



a framework for
**women-
centred
health**

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Working Together for Better Health

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Contents

5	Introduction
12	Diagram of the Framework for Women-Centred Health
14	Elements of the Framework for Women-Centred Health
15	The need for respect and safety
18	The importance of empowering women
20	Involvement and participation of women
22	Collaborative and inclusive work environments
24	Women's patterns or preferences in obtaining health care
26	Women's forms of communication and interaction
28	The need for information
30	Women's decision-making processes
32	A gender-inclusive approach to data
34	Gendered research and evaluation
36	Gender-sensitive training
40	Social justice concerns
43	Bibliography

Introduction

On February 24, 2000, the Vancouver/Richmond Health Board (V/RHB) approved the use of the Framework for Women-Centred Health to guide its policies, programs, services and structures. The framework assists the V/RHB to improve the health of women by making women-centred approaches to health care a primary focus within the Vancouver/Richmond region.

Elements of a Framework for Women-Centred Health

The framework consists of 12 elements:

- The need for respect and safety
- The importance of empowering women
- Involvement and participation of women
- Collaborative and inclusive work environments
- Women's patterns or preferences in obtaining health care
- Women's forms of communication and interaction
- The need for information
- Women's decision-making processes
- A gender-inclusive approach to data
- Gendered research and evaluation
- Gender-sensitive training
- Social justice concerns

How the Framework for Women-Centred Health came about

For many years women have repeatedly told health planners and providers that the current health system does not respond well to their needs. They want the system to consider their specific needs and develop appropriate responses, with women at the centre of services and activities.

The framework outlined in this guide was developed from the work of over 75 people in the Vancouver Richmond area who participated in the V/RHB Women's Health Planning Project. Their goal was to understand women's experiences of the system and to improve planning so that the system would meet women's needs better. The project included participants representing the community, as well as

In using the term “women,” we realize that women come from diverse backgrounds and that complex factors affect their lives. When used here, the term is meant to include health care consumers and caregivers, both paid and unpaid.

people working in health services ranging from community settings to hospital care, health planning, research and policy making.

The Framework for Women-Centred Health emerged from extensive discussions that were informed by:

- current international literature on women's health
- a survey of programs within the V/RHB providing services to women across the continuum of care
- a focus group of V/RHB providers working with violence issues
- information about women-centred models and frameworks from across Canada and elsewhere.¹

The discussions were enormously enriched by the diverse perspectives and roles that participants brought to the project.

The Women's Health Planning Project was undertaken by the V/RHB and its Women's Population Health Advisory Committee under the leadership of B.C. Women's Hospital and Health Centre, part of the Children's and Women's Health Centre of B.C. (see *Women's Health Planning Project Final Report*, January 2000).

Women-centred health applies across the life span to include girls and young women, seniors and elders.

Why women-centred health?

There are biological (sex) differences between females and males that affect some health needs. But women's health is not simply about biological differences or reproductive health. Social, or "gender" differences interact with sex and have a profound and far-reaching effect on women's health.

What is gender?

Gender is an analytic tool for understanding social conditions and processes. It refers to the differences between men and women that are socially defined, that are created by cultural norms rather than biology. These differences are not fixed; they vary between cultures and change over time.

Social constructions of gender determine attitudes about what men and women are capable of, how they should behave, what kinds of role models and images are presented to women and men, and who will occupy positions of power. Gender affects almost all aspects of women's and men's lives, their needs, opportunities and access to resources.²

1. Information was gathered in the summer of 1998 from the Women's Health Clinic, Winnipeg; Peterborough Civic Hospital, Peterborough; Women's Health in Women's Hands Community Health Centre, Toronto; Women's College Hospital, Toronto; B.C. Women's Hospital and Health Centre, Vancouver; Brief Psychotherapy Centre for Women, Toronto.

2. B. Hedman et al. *Engendering Statistics: A Tool for Change*, Stockholm: Statistics Sweden, 1996, p. 13.

People do not always conform to socially defined gender roles. Some women may adopt characteristics or behaviour which more closely resemble the socially defined gender role of men. They are born biologically female and perceive themselves (identify) as women but do not conform to traditional social roles of women.

There are also people who were born genetically female but do not perceive themselves to be women. They may identify as male or as transgendered. Women who are lesbian may identify with terms such as lesbian, queer, butch or dyke.

How does gender affect women's health?

Women make up 50.9 percent of the Vancouver/Richmond population,⁴ yet we know that they do not share equally in the benefits of society. One of the most basic manifestations of gender difference is economic inequality. We know, for instance, that in Canada women earn less than men for work of equal value, own less property, have less access to capital, are more often single parents, and as single parents live more often in poverty. In Vancouver, half of the Aboriginal families with children are headed by a single female parent, and in Richmond, one-quarter.⁵

The evidence that poor health is related to patterns of disadvantage is overwhelming. Many studies link health, gender and social and economic inequality. They show that:

- Social class is important in predicting how individuals will rate their own health status.
- There is some evidence that women with no partner, and especially those who are parenting alone, have poorer health. They are also more likely to report stress.
- Aging is related to poorer health.⁶ The effects of the socially disadvantaged position of women and girls are often cumulative.⁷

There are increasing indications that there are differences between women and men in health status and in access to and utilization of health services.

For example, cardiovascular disease is the leading cause of death for Canadian

A DEFINITION OF WOMEN'S HEALTH

“Women’s health involves women’s emotional, social, cultural, spiritual and physical well-being, and it is determined by the social, political and economic context of women’s lives as well as by biology. This broad definition recognizes the validity of women’s life experiences and women’s own beliefs about and experiences of health. Every woman should be provided with the opportunity to achieve, sustain and maintain health, as defined by the woman herself, to her full potential.”³

3. S. Phillips, “The Social Context of Women’s Health: Goals and Objectives for Medical Education,” *Canadian Medical Association Journal* 152, no. 4 (1995): 507.

4. Tabulation prepared from Statistics Canada 1996 Census data by V/RHB Planning and Evaluation.

5. Rhea Joseph, *Healing Ways: Aboriginal Health Service Review*, Vancouver: Vancouver/Richmond Health Board, October 1999, p. v.

6. V. Walters, R. Lenton, and M. McKeary, *Women’s Health in the Context of Women’s Lives: A Report Submitted to the Health Promotion Directorate*, Ottawa: Health Canada, 1995, p. 2.

7. A. Hammad, J. Sayegh and T. Turmen, *Women’s Health: Towards a Better World. Report of the First Meeting of the Global Commission on Women’s Health*, Geneva: World Health Organization, August, 1994, pp. 2, 18.

women. A gender difference has been consistent over the last five years: there are more strokes than heart attacks among women, and more heart attacks than strokes among men. When admitted to hospital for either condition, women spent more time in hospital than men. For women admitted for heart attacks in 1998/99, the average length of stay was 9.2 days compared to 7.8 for men. For strokes, the average length of stay was 16.0 for women and 13.8 for men.⁸

Another example of the link between gender and health can be seen in the effects of violence on women. Twenty-five percent of all women in Canada have experienced violence at the hands of a current or past marital or common-law partner, and 50 percent have experienced at least one incident of violence since the age of 16. Being a victim of violence is linked with a number of health consequences for women: addictions, mental illness, migraine headaches, eating disorders, arthritis, irritable bowel syndrome, reproductive health problems like chronic pelvic pain, sexually transmitted disease and death.⁹

When a care approach is women-centred, women can turn their life around.

A MENTAL HEALTH WORKER

What about family or patient-centred health care?

Some practitioners who use a family-centred or patient-centred approach may already be using many of the practices outlined in this framework, without labeling them women-centred. Some practitioners may also support many of the concepts of a women-centred approach, but lack opportunities to further explore solutions to meet the needs of women.

Others may work in a “gender neutral” fashion. Because of inequities affecting women’s health and access to health care, “gender-neutral” health services can mean that gender issues remain invisible and women’s needs are not always met. A women-centred approach to health enables us to analyze and develop practices from the understanding that women and men are affected differently by health policies and programs.

What about men?

The mandate of the Women’s Health Planning Project was to develop a women’s health profile. However, many elements of the Framework for Women-Centred Health will help make the system more responsive to men as well as to women.

8. Canadian Institute for Health Information, Media Release, Ottawa, February 28, 2001.

9. Minister’s Advisory Council on Women’s Health, *Moving Towards Change: Strengthening the Response of British Columbia’s Health Care System to Violence Against Women*, B.C. Ministry of Health, Victoria: Queen’s Printer, 1999, pp. 7-8.

