rates, rates of tobacco smoking and affordability of housing).

Statistics Canada

Statistics Canada compiles many reports that are useful for developing an understanding of the situation of women in Canada. Over the past 20 years, Statistics Canada has published several reports on women specifically. The most recent, *Women in Canada 2000*, explicitly uses a gender-based approach. Health data is included in a separate chapter.

Free publications of health reports are also available. The 2001 annual report examines the factors that affect health and well-being and looks into the health differences between men and women. This document is available free of charge by mail or through the Statistics Canada Web site (www.statcan.ca).

Establish Mission, Vision, Goals and Objectives

Incorporating women's health into the mission, vision, goals and objectives of a HA helps to demonstrate a commitment to improving women's health and encourages the allocation of resources, staff and volunteers to activities directed at women's health.

An excellent resource for reflecting on HA's goals and objectives is to refer to the *Health Goals for B.C. Women* document developed by the WHB. This document offers a woman's health perspective on the goals and objectives that are derived from them.

For example, the first provincial health goal is – positive and supportive living and working conditions in all our communities. Framed in terms of women's health, this goal has been elaborated as follows: *The most important influences on women's health are the conditions experienced in our day-to-day lives. Having a safe workplace that supports gender equity, income based on the value of work, opportunities for advancement, safe communities and adequate, affordable housing significantly enhances our health.*

Similarly, the fourth provincial health goal is an effective and efficient health service system that provides equitable access to appropriate services. *All women need gender- and culture-sensitive health care that is accessible, regardless of where they live. That health care must be available to women who are caregivers of children, elderly parents or spouses. At the same time, women need health care that does not restrict natural processes, such as childbirth and menopause, to medical terminology only and care that does not substitute drug therapy for sensitive care and lifestyle education. Women need a balanced health care system that takes concerns seriously without an emphasis on the 'medical' side. Women need accessible gender, culturally-sensitive health care.*

Some HAs have begun to write women into their mission, vision, values and goals. For example, the Northwest 1999-2002 health services plan has an explicit goal of improving the health of women that includes strategies for smoking cessation and screening mammography. Outcome indicators are rates of lung and breast cancer deaths respectively. Moreover, the region has declared that they will plan and introduce strategies to address identified women's wellness issues.

ACTIONS TAKEN BY B.C. HEALTH AUTHORITIES TO ADDRESS WOMEN'S HEALTH

Women and women's health advocates throughout B.C. have been engaged in many activities related to women's health and women's health planning. A few years ago, women's groups were leading the way by preparing reports for their local health boards on women's health concerns and the need for women to have voices in local decision-making. This process has been used in Prince George, Kamloops, Surrey, Victoria and Vancouver, to name but a few of the many communities who have taken on the challenge of raising awareness about women's health concerns (e.g. see Dale and Goldberg, 1996).

More recently, HAs have been initiating and supporting women's health planning. This is most notable in Vancouver, where a large, multi-stakeholder process in 1999 led to significant policy changes and implementation regarding women's health. All over B.C. we see HAs committed to exploring gender-inclusive health planning. This section introduces a few of those communities.

The WHB is supporting networking activities among people interested in women's health and gender-inclusive health planning through their Web site, conferences, educational sessions and project funding. An exciting series of projects conducted by HAs are currently underway with ministry support through women's health grants.

In early June, 2001, representatives from each of the dozen communities working on these grants came together to share stories of their successes to date and the lessons they have learned about working toward improving women's health. Grouped together, these projects can be usefully seen as four kinds of initiatives:

- 1) Development of a women's health strategy, which often entails developing a women's health profile and policy statement for a particular region;
- 2) The creation of direct services targeted at women and girls;
- 3) Public awareness-raising activities; and,
- 4) Program development.

1. Strategy Development

In order to develop women's health strategies tailored to a particular community, several HAs constructed women's health profiles for their areas and developed strategies for communicating the profiles to their local decision-makers. The following are examples of projects being carried out throughout the province:

North Okanagan Health Region

The goal of this project is to improve the health of women in the North Okanagan Health Region through the development of a woman's health profile and plan. Based on the data profile they develop, this group wants to look at the challenges in their health region with respect to women's health. They have already observed that in their region, in smaller communities (local health areas) more women than men receive B.C. Benefits, have low incomes and lower levels of education, reflecting a difference in poverty rates among women and men in the region. This group has obtained data from several sources to develop a health profile of the region, including the provincial health data warehouse and the Canadian Institute for Health Information. They have tried to document mental health, education levels and alcohol and drug use in addition to standard indicators like economic status, heart health and cancer.

