MARITIME CENTRE of EXCELLENCE for WOMEN'S HEALTH

PROMOTING SOCIAL CHANGE THROUGH POLICY BASED RESEARCH IN WOMEN'S HEALTH.

Synthesis Papers

Executive Summaries

Prepared for Made to Measure:
Designing Research, Policy and Action Approaches to Eliminate Gender Inequity,
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MARITIME CENTRE OF EXCELLENCE FOR WOMEN'S HEALTH
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IWK Grace HEALTH CENTRE

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Centre d'excellence pour la santé des femmes, Montréal
Equity and Diversity Approaches For Women Caregivers: The Impact of Health Reform

The health and social services system reform in Quebec, as in several Canadian provinces, is focussing on the development of continuous care in people's living environment. A number of services are affected, including in relation to the *trend toward more ambulatory care*, which makes it possible to avoid or shorten hospitalizations and which is in addition to the deinstitutionalization of persons suffering from mental health problems or from physical or intellectual impairments and to home care for the frail elderly, including end-of-life home care. The rate at which the changes are occurring has increased very quickly and under pressure from such large reductions in public health spending that the measures which should have been developed first were neglected - that is, reinvesting sufficiently in CLSC[i] home care, in order that persons released early from hospital might receive in their home the care they need.

This reform is aimed at promoting integration and complementarity of services, as well as co-operation among the various health institutions, against the background objective of improving the efficiency of the overall system. It calls for a new division of responsibilities between families and the State. However, analysis of the policies of the Quebec department of health and social services, the regional boards and the CLSCs reveals that the public system is tending to redefine its role as one of support or back-up for family and community resources, and that it generally considers caregivers necessary resources in connection with its objective of keeping dependent persons in the community. The services provided to caregivers essentially serve to keep them from suffering burnout, in order that they may continue to fulfill their commitment. Thus, the availability of assistance from the family is becoming a routinely used criterion in assessment of needs and allocation of home care services.

Over-representation of women among caregivers has been found in most of the research on informal care for family members who are sick or frail, regardless of the community. Various studies also confirm that, if the caregiver is a man, use of formal and informal support is different. This points to the pressure exerted by the social roles women are expected to play.

In the context of the trend toward more ambulatory care, the home is becoming a formally recognized location for provision of care and family members are increasingly being considered caregivers. The complexity of care is increasing, without sufficient preparation of the caregivers, whose responsibilities are growing. The role of caregivers is no longer limited to providing psychological support or assistance with the tasks of daily living; rather, it involves increasingly difficult and complex care. The caregiver is often obliged to provide co-ordination of fragmented services and to learn to provide care with little preparation, and this is a source of anxiety and raises ethical and legal issues with respect to responsibility when errors are made in treatment. In addition, the transfer of costs that used to be covered in the institutions, with these costs becoming private expenditures by households, is increasing, such that some organizations are talking about the "soft privatization" of health services.

Some writers speak of the impact of this role on the living conditions and quality of life of women, as well as on their health (stress, anxiety, physical and psychological burnout), and on their personal and family life and life as part of a couple (role conflicts being a sources of tension on many levels), and in terms of obstacles to participation in other social activities in their jobs, recreation or volunteer

work. Considering the increased presence of women in the labour force, the demands connected with the role of caregiver are therefore exacerbating the problems connected with reconciling family responsibilities and responsibilities as a paid employee.

The consequences of care responsibilities for someone who is sick are different in some respects in the ethnocultural communities. Women who have recently arrived in Canada and find themselves caregivers, in accordance with Quebec's health and social services system standards, are finding themselves torn between their childcare responsibilities and their responsibilities with regard to support for sick parents, in a context of often unstable working conditions. In addition, the excess workload and the isolation that flow from these many responsibilities are contributing to slower adjustment to the host society and are increasing these women's vulnerability. Certain specific aspects of family dynamics, cultural norms, social relationships between men and women, and the meaning assigned to assistance must also be considered in the orientation and implementation of more culturally suitable home care.