A Framework for Women-Centred Health

The Framework for Women-Centred Health was developed as a resource and guide to help with the planning and implementation of policies, procedures and initiatives across the spectrum of health services that affect women. The framework consists of 12 elements that, taken together, provide tools and strategies to improve responses to the health needs of individual women and specific populations of women.

When women talk about health, they talk about their whole lives. Women are clear that their health cannot be looked at in isolation. Health is a product of many interconnected factors, including age, ethnicity and culture, language, physiology, ability/disability, financial circumstances, sexual orientation, religion and spirituality, education level, geography, housing, and access to information and services. Rather than seeing these factors as “barriers,” the Framework for Women-Centred Health attempts to recognize them as integral parts of each woman’s life experience. (See diagram of women-centred health model, page 15.)

As a result of listening to the voices of women who participated in this project, the Women’s Health Planning Project embraced the definition of “health” from the World Health Organization and the Ottawa Charter for Health Promotion:

“Health is the extent to which an individual or group is able, on the one hand, to realize aspirations and satisfy needs, and on the other hand, to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. It is a positive concept, emphasizing social and personal resources as well as physical capacity.”¹⁰

The Framework for Women-Centred Health takes a comprehensive approach so that women’s health is integral to the whole health system, rather than being an “add-on” issue. It incorporates issues that extend beyond traditional medical interventions, placing health in its broader context of social determinants.

The Framework for Women-Centred Health begins with women’s lives and places women at the centre of services and activities.

10. World Health Organization (WHO), *Ottawa Charter for Health Promotion: An International Conference on Health Promotion: The Move Towards a New Public Health*, Ottawa: WHO, Health and Welfare Canada, and Canadian Public Health Association, November 1986.

All elements of the Framework for Women-Centred Health are interconnected.

Elements of the framework

The Women's Health Planning Project distilled the concepts and strategies that inform a women-centred approach into 12 different elements.

The first four elements deal with processes that engage and empower women:

- The need for respect and safety
- The importance of empowering women
- Involvement and participation of women
- Collaborative and inclusive work environments.

The second four elements address gender differences that affect women's health and access to health care:

- Women's patterns or preferences in obtaining health care
- Women's forms of communication and interaction
- The need for information
- Women's decision-making processes.

The next three explain methods that support a women-centred approach:

- A gender-inclusive approach to data
- Gendered research and evaluation
- Gender-sensitive training.

The last element discusses systemic inequalities that have an impact on women's health and services for women:

- Social justice concerns.

These elements are not necessarily placed in order of importance. All the elements are interconnected, and you may choose to focus on different elements at different times.

Implementing the Framework for Women-Centred Health is a long-term process, and it can be approached in different ways. You can use the framework to guide the design and planning of new programs or to assess whether existing programs are women-centred. You may want to expand on the framework to include other aspects or elements you consider important in meeting women's health needs. As well, you may choose to integrate the content of the framework into other frameworks addressing such issues as diversity and quality improvement. There are overlaps within and between concepts in all these models.

Using this guide

In this guide, each element of the Framework for Women-Centred Health is discussed in a separate section. For each element you will find a section on understanding the element (a description) and a section presenting some ways to apply the element.

The description of each element does not provide strict definitions, but rather some understandings gained during the Women's Health Planning Project. Similarly, the section on applying the element does not provide checklists or a "how-to" list, but rather examples that suggest some ways to put the element into practice. The examples can assist you to:

- build upon what you are already doing
- integrate women-centred concepts into your practice
- generate new ways of working
- evaluate or create programs.

While there are many examples from around the world of how these elements can be applied, most examples included in this guide come from within the Vancouver/Richmond area so that readers can build on local practices, share experiences and collaborate on problem-solving.

The examples of local women-centred practices demonstrate that many concepts and strategies included in the framework are already familiar and firmly established within the V/RHB region. This indicates that there is substantial expertise available locally to provide a foundation to further develop women-centred approaches.

The reader may find it useful to review specific sections from time to time rather than working through the entire guide from beginning to end. Certain sections may be more useful and appropriate for your work than others. The guide is designed so that you can pick a place to start that feels right for your needs. When implementing the framework, it will be helpful to work with colleagues and women in your programs and to form networks with other people who are also engaging in this approach.

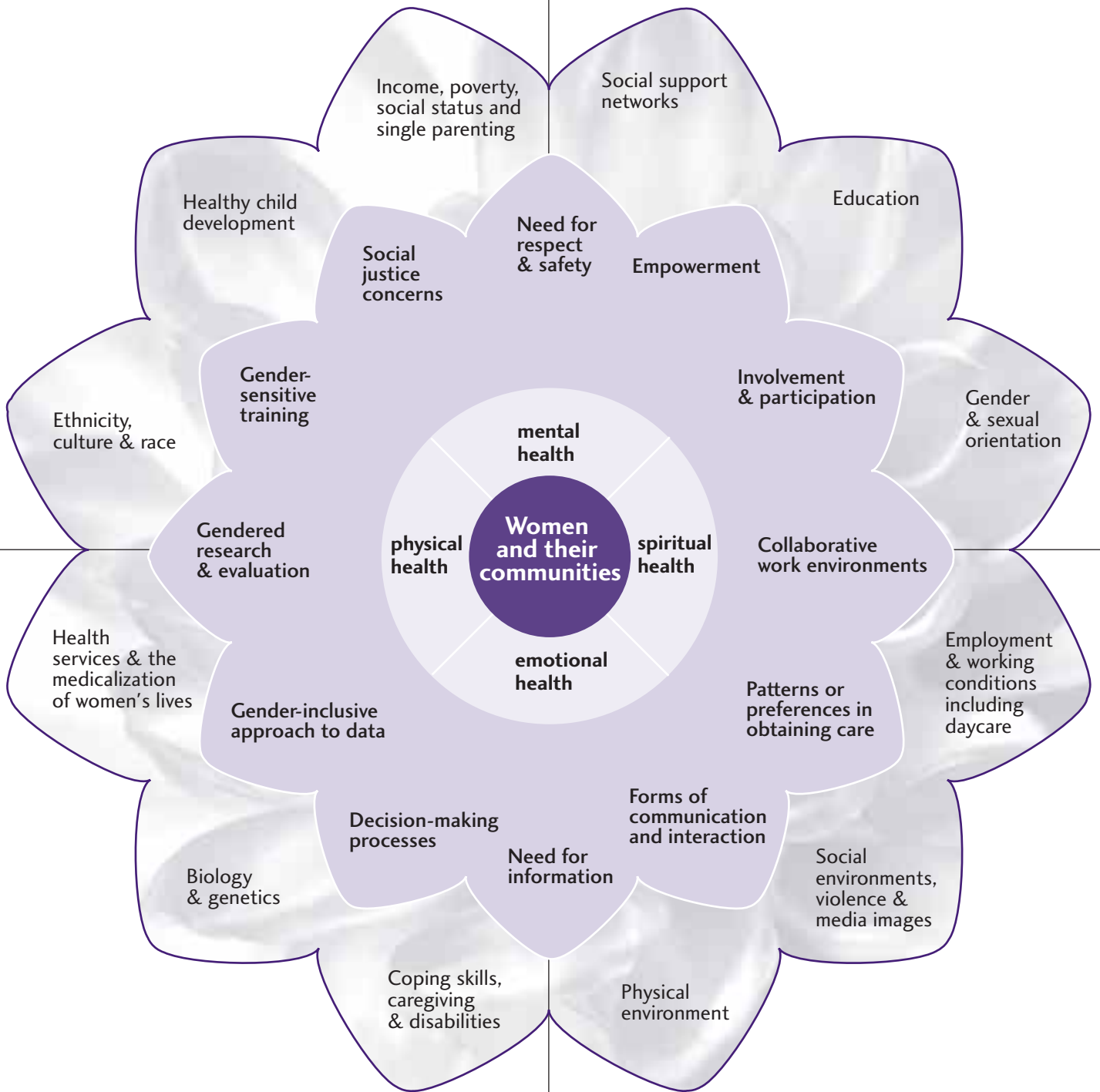
Women, community groups, service providers, policy makers and planners can all adapt the framework to respond to their own situations.

Diagram of the Framework for Women-Centred Health

This visual design allows you to see the Framework for Women-Centred Health integrated with Health Canada's determinants of health and the four-quadrant Aboriginal medicine wheel framework. This is useful for placing the Framework for Women-Centred Health within the context of women's lives.