North Shore Health Region

The primary goal of this project is to develop an information base/profile of women's health to provide an accurate picture of women's health. This will help to inform HA planning and program decision-making. There is a common perception that there are no health problems in this region because it has an average-to-high per capita income and standard of living. This makes it hard to advocate for those who are not receiving proper care – but you have to fight harder. This can be a barrier to decision-makers recognizing that there are some groups in the community who do not share this same standard of economic security and its attendant well-being. Among women in the region who need additional attention are socially marginalized women, women who are caregivers and women receiving pre and postnatal care. The project organizers are seeking local solutions for local issues and sees the health board as the target audience for their health profile. Hopefully, the profile will give a statistical basis for their argument that there are women in need in the North Shore Health Region.

South Peace Health Council and Women's Advisory Committee

A women's health profile was begun, sponsored by the women's advisory council on the health of women. Some 250 women were interviewed (most aged 25-49) in Chetwynd, Moberly Lake, Dawson Creek, Tumbler Ridge and Pouce Coupe. The group found that health status and health-related behaviours are well documented in this community. From their work, seven main areas of concern have been identified: cancer, nutrition education and food security, reproduction and sexuality, home supports, health professionals and mental health. The inquiry also identified that women like living in the region: 72 per cent of the respondents not only wanted to remain living in a rural area, but wanted to remain in this specific area as well. This speaks well for the future of the community as well as women's commitment to the area. The interviews also revealed that greater attention needs to be paid to the creation of a communication strategy, mental health services and issues of access and flexibility of services.

2. Direct Service

These projects approached improving women's health in their communities by offering some sort of service or program that had either not been available before, met a specific request from the community, or was not possible without an infusion of new resources:

Upper Island/Central Coast Community Health Services Society

This project targeted women who suffer from postpartum depression. A support group was established and educational sessions arranged. Among the topics discussed were the myths surrounding motherhood. A session was held called *Heartache and Hope* to educate women on what postpartum depression is and how to deal with it. A public health nurse attended to answer questions and provide information.

Central Vancouver Island Region & Tillicum Haus Native Friendship Centre

This innovative program taught people how to identify personal and family nutritional needs and provided lessons on economical food preparation. The program was specifically aimed at local Aboriginal communities, particularly single mothers and low-income families at risk for poorer health status, lower birth weights and a higher prevalence of diabetes. This was a client-driven program that involved 10 teaching sessions over 20 weeks that were fun as well as educational. Examples of topics covered include healthy eating, feeding children and diabetes. This collaborative project included a partnership with the Nanaimo Community Kitchen.

3. Public Awareness Activities

These projects entailed some form of raising public awareness as a health promotion strategy. These could be: holding a special health information event, creating educational displays or developing resource materials.

Bella Coola Transitional Health Authority

Bella Coola is geographically isolated with a small population. The group in this community held a Women's Wellness Day to promote healthy lifestyle practices such as breast and cervical cancer screening, blood pressure monitoring and physical activity. Women were encouraged to attend and assess their lifestyle at this event in the hope that they would establish personal health goals and gain knowledge about how to reach those goals. Each participant was presented with a health passport and a survey to assess personal health such as body mass index (BMI), fat intake and weight as part of the promotion of healthier eating.

Bulkley Valley Health Council

Five workshops were planned to address women's health issues, each with a different target audience: adolescents, 13-19 years old, mothers with young children, women in mid-life and seniors. The aim of the workshops was to identify health concerns, create awareness of local resources and to provide networking opportunities for the participants. A survey was conducted about women's health concerns. There were 210 surveys completed and returned, representing 13.5 per cent of the female population in the region. From the survey responses, nine workshops were created (nearly twice as many as originally planned) to help women address their health concerns. Topics covered were self-esteem and body image, fitness and nutrition, self-defence, health, nutrition and yoga, aqua aerobics and stress management, breast and lung cancer, alternative medicine and balancing lifestyles.