In Aboriginal communities, studies on intergenerational co-residence show that this situation is nearly twice as frequent among Aboriginals than in the rest of the population, owing to factors related to the persons' socio-economic situation and to family and cultural values. Elders are considered active members and play an important role in family life, providing support to younger generations both on a spiritual level and with regard to protecting cultural heritage. In addition, jurisdictional issues complicate delivery of continuous care in the living environment for the First Nations and Inuit communities. Consequently, there is a need to study the situation of female caregivers in Aboriginal communities more systematically, in order to understand the dynamics of care, the burden created by and the specific characteristics of the caregivers' responsibilities, the impact on their health, and the socio-community support available in the community.

Increasing efforts are being made in Quebec to correct the negative impact of the health system reform on female caregivers and to develop support in the population, in order that these women's needs may be recognized and in order that appropriate support measures may be put in place. To feel comfortable in their role as caregivers, these women must have the choice of helping of their own free will, without pressure from public services. They must also have available to them real alternatives to family care. With the action of caregiver support groups, women's networks and community and union organizations, more and more attention is being paid to the issues of respect for personal choices, effective support and empowerment of female caregivers in discussions concerning the impact of health system reform in Quebec.

Ronald Colman
Gender Equality in the Genuine Progress Index

Because the Gross Domestic Product counts only goods and services exchanged for money, unpaid work is invisible in our measures of progress, and most of the work performed by women is therefore unvalued. Caring work, voluntary community service, household production, and child-rearing are more essential to our standard of living and quality of life than much of the work done in factories, offices and stores. Because this unpaid work is effectively de-valued in our measures of progress, essential policy issues of vital concern to women receive low priority on the policy agenda. Gender equality is a core value in the Nova Scotia Genuine Progress Index, and unpaid work is explicitly valued. The GPI found that, despite a doubling of women's participation in the paid work force, women still do two-thirds of the housework, a ratio that has hardly changed in 40 years.

The double burden of paid and unpaid work has produced an absolute loss of free time for women, and higher levels of time stress. Statistics Canada found that one-third of employed mothers are "extremely time stressed" and more than 70% feel rushed on a daily basis. Time use surveys, on which four of the 20 GPI components are based, reveal that employed mothers average more than 11 hours of paid and unpaid work on weekdays and another 15 hours of unpaid work on weekends. A shift to paid child care also means that parents have less time with their own children than ever before. The invisibility of unpaid work ensures that the social, psychological and health costs of this double burden on both parents and children receive scant attention in the policy arena.

Other policy implications for gender equality of valuing unpaid work include:

- Child care, house cleaning and other types of work traditionally regarded as "free" fetch very low rates of pay in the market economy, producing continuing wage inequities between men and women. In Nova Scotia women working full-time earn 66 cents to the male dollar.
- Access to credit, pension plans, employment insurance, and even court awards are generally based on paid work only. Failure to value unpaid work, most of which is still done by women, therefore perpetuates subtle economic discrimination.
- Single mothers dependent on the household economy put in more than 50 hours a week of productive household work. Because it is unvalued, social supports are inadequate and more than 70% of Nova Scotian single mothers live in poverty. More than half of Nova Scotia's 50,000 poor children live in single parent families.
- There is an urgent need for family-friendly workplaces that enable an easier balancing of job and household responsibilities. Canada has much to learn from Holland, Denmark, Sweden, Norway and other European countries in this area.

The Genuine Progress Index also includes a gender dimension in other components to ensure that gender equality is clearly seen as an essential component of the quality of life and a core measure of well being and progress.