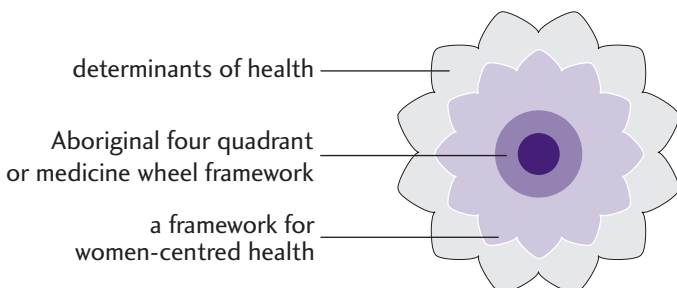
The twelve determinants of health derive from Health Canada's Population Health framework. Additional factors have been added to some determinants to help make them more reflective of women's lives.

Imagine if each concentric circle could spin around the centre. You could spin the determinants of health or the Framework for Women-Centred Health. You can use any element from the model as an entry point. Wherever you point, you can imagine everything else relating to that element as it moves around the centre. All variables can be seen at a glance. This diagram becomes a potential blueprint for action.



A framework for women-centred health

KEY TO CHART



elements of the framework

for women-
centred health

The need for respect and safety

Understanding this element

Addressing women's health in the context of women's lives begins with respect and safety. This need has been articulated repeatedly in twenty years of reports about women's health.

A significant number of women avoid the health care system because of past encounters where they have experienced discrimination or felt unsafe or unwelcome. Many women feel their voices are not heard when they seek health care. They want providers and administrators to accept the validity of their opinions and feelings. Others find their concerns or contributions are not treated with respect, or that the system's response further compounds their problems.

Providers may be unaware of how their language, training and behaviour discount women's realities. Typically, health care providers are in positions of greater power than their clients/patients. Although this affects both genders, it is more significant for women because of their unequal social status and the complex and diverse factors affecting their lives. Women who are health care providers may also feel that they have no power in the system and may face lack of respect or safety on the job.

To avoid retraumatizing women, it is important for health care providers to be aware of the effects of violence and abuse. Several kinds of abuse are common among specific groups of women, for example, financial (seniors), racism (women of colour), residential school (Aboriginal), state-sanctioned torture and violence (refugees), homophobia and transphobia (lesbian or transgendered people). Some providers may try to protect themselves from what may seem like uncomfortable situations and may deny, blame or invalidate women who have been abused rather than try to understand their coping strategies.

The level of documentation required by the health system may operate as a systemic barrier to safety for some women, particularly those who have experienced violence. Women who fear child apprehension or loss of custody may be reluctant to share health information. In some cases chart information has been used against them, or charts have been subpoenaed by courts; yet women may be viewed with suspicion when they ask not to have something charted. Aboriginal women are particularly affected by a foster care/adoption cycle. About one-half of Vancouver children in care are Aboriginal.¹¹

Privacy and confidentiality are also issues for women regarding sensitive information like dependence on social assistance, requests for subsidies, and sexual health.

Women are put down daily. It is such a part of our society, and this includes the health care system.

COMMUNITY PARTICIPANT IN
THE WOMEN'S PROJECT

11. Rhea Joseph, *Healing Ways*, p. vi.

Don't start out with what is most difficult to talk about (the health problem). Start with questions about the social determinants, the core things which affect women's lives.

PRACTITIONER AT SHEWAY

Some ways to apply this element

Take the time at the outset to explain the worker's role, identify and provide for the patient's needs, and explain the system and process (rather than immediately starting to write notes or fill out reports).

An Aboriginal woman explains in the V/RHB Aboriginal Health Service Review: "I find that when [women] come in for an assessment, it takes about half an hour or 45 minutes and it's just, right into the questions and no getting to know the client at all. There's no 'How is she feeling? Does she look comfortable in her seat?' Nothing of that; she comes in and the psychiatrist starts asking her some very, very personal questions just a few minutes after she sits down. Regarding sexual abuse – who abused her, how many times, and stuff like this..."¹²

"Many clinicians harbour a strong sense of responsibility and feel conflicted about raising personal issues when they do not feel they have the time to respond or the expertise and resources to help 'fix' the situation or resolve the 'problem'... Listening and expressing genuine concern are 'doing something' important; it is okay to say, 'I wish we had more time today. I'm really glad you felt comfortable enough to talk. Let's try to take some more time on your next visit,' or 'This seems important, do you want to talk to someone about this in more depth?'"¹³

Provide women-only space.

The Kettle Friendship Society has a women-only lounge. A woman using the Kettle drop-in centre may have a restraining order against her husband who might also come to the same drop-in centre. The women-only lounge can help deal with safety issues. The women-only space also has a shower, as many women living in rooming houses are afraid to shower because men have access to the bathroom.

Listen to women, take their concerns, opinions and feelings seriously. Take time to build relationships (without office interruptions), provide room for women to tell their own story, and be nonconfrontational. This communicates that it is safe to raise issues and ask questions.

Cooking Fun for Families is a food skill-building program facilitated by a V/RHB nutrition consultant. It supports families around a variety of issues including food security, life skills, socialization and integration within communities. Women feel safe, respected and at ease as a result of the atmosphere and tone that the program facilitator has created. The facilitator uses a soft, gentle and nonjudgmental approach to welcoming the participants. All women are invited to share their knowledge, ideas and food skills with the rest of the group. Respect and con-

12. Rhea Joseph, *Healing Ways*, p. 12.

13. Carole Warshaw, "Intimate Partner Abuse: Developing a Framework for Change in Medical Education," *Academic Medicine* 72, no.1 (January 1997 Supplement): S32.

tributing to the well-being of others are part of the philosophy of the program. Program planning is done each week with parents so that their needs and interests are met during the sessions.

Provide accessible services.

Most of the agencies surveyed during the Women's Health Planning Project indicated that they were accessible to women with physical disabilities. However, attitudinal barriers as well as many disabilities, like hearing or sight impairment, were not comprehensively addressed. Women with disabilities often discover that accessibility means only wheelchair access to entrances and washrooms. They often experience embarrassing and uncomfortable situations when physicians perform gynecological and other exams without accessible exam tables.

Acknowledge the likelihood of any woman having experienced violence and abuse and recognize the consequences of violence on women's physical and mental health. Facilitate referrals to, and work with, community agencies, especially those that address violence and other women's issues.

A woman went to her doctor because she felt she was burnt out from her work. Since her doctor was away, she saw a locum who looked through her file and brought up the fact that she had a history of depression. The physician then recommended a course of antidepressant medication. The woman felt that she knew herself best and that she was not depressed, just burnt out. She attributed her earlier mental health diagnosis to a failure on the part of health care providers to understand her situation as a battered woman. She refused the medication and left the office upset. She returned when her own physician was available and received help that felt appropriate to her.

Provide an environment that welcomes diversity and those with different needs (women with disabilities, lesbian or transgendered, women who speak various languages, mothers who need childcare, etc.).

To help create a safe and respectful environment for lesbian, bisexual and queer women, providers can:

- Reframe the question put to hospital visitors, "Are you family?" to "What is your relationship with the patient?" and accept a broad definition of family, especially one defined by the patient.
- Ask if women have need of birth control, rather than asking what kind is used. Many lesbians feel unsafe when they answer "no" to questions about whether they use birth control and are met with disdainful looks or uncomfortable comments. Avoid making assumptions – some lesbians may also have sex with men.

Our focus group of service providers who work with abused women said that the women they work with feel like health providers are trying to "fix" them, as if something were wrong with them rather than the perpetrators... Medication is seen as the answer, rather than addressing the root cause and the woman's life as a whole.

WOMEN'S HEALTH PLANNING
PROJECT FINAL REPORT,
JANUARY 2000

The importance of empowering women

Understanding this element

Health status improves when a person has a greater sense of control over their life situation. Four factors that contribute to women's empowerment are:

- a core sense of self
- the ability to take action based on that sense of self
- a sense of control over one's life
- being connected with others.¹⁴

“The inferior social status of women begets self-doubt and low self-esteem, [therefore] women may have difficulty expressing their feelings and opinions openly and directly, especially if their opinions are at variance with prevalent norms.”¹⁵

Achieving individual empowerment can be particularly difficult for women who have experienced violence and abuse. There is often an expectation of rapid recovery from abuse, which sometimes cannot be achieved.

Women who feel individually empowered are more likely to participate and take action in their communities. And community participation builds community capacity – the ability of individuals and groups to identify common problems or concerns, take action to effect change within the community, and improve the quality of life for all community members.

Some ways to apply this element

Give women space and support to change their lives and improve their well-being. Use health “coaches” or a system of health advocates to assist women to build knowledge and skills and have a voice.