Coast Garibaldi Health Services Society

A women's health advisory network team was created to educate women about health and to create a woman's health network. The team planned educational workshops in conjunction with the women's network. Both volunteers and employed women attended the workshops. Topics covered included women's heart health and breast cancer. Workshops were evaluated.

4. Program Development Grants

Communities used these grants to work toward a larger program of activities, which required resources before continuing.

James Bay Community Project, Capital Health Region

The group is working on the development of a health centre for women in mid-life. The project will use a women-centred model of care to provide health services to women. This non-profit community group is particularly interested in trying to meet the needs of the local population, mainly consisting of seniors. Also under development is a primary health care project that includes a women-centred clinic. The project entails long-term planning. Currently, the group is at stage three of a six-stage planning process.

Powell River Community Health Council

This community is looking at enhancing, expanding and developing medical and social programs designed specifically for women who were victims of violence. They have held several forums to inform people about available services for victims of violence. For example, they have held a session entitled *Violence Against Women is a Health Issue* to raise awareness, especially about services offered for abused women and children. This session involved physicians, nurses, community members and others. The event served to identify barriers to service and enabled women to share their stories.

Comox Valley Community Health Council

The project specifically looked at the needs of women suffering from chronic illnesses in the Comox Valley. A self-selected group of women living with chronic health challenges was formed and they met to discuss their experiences. This project entailed three phases: information gathering, education and feedback. Phase one involved focus groups of women with chronic illnesses. Phase two involved education sessions. Examples of topics included: how to communicate better with doctors and conventional and complementary medicine for women with chronic illnesses. Future education sessions are planned, including one to develop a peer support network. Phase three involves feedback and project evaluation.

Women's Health Planning in the Vancouver/Richmond Health Region

No discussion of women's health planning in B.C. would be complete without a description of the significant activities of the Vancouver/Richmond Health Board.

The board is actively engaged in women's health planning. Many elements contribute to this work, including existence of a designated mechanism for public input, a dedicated women's health planning project in 1999-2000 and an ongoing implementation plan. Management and board support have ensured that this work is visible and increasingly integrated into the everyday work of staff in the region.

The Vancouver/Richmond regional health board maintains a set of population health advisory committees comprised of volunteers and staffed by experienced community developers. The women's population health advisory committee has been extremely active and, with support from the board and under the leadership of B.C. Women's Hospital and Health Centre, spearheaded a women's health planning project.

The project adopted a multi-committee structure led by a steering committee to ensure that researchers, practitioners and community members each contributed to the development of a plan for women's health in the region. The report of this work is available on-line or from the board offices (see <http://www.vcn.bc.ca/vrhb>).

The report includes a *Framework for Women-centred Health* that has been adopted as board policy. Elements of the framework include:

- Need for respect and safety;
- Importance of empowering women;
- Involvement and participation of women;
- Women's patterns or preferences in obtaining healthcare;
- Women's forms of communication and interaction;
- Need for information;
- Women's decision making processes;
- Gender-inclusive approach to data;
- Social justice concerns; and,
- Gender sensitive training.

This framework was released in a separate supporting document, with detailed examples of the elements within the region, in June 2001.

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SELECTED RESOURCES FOR GENDER-INCLUSIVE HEALTH PLANNING

Training Resources

- Commonwealth Secretariat (2001), *Gender and Health Training Materials*. London: Commonwealth Secretariat.
- B.C. (nd), *Gender Lens: A Guide to Gender-inclusive Policy and Program Development*. B.C.: Ministry of Women's Equality.
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Women's Health Resources

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Case Studies/Reports for Local Health Areas/Regions

Dale, E. (nd.), *Women's Access to Regional Health Planning Project Report*. Report to Kamloops Women's Resource Group Society, 7E 750 Cottonwood Avenue, Kamloops, B.C. V2B 3X2
Tel: (250) 376-3009 Fax: (250) 376-3080

Goldberg, S. (1996), *Women's Health Needs and Priorities in the Surrey Central Community Health Council Region*. Available from Surrey Women's Centre Society, P.O. Box 33519, Surrey Place Mall, Surrey, B.C. V3T 5R5, Tel: (604) 589-1868 Fax: (604) 589-2812

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Data Sources Available

Population and Demographics

Health Data Warehouse (HDW)

<http://www.hdw.moh.hnet.bc.ca/hdw/subjects/ppop2.htm>

Mortality by Health Region and Local Health Area

Vital Statistics (Annual Report, Appendix 3)