The Avalon Women's Centre, a centre for women with alcohol and drug problems, helps women connect with other women who will support them with an empowering approach. Women who need housing are linked up with women in recovery who can provide short-term housing – “foster houses for adults.” Other women who are farther along in their recovery become job mentors or provide transportation.

14. Laurene E. Shields, *Women's Experiences of the Meaning of Empowerment*, California: Qualitative Health Research, Sage Publications, Inc., 1995, pp. 23-31.

15. L.K. Woolsey and L.Y. McBain, “Issues of Power and Powerlessness in All-Woman Groups,” *Women's Studies International Forum* 10, no. 6 (1987): 582.

Initiate community development projects that assist women to take action and learn skills that help them contribute to building community capacity.

A group of Somali women were concerned about stories they heard from women in their community about the treatment they received in hospitals from health care providers, particularly when they were pregnant and giving birth. The treatment was of particular concern because most Somali women are circumcised and face not only health consequences from that procedure, but possible discrimination from workers not familiar with their needs.

As members of a small, new refugee community in the Lower Mainland, the women had few community resources to support them. A partnership developed between the Somali Women's Support Group, MOSAIC and B.C. Women's Hospital and Health Centre. Using a community development approach, the Somali women conducted focus groups within their community and prepared a report in their own language. The report was then translated into English. The partners worked together to add cultural information to the report which clarified data for the English reader.

Through funding from the V/RHB, a Somali women's health worker was hired to support women through the health care system and to educate health providers. Another worker through MOSAIC continued community development and empowerment activities with women in her community.

Equalize power by letting women know their rights. Ensure women's rights by giving them access to their own health files and information.

Aboriginal women from around the province were seeking information about their rights because of the ways they were being treated when seeking health care. Both the First Nations advocate and the coordinator of the Aboriginal Women's Health Program at the Children's and Women's Health Centre of B.C. received these requests and heard how negative experiences were keeping Aboriginal women away from the health system and leaving some feeling silenced.

As a result, the advocate and coordinator developed a brochure called *Speak Up!*, which provides information to Aboriginal women about their rights and describes good medical care. It also tells where to get support and encourages Aboriginal women to be the experts on their own health.

Whether we work for love or money, whether we have kids or don't, whether we're nursing babies at 3 a.m. or sending grown children into the world, we change our lives – and our communities – when other women cheer us on.

RONA MAYNARD, AVALON
NEWSLETTER, FEBRUARY 1995

Involvement and participation of women

Understanding this element

“People want to participate meaningfully in decisions about their own health system. Representation on community or regional boards and participation in community needs assessments are two forms of participation. Greater public involvement at a community level will ensure that needs and values of different cultural, linguistic and religious groups will be represented and upheld. Public participation is facilitated when sound, accurate information is readily available to ensure the system is accountable.”¹⁶ Friendly and accessible communication increases the availability of new knowledge and relevant data.

Social roles and limited financial resources can limit women’s participation in decisions about the health system – in service and program planning, implementation, evaluation, policy and research. Encouraging full and equal participation by diverse women in these activities will help ensure that all women’s perspectives and needs are included.

Women’s participation can be supported by asking women what they need and providing it – it may be childcare, transportation, honoraria, accessible physical environments, mentoring for skill-building or orientation to the health system.

Ongoing feedback mechanisms can provide opportunities for women to have input when they might otherwise be unable to participate. Key informant surveys, exit interviews and follow-up evaluations after service offer a chance for these women’s voices to be heard.

It is important to build on the strengths of both women and men to make changes in the health system. This can be achieved by working together, taking advantage of the synergistic power that is created when people work collaboratively.

Some ways to apply this element

Achieve equitable representation of women on advisory committees, steering committees and boards, and facilitate women’s input into decision-making about resource allocation.

The Women’s Health Planning Project addressed women’s participation by creating a structure that included three theme groups coordinated by a steering committee. One theme group was comprised of women from diverse grass-roots groups. Another group included providers from across the continuum of care and

16. National Forum on Health, *Canada Health Action: Building on the Legacy, Vol. 2: Synthesis Reports and Issues Papers*, Ottawa: Minister of Public Works and Government Services, 1997, p. 6.

One place to start is to review the gender balance on governance structures, volunteer committees and management structures in your organization.

the third was made up of policy makers, planners and researchers. Two representatives from each group sat on a steering committee, which also included three representatives from the Women's Population Health Advisory Committee of the V/RHB.

This ensured the inclusion of women who have been traditionally left out of planning. It also brought community women together on an equal basis with the other committees, rather than including one or two “consumers” on predominantly professional committees.

Make a commitment to involve community groups and/ or obtain their input. Work in partnership with community-based women's organizations.

An evaluation of the structures, process and participation within the Women's Health Planning Project found that the collaborative inclusive process was successful overall, though there were certain difficulties in working together. Among the factors that helped community women to speak and be heard in a setting where they had previously, at most, been consulted were:

- the Women's Population Health Advisory Committee and community committee developed Guiding Principles and other initial guiding documents for the project
- support was provided by experienced community development staff whose mandate was to encourage community women to speak about what they knew.

The Steering Committee gave its members the opportunity to work together across sectors. Although it took time for Steering Committee members to get to know one another and develop a sense of trust, they eventually moved away from thinking stereotypically about each other as health providers, social scientists, doctors or community representatives.

A service provider who sat on the Steering Committee stated, “At first we were afraid of the members from the community committee – lay knowledge is always different from professional knowledge. When they first laid out their issues, there was a collective gulp because they were so different from ours – we believe the issues should be based in research and knowledge. So it was difficult to meet face to face. But the strength of the Steering [Committee] was that we had to face each other as people, not just as reports or research, and there are so few places for that interaction to occur. I think the Steering [Committee] over time did listen to each other when we came to realize that we were all working on the same side – we didn't see each other as threats.”¹⁷

17. Diana Ellis, *Evaluation Report, Vancouver: Women's Health Planning Project, 1998-99*. Vancouver: V/RHB, November 1999, p. 25.

Some questions to raise about participation on committees and boards

What are the backgrounds of the women who are there?

Who has time to participate?

What women are not there? Why are they not there?

How free are women to speak?

WOMEN'S POPULATION HEALTH
ADVISORY COMMITTEE
GENDER LENS WORKSHOP
FACILITATED BY FRANCES KIRSON

Collaborative and inclusive work environments

Understanding this element

A collaborative work environment, rather than a “power over” hierarchical one, follows from an awareness of power issues between providers and women and the effects of the abuse of power. Models of work should support the health and well-being of staff. Mutual empowerment is the goal. Disempowered workers have difficulty working with women in mutual association and partnership.

Interdisciplinary teamwork has come to mean working together across professions such as nursing, medicine, nutrition, social work and physical therapies. It can also mean including patients and community workers. Such an approach can bring together different perspectives from professionals, lay workers and community volunteers, which may provide a more comprehensive view of individual and population health. Alternative or traditional medicine practitioners could also be included.

In Glasgow, Scotland, which has a Healthy Cities designation from the World Health Organization for its work on women’s health, the health of female staff is considered a policy priority. A survey found that women, in particular, held jobs with little influence and few professional development opportunities and were struggling to balance work and home.¹⁸

“The Vancouver/Richmond Health Board is committed to achieving, at all levels of the organization, a qualified workforce that reflects the diversity of the population it serves...Federal legislation and provincial policies refer to four designated groups [targeted under employment equity]: women, aboriginal people, persons with disabilities, and visible minorities. The V/RHB has also included lesbian, gay, bisexual and transgendered as a fifth designated group.”¹⁹

The V/RHB’s comprehensive approach to diversity includes the goal of ensuring an organizational and working environment where there is respect and dignity for health workers. It focuses on the working conditions between and among employees as well as the overall organizational climate. Organizational environments ultimately affect how service is provided.

18. Glasgow Healthy City Project, Women’s Health Working Group, *Women’s Health Policy for Glasgow: Phase 2: Creating Equality in Health for Women*. Glasgow: Glasgow Healthy City Project, October 1996.

19. Vancouver/Richmond Health Board, *Framework for Diversity: Diversity in Health Services, Human Rights and Employment Equity Initiatives*, Vancouver: V/RHB, June 2000.

Women make up 86.9 percent of the V/RHB work force.

Some ways to apply this element

Use team models that allow team members to provide support to each other, encourage commitment, and mitigate the effects of staff turnover. People doing the work have input into program planning. You do better work if you feel good about work.