<http://www.vs.gov.bc.ca/stats/annual/index.html>

Life Expectancy by Health Region and Local Health Area

Vital Statistics (Annual Report 1999, Appendix 1)

<http://www.vs.gov.bc.ca/stats/annual/index.html>

Births

Vital Statistics

<http://www.vs.gov.bc.ca/stats/annual/index.html>

Teen Pregnancy

HDW

<http://www.hdw.moh.hnet.bc.ca/hdw/>

Vital Statistics (Annual Report 1999, Information Box III)

<http://www.vs.gov.bc.ca/stats/annual/1999/box03.html>

Morbidity

PURRFECT 6.0

Indicators of Progress Toward Provincial Health Goals

HDW

<http://www.hdw.moh.hnet.bc.ca/hdw/indicators.htm>

Local Health Area-level Population Health Indicators and Data Sets

HDW

<http://www.hdw.moh.hnet.bc.ca/hdw/>

Aboriginal Health Data

HDW

<http://www.hdw.moh.hnet.bc.ca/hdw/>

Utilization of Health Services

PURRFECT 6.0

Bed List

Regional Programs Web Page

<http://admin.moh.hnet.bc.ca/acc/profiles/index.html>

Mental Health

PURRFECT 6.0

Revitalizing and Rebalancing B.C.'s Mental Health System 1998

<http://www.hlth.gov.bc.ca/mhd/mhpd.pdf>

Foundations for Mental Health Reform: The Mental Health Policy Framework and Key Planning Tools, June 2000

B.C.'s Mental Health Reform — Best Practices (January 2000)

Continuing Care

PURRFECT 6.0

Medical Services Plan

PURRFECT 6.0

Public and Preventive Health

HDW

<http://www.hdw.moh.hnet.bc.ca/hdw/indicators.htm>

Communicable Disease

HDW

<http://www.hdw.moh.hnet.bc.ca/hdw/subjects/rcd.htm>

B.C. Centre for Disease Control

<http://www.bc.cdc.org/cdcmain/reports.shtml>

Socio-economic Status

Health Data Warehouse

<http://www.hdw.moh.hnet.bc.ca/hdw/>

Health Human Resources

Health Human Resources Unit

For the Province:

HHRU 2000:8 ROLLCALL 99. A Status Report of Health Personnel in the Province of B.C., August 2000.

By region:

HHRU 2000:9 INVENTORY 99. A Regional Analysis of Health Personnel in the Province of B.C., September 2000.

<http://www.chspr.ubc.ca/cqi-bin/pub?program=HHRU>

AGENCIES

B.C. Centre Of Excellence For Women's Health

B.C. Women's Hospital and Health Centre
E311 – 4500 Oak Street
Vancouver, B.C.
Canada V6H 3N1

www.bc.cewh.bc.ca
Tel: (604) 875-2633
Fax: (604) 875-3716

Prairie Women's Health Centre Of Excellence

Room 2C11A – The University of Winnipeg
515 Portage Avenue
Winnipeg, Manitoba
Canada R3B 2E9

www.pwhce.ca
Tel: (204) 786-9048
Fax: (204) 774-4134

National Network On Environments And Women's Health

Centre for Health Studies
York University
4700 Keele Street
214 York Lanes
Toronto, ON
Canada M3J 1P3

www.yorku.ca/research/nnewh
Tel: (416) 736-5941
Fax: (416) 736-5986

Maritime Centre Of Excellence For Women's Health

IWK Grace Health Centre
5980 University Avenue
P.O. Box 3070
Halifax, Nova Scotia
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www.medicine.dal.ca/mcewh
Tel: (902) 420-6725
Toll Free: 1-888-658-1112
Fax: (902) 420-6752

Canadian Women's Health Network

Suite 203, 419 Graham Avenue
Winnipeg, Manitoba
Canada R3C 0M3

www.cwhn.ca
Tel: (204) 942-5500
Fax: (204) 989-2355

Women's Health Bureau, Health Canada

www.hc-sc.gc.ca/main/hc/web/datapcb/datawhb/cewheng.htm

Women's Health Bureau, B.C. Ministry of Health Services

5-2, 1515 Blanshard Street
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www.healthservices.gov.bc.ca/whb/
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