As a community health centre with a 30-year history of working to deliver care differently, REACH Clinic's structures and processes reflect established democratic management principles. The board makes decisions by consensus. The staff meet as a group and in service teams. Few things are implemented without discussion among both staff and board, especially major changes.

Part of the executive director's role is to listen to staff, support their ideas and help to implement them. She also supports all staff to have a voice and works towards equalizing some power imbalances. She particularly believes in sharing as much information as possible and modeling good communication skills. This enables staff to be more empathetic. "If I value myself, then I can value others."

The people working at REACH have a passion for their work. Establishing a collaborative environment may seem easier in a smaller system like REACH. However, their executive director thinks that any system can work collaboratively. Getting management on side and taking the necessary time can help to facilitate change.

Set up mechanisms within team structures to deal with inherent differences among people and roles. Include the community sector in hospital teams.

The Sexual Assault Service at B.C. Women's Hospital and Health Centre established collaborative working relationships when it began in 1982. An interdisciplinary team, including a counsellor, nurse, medical director and community agency now work together to administer the emergency service located at Vancouver General Hospital. The community agency is contracted to be part of the team, participating in meetings and protocol development, and providing training both in the community and hospitals. On-call staff, who are both physicians and nurse examiners, are involved in major decisions for patient care, for example, whether to offer post-exposure prophylaxis for HIV to patients.

Another example of the collaborative approach of the Sexual Assault Service is that it initiates roundtable discussions with community stakeholders when facing controversial decisions. Some of the complex issues the service deals with overlap between areas of medicine and health, law, ethics and counselling.

Until we empower ourselves, we can't support others in empowerment. No one is going to do it for us.

MEMBER OF THE WORKING GROUP ON THE FRAMEWORK FOR WOMEN-CENTRED HEALTH

Is there a Native person on the Board of B.C. Women's? It would benefit you a lot to have Native women working at B.C. Women's ... You have to find a way to attract these people.²⁰

20. Consultation Working Group, *The Challenges Ahead for Women's Health: B.C. Women's Community Consultation Report*, Vancouver: B.C. Women's Hospital and Health Centre, September 1995, p. 51.

Women's patterns or preferences in obtaining health care

Understanding this element

Women seek health care within the context and circumstances of their lives. This determines when and how they seek services, and whether they are able to access services at all.

Women's multiple roles as homemakers, paid workers, caregivers and family caregivers often mean that they will minimize their own needs because there are others to take care of. They may also feel that they can or should take care of themselves rather than seek care from others.

Some women lack independence or have difficulty leaving their homes for various reasons, for example, if they have disabilities, are isolated as immigrants or refugees, are abused by their spouse, or as seniors are afraid or physically unable to leave their homes.

Poverty is a limiting factor to women's access to services. Women with low incomes use public transit more than other women and more than men in general, and often travel with dependent children. Shift work and night work create barriers to access and are associated with ill-health for women. Poverty particularly affects women who have been abused, who may face health issues that limit their ability to work. Mental health problems associated with violence also affect the ways women obtain health care.

Lack of understanding of how the health system works or what services are available may also limit women's access to services. For example, some newcomers to Canada may use emergency departments rather than a family doctor because no one has explained the role of a family physician to them.

Many women prefer to see women practitioners for a variety of reasons, including religious and cultural beliefs, past abuse experiences, or the belief that women are easier to communicate with and take more time during appointments.

Women request and use alternative, traditional and complementary therapies more often than men. However, many women cannot afford these therapies.

Some ways to apply this element

Collaborate with women to plan and provide services that meet their preferences in obtaining health care. Research shows that women often want comprehensive services in one place.

Researchers at the Asian Women's Health Clinic and the South Asian Pap Test Clinic found that women coming for Pap tests wanted:

In the Vancouver General Hospital Women's Clinic, 296 women completed a survey. Some results were surprising. The majority of women did not prefer to have women doctors, although there were some who had strong feelings about seeing a female.

Provide childcare and a safe space for children to play. Schedule programs for children and women at the same time and place.

- respectful and culturally appropriate interactions with providers
- different services for different communities
- alternatives to traditional clinic models
- comprehensive health services in one place.²¹

Locate services together (“one-stop” services) so women do not have to go from person to person repeating their story. Provide access to translation and interpretation services.

When numbers of refugees arrived from Kosovo in the summer of 1999, the Bridge Clinic designed a comprehensive welcome plan. Clinic staff teamed up with counsellors from Vancouver Association for Survivors of Torture (VAST) to meet with everyone during an initial screening. Both mental and physical needs were attended to. Using interpreters, Bridge staff were able not only to determine any current medical concerns but to introduce women to Canadian practices for well-being. Medical care varies from country to country, so Bridge staff described screening tools like Pap tests and mammograms. Attendees were able to follow up with counselling through VAST, and medical care through Bridge.

Provide financially accessible preventive and complementary services.

A study in Richmond found that many people used and wanted better access to traditional and alternative therapies. Some women seeking alternatives to the medical model go to the Richmond Women’s Centre. The Centre has a library that contains information about complementary therapies, and it hosts a Holistic Health night once a month. Practitioners of different therapies come and will work individually with women to demonstrate “hands on” what their practice is about.

Change the organization of care to allow for more flexible and comprehensive services.

The B.C. Ministers Advisory Council on Women’s Health is assessing whether women-centred health could be achieved in the delivery of primary health care. Primary health care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and the country can afford. It brings health care as close as possible to where people live and work and constitutes the first element of a continuing health care process.²² Primary health care addresses the main health problems in the community, providing promotive, curative, supportive and rehabilitative services accordingly.

21. Joan Botorff, Lorna Sent, Suki Grewal and Lynda Balneaves, Presentation at the B.C. Centre of Excellence for Women’s Health, Vancouver, 2000.

22. World Health Organization, 1978, <http://www.who.int/aboutwho/en/ensuring/primary.htm>

Our staff are always seeking more information about cultural attitudes and practices with regards to ... care. However, we have come to learn that all women must be treated as individuals and we cannot make assumptions about values, attitudes or practices. Therefore, now, if we want to know how a woman will approach her care experience and recovery, we *ask her*.

EXECUTIVE DIRECTOR,
ELIZABETH BAGSHAW CLINIC

Women's forms of communication and interaction

Understanding this element

Gender socialization encourages women to be gentle, compassionate and nurturing. Consequently, certain patterns of communication and interaction are more characteristic of women than of men. For example, women are more likely to allow themselves to be vulnerable with other women. They are more comfortable asking for help and relying on others for support when needed. Women consider it important to have a network of friends and they often use stories to describe their situations in context.

Women who have experienced violence may not want to talk to others and often prefer to have something to take away and read. Abused women are not likely to share information easily and may have dissociative behaviours or become numb to pain. If they do not recognize pain, they may not seek medical help early or at all.

Cultural differences can also have an impact on communication and interaction. "Physical actions can . . . be intimidating. For example, standing over someone with arms folded, asking questions too quickly, and not waiting for an answer discourages communication."²⁴

Some ways to apply this element

Provide venues where women can share experiences and knowledge, or refer women to peer support programs.

Milap is an Indo-Canadian senior women's group facilitated by Richmond Health Services. Many of the women who participate are isolated because their families leave daily for work and school. Grandchildren might speak only English and watch TV. There may be problems in the family. If the women were in India, some might have more status and power than they have here.

When some of these women initially attended a focus group, they liked being together so much that they decided to keep meeting. An interpreter from Population Health heard their wishes and volunteered time to support the group. These women now meet twice a month and have a place where they find support and encouragement. They can help each other with decisions and coping with everyday living.

23. Bishop Desmond Tutu, *No Future Without Forgiveness*, New York: Doubleday, 1999, p. 229.

24. Rhea Joseph, *Healing Ways*, p. 13.

We established statistically that, when women came to testify to the [Truth and Reconciliation] Commission, they almost always told the story of what had happened to somebody else; whereas, when men testified, almost equally invariably they told about what had happened to themselves.

BISHOP DESMOND TUTU²³

Listen for what is happening in women's lives.

Gender socialization can affect women's communication in a variety of ways. Sandra Friedman describes how girls in Western society often say things like, "I feel fat," or, "Look at my thighs," or, "If only I was thinner," instead of talking about what's real.

When girls talk about "feeling fat" they are usually not referring to their size. Thin girls feel fat and fat girls feel fat. As girls grow up they are socialized to repress their feelings and internalize their distress – to draw their pain into themselves. Instead of addressing situations directly, they blame themselves. They ask "What's wrong with me? What did I do?" They worry about what people think about them and accommodate others at the expense of themselves.

When girls can't express their feelings or talk about what's bothering them directly, they learn to do so indirectly by learning to speak in code – through the "grungies" – a term coined to describe the negative voice that girls develop.²⁵ Friedman's "Girls in the Nineties" workshops begin by asking young women what is happening in their lives.

Provide a supportive learning atmosphere, and women will build friendships.

The CHOICES Bridging Program is run by Helping Spirit Lodge. In this 20-week program participants learn, but also support each other and become very close during the process. The program's goals are:

- to provide a foundation for First Nations women to enter the workplace in mainstream society by creating a bridge to further education, skills training, and/or employment
- to develop positive self-esteem through education about First Nations culture and the history of Canada's relationship with First Nations people
- to provide education to women on family violence issues in a safe and supportive environment.

Many women build long-term friendships and networks as a result of participating in the program. These often include maintaining links with Helping Spirit. Some participants become members of the board of directors.

Underneath every "grungie" is the story of a real feeling or experience waiting to find expression.

Enhance communication by encouraging discussion and allocating appropriate amounts of time.

25. Sandra Susan Friedman, *Nurturing Girlpower*, Vancouver: Salal Books, 2000, pp. 12, 21.

The need for information

Understanding this element

Women ask for information more than men, and often obtain information from other women. As well, they often pass on information to others – to family, neighbours and friends. Women's information needs are individual and varied. Some women limit the amount of information they receive.

Women's learning styles are influenced in part by their forms of communication and interaction. Women remember testimonials from other women and learn from them. Exchanging stories may be an important educational method.²⁶

Constraints on women's lives limit time for structured learning. Literacy rates and language training affect women's access to information. For instance, immigrant and refugee women in some communities do not have access to English as a Second Language (ESL) training on an equal basis with men.

Education materials need to be tied directly to women's needs and interests and be directed to their developmental stage and period of life. For example, pregnancy is a time when women are often open to learning about parenting, whereas older women may need information about health issues related to aging.

Women may require an advocate, interpreter, community worker or intermediary to get information. The use of technical and mystifying language may be a barrier to understanding information.

There is an overabundance of health information available on the Internet. However, it is difficult to find information and resources that are good quality, credible, unbiased, well-rounded and timely. Still more difficult to find is information that takes into account the diverse realities of women's experiences, the diversity of our population, and a Canadian perspective.

Some ways to apply this element

Provide information on issues specific to women in accessible formats – in plain and inclusive language, in translations, and in alternate formats such as large print or audio.

Women in organizations serving immigrant and refugee women requested resources that introduced newcomers to the Canadian health care system. One local response was to develop a special issue of *The Westcoast Reader* in March 1996. This four-page newspaper goes to all ESL classes within the province of B.C. An advisory group of women from different communities, a public health nurse

26. Marion Crook, *Finding Health Information: Women's Experience: A Study of Women's Need for Health Information on the Tri-Cities*, Port Coquitlam: Port Coquitlam Area Women's Centre Society, 1994, pp. 28-29.

who worked at Bridge Clinic, and a health promotion consultant from B.C. Women's contributed content for the newspaper. A teacher's guide was also developed to facilitate classroom discussions on the topic of women's health.

Develop innovative ways to get information to women.

The Toronto Immigrant Women's Health Centre has a mobile medical unit ("Take a Ride with Us to Good Health") to reach women who usually do not have easy access to health care facilities and information. Many immigrant women are employed in factories where conditions of employment and family responsibility make it hard for them to use health care services until a time of crisis. The Centre works with companies to arrange presentations to groups at lunch time. These seminars are conducted by health counsellors who speak the language of the workers. Topics include sexuality, stress and nutrition, well-being and fitness, reproductive concerns, and health screening tests (mammograms, Pap tests).

Use principles of peer education. Popular education is a method that starts with women's experiences.

Popular education allows women to actively participate in their learning and to speak for themselves, and it prevents individuals from dominating the group. The basic principle of this method is the belief that learning occurs best when people define their own needs and start from their own experience. Participants are both learners and teachers. Thus, the facilitator is not a teacher or an expert, but is an equal group member with a slightly different role.²⁷

Operate health information resource centres with trained nurses, librarians or volunteers to answer phone calls.

Women living with breast cancer can access a computer-based information and support system run from St. Paul's Hospital. CHESS (Comprehensive Health Enhancement Support System) is an information website accessed through the Internet. It includes a section of frequently asked questions (FAQs), a library of articles and resource materials, real-life accounts of women living and coping with breast cancer, an "Ask an Expert" email service that allows users to send experts anonymous questions and receive confidential responses within 48 hours, and a dictionary that provides easy-to-understand definitions of health terms. The website also offers online discussion groups and provides links to other health information sites. A nurse is available by telephone to provide support, answer questions and refer women to local resources and services.

Young women bring in their friends, and we can and do include them in teaching sessions, where we can see them share information, experiences and choices ... But it is difficult with young women because they come to us and require immediate assistance ... We find self-help support groups are more valuable to older women.

NURSE AT PINE CLINIC

27. Women's Self-Help Network, *Working Together for Change: Training Manual*, Courtenay, B.C.: North Island Women's Services Society, 1984.

Women's decision-making processes

Understanding this element

Women make health decisions not so much from an individual perspective, but in consideration of their families, their caregiving and interpersonal relationships, and the social and economic environments in which they live and work (their economic status).

“Women often have been expected or required to put the needs of their families before their own. For instance, to ensure that their children and partners have sufficient food, mothers may eat last and suffer malnutrition.”²⁸

Women who have experienced violence and coercion may have had few opportunities to make their own decisions. They may not have been asked to make choices before and may not know what is involved in decision-making.

Women patients and health providers both bring important knowledge and perspectives to decision-making.

Some ways to apply this element

Listen as women discuss the context of decisions, rather than force simple either/or “choices.” Allow women to decide how much they want to discuss.

Adult males and females smoke for different reasons and under different circumstances. Recent qualitative studies with female smokers suggest that women smoke to cope with the stress in their lives. Smoking fills an important function for women. Women with multiple disadvantages (including poverty, unemployment and ethnic minority status) have described cigarettes as one small “luxury” in their lives. Smoking may be the only time a woman has to relax and put both physical and emotional distance between herself and the responsibilities of child-care and household work.²⁹ Smoking allows a release for emotions such as anger and frustration – which may be dangerous for women to express. Some women describe a smoke break as a way to momentarily stop a partner from battering.

“Catching Our Breath” is a smoking cessation program that recognizes the differences between women's and men's smoking patterns and strives to restore the power of participants to heal themselves in a positive affirming way. It is a group program that incorporates keeping a journal, writing exercises, relaxation and

28. S. Ruzek and J. Hill, “Promoting Women's Health: Redefining the Knowledge Base and Strategies for Change,” in *Health Promotion*, Oxford: Oxford University Press, 1986, p. 305.

29. Lorraine Greaves and Victoria Barr, *Filtered Policy: Women and Tobacco in Canada*, Vancouver: B.C. Centre of Excellence for Women's Health, 2000, pp. 18-19.

Advocates or patient representatives can do research on medications, side effects, alternative treatments, etc., to support decision-making.

We hear where women are at, what they want to do and we support that, rather than impose a plan of recovery.

WORKER AT DAMS
– DRUG AND ALCOHOL MEETING
SUPPORT FOR WOMEN

visualization techniques. Women write about their lives and put quitting smoking in that context.

Present all options as clearly as possible and support women in making informed decisions within the context of their lives. Support whatever decision they make.

The term “midlife decision-making” often refers to making decisions about whether to use hormone therapy. Some women get prescriptions for menopause hormones and then never fill them; many others never get a refill. Many women also use alternative therapies for midlife and do not disclose this to their medical providers.

James Bay Community Health Centre in Victoria developed a community model for informed midlife decision-making with a women-centred approach. It includes:

- giving and receiving information
- validation of experiences, ideas and feelings
- empathy – understanding and caring commitment about women’s experiences
- emotional support
- collaborative guidance – choice/empowerment relationship
- acknowledging the context of women’s lives – menopause is more than a medical event, it is a life process
- for women, about women, by women learning from women and sharing with women.³⁰

The Arthritis Society has a peer support and self-management framework for facilitating informed consent to health care. Women can build confidence and self-esteem in order to advocate for themselves.

The UBC Hospital Breast Reconstruction Program provides names of former patients who have volunteered to connect with women who currently have breast cancer and are considering breast reconstruction.

30. Judy Burgess, “James Bay Community Health Centre” (“Powerpoint” presentation), Richmond, December 2000.

A gender-inclusive approach to data

Understanding this element

Data provide a basis for formulating policies, monitoring change and evaluating outcomes. Data that reflect gender issues help to promote change, eliminate stereotypes, promote understanding of the health status of women and men, and identify access issues and/or gaps in service delivery.

The production of gendered statistics is not only a matter of including a breakdown by sex in all official data. It also requires that concepts and methods used in data collection and presentation adequately reflect gender issues in society and take into consideration the factors that can produce gender bias. All variables and characteristics should be analyzed and presented with sex as a primary and overall classification. This in turn enables all analyses and presentations to be sex specific.³¹ Data may reveal sex differences, but differences in health status, outcomes, access, utilization, etc., must be analyzed carefully to reflect the influence of gender issues.

Women's voices are an important part of evidence. Using qualitative methods of data collection provides a particularly valuable perspective. It also provides information that can help develop quantitative data elements to incorporate into traditional databases so that they better reflect the context of women's lives. When using qualitative methods, it is important to develop inclusive strategies for consulting with different communities of women.

Data should be presented in user-friendly ways.

Some ways to apply this element

Use innovative and inexpensive methods to create “snapshots” of women's health status. Snapshot health profiles can use both quantitative and qualitative methods and are a cost-effective and methodologically sound way to gather information.

A snapshot survey that collected client information from Mental Health Services on one particular day revealed gender differences. Case managers of the adult program completed survey questionnaires for the 3,572 clients that were active on their caseload for May 26, 1998. The goal of the survey was to identify and analyze factors that reliably distinguished women from men.³² The resulting profile presented gender comparisons for a range of factors, for example, clinical characteristics, demographics and use of services.

31. B. Hedman et al., *Engendering Statistics*, p. 42.

32. Ron Peters, *Women's Mental Health: Gender Differences among Adult Mental Health Team Clients*, Vancouver: Greater Vancouver Mental Health Services, February 1999.

Qualitative and quantitative data provide two different kinds of knowledge. Qualitative data gathered from women may highlight rich, in-depth information, while quantitative data shows an overall statistical picture of those women in a survey.

A poignant example of gender differences that emerged from the findings was the medicalization of women's depression. Both men and women were very likely to be using medications, although women were prescribed more combinations of medications than men (2.00 on average, versus 1.86 for the men). One significant difference was in the use of antidepressants. Women were more likely to have been prescribed antidepressants whether or not they were diagnosed with a primary or secondary mood disorder. (This challenges the belief that women are prescribed antidepressants more often because they are actually depressed more often.)

To confirm this finding, clients who had no affective disorder but were using antidepressants were divided into those who had, and those who did not have, a personality disorder. Women were still significantly more likely to be prescribed antidepressants, regardless of whether they had a personality disorder or not.

Reflect gender issues in all statistics.

The Aurora Centre is a provincial alcohol and drug treatment service for women, based at B.C. Women's Hospital and Health Centre. It has created a database that captures the profile of the lives of clients served, the needs for service identified by clients, and client satisfaction and outcome information. Information is gathered from women on a wide range of issues such as age, income source, Aboriginal status, housing, diversity, parental status, referral source, frequency of household moves, smoking status, physical health, antidepressant use, experience of violence as a child and/or adult, employment challenges and previous use of services. A mix of qualitative and quantitative methods is used.

This data provides a comprehensive profile of women seeking treatment at Aurora and provides a platform for program planning and policy development. Many program adjustments have been made on the basis of this information. For example, when the data showed at one point that younger women (19 to 29 years) were more likely not to complete treatment, strategies for engaging and retaining these women were put in place and this trend did not continue.

Collect time series data.

Gathering data on the same questions/issues for women at different points in time is another methodology to consider for some program initiatives. This method samples different groups of women at each time, but shows emerging trends and allows program outcomes to be monitored. It is less costly than either continuous data-gathering or longitudinal periodic studies that require that the same group of women be tracked over a period of time.

Gendered research and evaluation

Understanding this element

In the V/RHB region, there is a need to improve our existing knowledge of health problems specific to women and gain a better understanding of sex and gender differences in those illnesses that affect both women and men. Identifying and asking the appropriate questions will capture the different experiences of women and men. This will require sustained research with adequate infrastructures for continuity.

Women may have different priorities for a research agenda than researchers.

There are major gaps in health research for populations of women such as: lesbians, bisexual and transgendered women; First Nations, Inuit and Metis women; immigrant and refugee women; women of colour; and women with disabilities. In particular, there is very little research that focuses on the priorities and needs of women in these populations.

Evaluations of women's services should include a gender perspective.

The findings of women's health research are not being adequately communicated to women – especially low-income women – in understandable, appropriate and useable formats.

Some ways to apply this element

Use the information from research and evaluation to enhance or change programs and services.

An evaluation of the Sheway Project for high-risk pregnant and parenting women brought together the perspectives of women who had used Sheway's services in 1998, the staff and governing council members, and service providers in nine health areas who were connected to the work of Sheway. The evaluation was shaped by a concern that information be gathered in a manner that was consistent with Sheway's philosophy of providing service in a respectful, unintrusive and self-determining way. Many of the women who use Sheway are Aboriginal and many have had negative experiences with how information about them has been gathered and used.

An innovative approach was taken to gathering information. A focus group that incorporated artistic expression captured the women's perspectives on their experience at Sheway. During the discussion part of the focus group, several women were very quiet. But when provided with art therapy materials, those women provided complex feedback through artistic expression.

By reviewing files of women who accessed services between 1996 and 1998,

evaluators gathered detailed information on the birth and health outcomes of women and their children. The evaluation identified what works well at Sheway and suggested ways to build upon current work to include broader community treatment and support services.³³

Involve women in setting research agendas. Ask relevant questions.

There are many concerns about the growing number of “families” (women and children) entering shelters for homeless people. The traditional definition of homelessness (used by the B.C. Ministry of Social Development and Economic Security) incorporates those individuals who stay overnight in shelters or who sleep outside. Under this definition, approximately 25 percent of homeless people would be women. Another definition encompasses people with unstable, nonpermanent addresses. This definition would include women and children in transition houses, increasing the overall percentage of women significantly. The absence of a gendered approach and use of the more conservative definition reduces the ability of any study or plan to fully address homelessness among women.

Use inclusive methodologies that respect and empower women’s voices. Research and develop appropriate, gender-sensitive indicators of women’s health and well-being.

The B.C. Centre of Excellence for Women’s Health carried out research on mental health by using a feminist collaborative process. It involved interviews and focus groups with service providers, over 200 women with chronic and persistent mental health problems, women family members, and caregivers in B.C. A 15-member advisory committee oversaw the project, led by women who were mental health consumers and including mental health service providers, policy makers and researchers.

Women identified language and culture as barriers to accessing care, as well as the stigma of being labelled a user of mental health services. “There was agreement among all of our respondents that women’s needs were not being met in the current system, especially those needs related to women’s past experiences of violence and trauma and the need for women to have a wider range of support and treatment options.”³⁴ Based on this data, the report included a section called “Best Practices for Meeting the Needs of Women” which outlines principles of women-centred mental health care.

To use the analogy of a theatre stage, we attempted to turn off the spotlights and turn up the stage lights. In the health care system, services, diseases and conditions tend to be in the spotlight, and we wanted to look at what is happening in the shadows and on other parts of the stage.

WOMEN’S HEALTH PLANNING
PROJECT FINAL REPORT,
JANUARY, 2000

33. Nancy Poole, *Evaluation Report of the Sheway Project for High-Risk Pregnant and Parenting Women*, Vancouver: B.C. Centre of Excellence for Women’s Health, 2000.

34. Marina Morrow with Monika Chappell, *Hearing Women’s Voices: Mental Health Care for Women*, Vancouver: B.C. Centre of Excellence for Women’s Health, 2000, p. 23.

Gender-sensitive training

Understanding this element

Providers of services and programs need resources and support in order to recognize the need for women-centred care and provide it on an ongoing basis. Where gender-sensitive training exists now, it is often dependent upon individual workers who bring forward this perspective. Resources and support include periodic updates, current information, and awareness workshops for board, staff and volunteers. A committee of staff and advisors can monitor training outcomes.

There is a clear need for gender-sensitive training in the area of violence against women, so service providers can recognize and respond appropriately to women who may have been abused.

Models of training need to include community agencies and community women as full partners with professionals in developing and implementing training.

Gender-sensitive training should address societal assumptions about women.

Our health systems are steeped in societal values that influence practices. Those values influence individual behaviour and affect group decisions. Gender-sensitive or women-centred practices may at times challenge some of the dominant values around which society and our health systems are organized. However, they also represent the values and practices of many people now working within the V/RHB.

Some ways to apply this element

Assess values and incorporate values that support women-centred health.

Workers in all areas of health provision can begin by evaluating the values that inform their practice and looking at how they might incorporate more women-centred values. Some questions that can guide this process include:

- What are my own values, training and experiences?
- How are they similar to or different from a women-centred perspective?
- Where do I get my information? Who are my contacts?
- Do my values prevent me from asking certain questions? From hearing answers?
- Am I measuring all women's experiences by one standard of race, ethnicity, sexual orientation, abilities, etc.?
- Am I measuring women's experiences according to gender-biased "professional" standards?
- What actions can I take to include more women-centred values?

Provide comprehensive gender-sensitivity training that can be adapted and integrated into all levels of services and program delivery.

The case study that follows on the next page is a shortened version of an exercise used in group training offered by the B.C. Women's Woman Abuse Response Program. Notes from a patient chart are included, but identifying information has been changed to protect confidentiality.

The group's task is to study a case where there were problems with the care a woman has received and identify the problems. Then, guided by the information that the woman is being abused, they are asked to reframe the patient assessment and recommend a response using a women-centred approach. (The purpose of the exercise is not to find fault with the initial providers, but to try to learn how a women-centred approach could result in a different response and outcome.)

Case study

A woman arrives at the hospital Outpatient Clinic with her husband to receive prenatal care. She is 30 weeks pregnant and has had no prenatal care during this pregnancy. This is her third pregnancy, but there have been no previous births. She moved to Canada just two months ago from Sri Lanka. She is married and is living with her Canadian husband and his parents. Her family remains in Sri Lanka.

Recently there had been a violent "episode" at home. Her partner attacked her and she picked up a bread knife to defend herself. Her partner called the police and she was taken to hospital with a psychiatric referral. At that time she was diagnosed with post-traumatic stress disorder and low self-esteem.

In the Outpatient Clinic she becomes agitated and strikes out at her husband. A security guard is called and escorts her to an assessment room. Referrals are made to Psychiatry and Social Work.

MEDICAL APPROACH

In Outpatient Clinic the woman is assessed as unstable, hysterical and potentially dangerous.

Response

Security guard is called and takes woman away to Assessment Area.

Medical history reported by husband

- Post-traumatic Stress Syndrome (PTSS)
- History of depression treated with prescription medication
- Unstable moods
- Insecure and “although she says she wants a divorce, she just needs a hug.”

Psychiatry assessment

- Lacks independence
- Marital discord
- Low self-esteem, insecure
- Post-traumatic stress syndrome and possible depression
- “History of physical abuse, but not clear whether the assault occurs within the context of a fight or if it is unprovoked.”

Social work assessment & additional action

- Referral to Ministry for Children and Families (MCF) Child Protection
- Based on documentation, the decision is made that “the woman must never be left alone with her baby. She must always be with her husband or mother-in-law.”
- Referral to counselling for couples

WOMEN-CENTRED APPROACH

Consider the woman’s direct response. Perhaps she is frightened, or perhaps her husband has said something to upset her.

Response

Security guard escorts partner out. Provide woman with privacy and translation as she speaks no English. Take her history in her own language and her own words.

Medical history reported by woman

- CONTEXT — Understand the woman’s “symptoms” in the context of abuse
- IMPACT of abuse can mean isolation and depression
- REFRAME “insecure” to “fearful of partner”
- SAFETY – Woman’s story is believed and supported

Women-centred assessment

- REFRAME – Forced dependence on her partner
- USE WOMEN’S WORDS – She says there is a history of abuse; neutral language of “marital discord” obscures this.
- IMPACT of abuse – low self-esteem, PTSS and depression pathologize the woman and remove CONTEXT of her life.
- SAFETY of this woman is compromised by the suggestion that some violence may be justifiable.
- Consider the safety of the woman and her future child together
- Ask this woman about her safety and her capacity to parent in the context of abuse – provide SUPPORT to her
- Provide supportive community REFERRALS for this woman.

Social justice concerns

Understanding this element

People who provide health and community services see many women who are affected by social determinants like poverty and discrimination. Workers may be overwhelmed by how to help individual women or by how to have an impact on societal levels of poverty and injustice.

The V/RHB mission, vision and principles addresses social justice issues: “The framework for the delivery of health care will be based on the ideals of integrity, excellence, social justice and access to service; respecting the rights of every individual regardless of socioeconomic status or personal belief or disability; supporting the efforts of our diverse communities to work cooperatively to address the issues of health and safety in their neighbourhoods as they apply to the broader determinants of health.”

It was once believed that equality could be achieved by giving women and men the same opportunities, on the assumption that this would bring sameness of results. However, the same treatment does not necessarily yield the same results for men and women because of different life conditions and experiences of discrimination.

“Gender equity” is the process of being fair to women and men based on a recognition of gender inequality. To ensure fairness, measures can be taken to compensate for historical and social disadvantages that prevent women and men from otherwise operating on a level playing field. “Gender equality” is what exists when women and men have achieved the same status. Gender equality means that women and men enjoy conditions that allow them to realize equally their full human rights, their potential to contribute to society, and their ability to benefit from it.

Some ways to apply this element

Provide advocacy as part of daily service delivery. Advocacy can involve help with anything from getting income assistance or disability benefits to housing or court support for women going through child custody cases.

Staff at the Mid-Main Community Health Centre felt that key populations were not represented in the V/RHB profile document on housing. This was especially true for single mothers. Staff began to network and were able to get statistics for a housing complex near the centre. They eventually linked with the V/RHB and B.C. Housing to look at the health needs of people who lived there. For instance, there were people in the complex who just could not get to Mid-Main. Single mothers

Equity leads to equality.

had no transportation, and taking the bus even a short distance with a number of children and a stroller was often too difficult.

At Mid-Main at least ten percent of people do not show up for appointments. The clinic has extended their hours, but that isn't the whole answer to working with people who can't access care. The partners are looking at a drop-in where they can ask residents what they would like. Hopefully, an on-site solution will be implemented.

Advocacy is part of every staff member's job at Mid-Main. There is no designated staff person to deal with the advocacy issues that come up on a daily basis. Even though it may take hours to resolve some situations, every staff person does it because they believe in the concept that health means more than a short medical appointment and they can see positive outcomes from their efforts.

Support the involvement of service providers and women in advocating for women's political, cultural, social and economic equality.

In June 1997, the case of a pregnant woman went before the Supreme Court of Canada. The question before the Court was whether the state has the right to force pregnant substance users into treatment programs. If the Court had agreed that it does – declaring that a woman legally owes a “duty of care” to her fetus – the door could have been opened to a wide range of actions to control the behaviour of pregnant women.

To protect women's right to autonomy, a strong campaign was mounted by healthcare providers, community groups and researchers to convince the Court and the public that legal force is the wrong way to handle complex social problems. Aurora Centre, a residential program for women with substance abuse problems located at B.C. Women's Hospital and Health Centre, was active in this national campaign. Staff coordinated various media events promoting greater understanding of FAS (fetal alcohol syndrome) and other drug-related developmental disabilities. Seven of the nine Court judges held that the courts cannot order “the detention and treatment of a pregnant woman for the purpose of preventing harm to the unborn child.”³⁵

Connect with community organizations that have more flexibility to advocate.

Many health care providers, researchers and services are not in a position where they can speak out about social issues to the media. Partnerships with community groups who have a passion for the issues at hand can facilitate advocacy.

We are involved in different youth advocacy projects to lobby for changes in youth health, for example, mental health issues for youth.

NURSE AT PINE CLINIC

35. Sherry Galey. “A Potent Mix of Issues” (editorial) *Network*, Winnipeg: Canadian Women's Health Network, Winter 1997.

For some years the B.C. Centre for Disease Control (CDC) has had pilot projects to study and promote the use of the female condom. The Positive Women's Network (PWN) was well aware of the advantages of this condom for prevention of HIV and other STDs for women. However, the female condom is very expensive if bought in stores.

PWN (in conjunction with the CDC) launched a successful postcard campaign both to raise awareness about the female condom throughout the province and to lobby government to make the condom available for free or low cost. PWN distributed the cards to AIDS and other grass-roots organizations and to public health nurses throughout the province. The return rate for the cards was four times higher than for most mail-back campaigns. The postcard campaign stimulated many nurses to inquire about training with the CDC in how to use the condom because many had been unaware of their existence or how to use them.

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