Ronald Colman
Measuring Genuine Progress

Although there is a broad consensus that security, environmental quality, equity and other values are essential to well being and prosperity, public policies frequently undermine those values. One reason is that we measure our progress according to a narrow set of market statistics based on the GDP. Economic growth rates are used to determine how "healthy" our economy is. In this system, the more money we spend, the "better off" we are. According to the principal architect of national income accounting, Simon Kuznets, this is a serious misuse of the GDP, which cannot actually tell us if we are "better off":

- The GDP does not distinguish economic activities that bring benefit from those that cause harm. In fact, more crime, pollution, gambling, sickness, divorce, accidents and war all make the economy grow.
- Unpaid work that really does contribute to well being, like voluntary community service, child-rearing and household production, are ignored and unvalued.
- The depletion of natural resources, on which wealth is ultimately based, is counted in the GDP as growth and "progress."
- Longer work hours contribute to economic growth, but no value is assigned to free time.
- The economy can grow even if inequality increases, as has been the case in the USA.

Although we have more possessions, we are not necessarily "better off" as a result of decades of economic growth. We have three times the crime rate of the 1960s, we are more time stressed, deeper in debt and less secure in our jobs. Child poverty is up 60% since 1989. Our environment is seriously stressed and our resources more depleted. Less than half of Americans say they are happier than their parents.

There is, therefore, an urgent need for better and more accurate measures of progress. The Nova Scotia Genuine Progress Index, currently under construction, integrates 20 social, economic and environmental variables into a comprehensive and policy-relevant measure of sustainable development.

Natural resources are explicitly valued; unpaid household work and voluntary work are measured; and costs are distinguished from benefits. The GPI subtracts rather than adds the costs of crime, pollution and accidents. The index goes up if we have more free time, greater equality, and a cleaner environment. It therefore more accurately reflects actual changes in our quality of life.

Measuring progress in this way has significant policy implications, examples of which are given in the *Made to Measure Symposium* paper. The cusp of the new millennium is a rare historical moment in which in it is actually possible to shift the view from the short-term materialist assumptions to which we are accustomed to new measures of progress that reflect our genuine vision of the society we want to inhabit and the legacy we want to leave our children.

Mary Coyle
Gender Equity: An International Perspective

Since the 1970s, great strides have been taken in the measurement of gender equity, culminating in the use of composite indices such as the gender empowerment measure and the gender development index in the annual report on human development produced by the United Nations Development Programme (UNDP). In broad terms such aggregates allow for cross-country comparisons, and assessment of progress.

While in aggregate terms the position and situation of women has improved world-wide, the association of poverty with increased gender inequality suggests that there are gender biases inherent in the prescriptions for economic structural adjustment.
An analysis of the experience of inequity therefore needs to be informed by an understanding of the relationship between the paid and unpaid sectors of the economy, in particular how the market economy is subsidised by the reproductive work of women. In this way, we address not only the basis of unequal gender relations, but also the dangers of an economic paradigm that is inherently off balance and unsustainable.

The aggregate trends must also be qualified by attention to contingency: different cultural contexts vary in the extent to which they open doors for women, and vary in the kind of influences they have felt through colonialism, integration into a global economy, and exposure to the media. Most significantly, gender inequity is cross-cut by other inequities such as class, age, and ethnicity. As the gap between rich and poor widens, the differences between women of different classes may prove to be as great as the differences between women and men.

The policy and programming implications of these trends centre around enhancing the value attributed to the reproductive, caring economy (broadly defined) in order to elevate the work that women do, attract more men into the reproductive sector, and ensure sufficient public sector support.

Action-Oriented Recommendations

- Continued attention to documenting the gender differentiated impact of macro-economic policy
- Screening of national budgets, and recommendations for shifts in expenditure to ensure gender equity
- Scrutiny of indicators to ensure that they are valid indicators of gender equity - assessment of the quality of education, for example
- Advocacy at the international level to ensure that unpaid labour is appropriately costed and valued, and that taxation, budgetary allocations, and regulations are adjusted accordingly
- Programmes that respond to changing family structures, particularly those that encourage greater participation of males in child-rearing and other aspects of reproductive labour
- Advocacy for legislation that requires "exit costs" for a parent who leaves the family
- Programmes that are genuinely addressing gender relations and gender equity.

Olena Hankivsky
Social Justice and Women's Health: A Canadian Perspective

Social justice is based on the idea that all members of society have an equal access to the various features, benefits and opportunities of that society regardless of their position or station in life. Alternatively, a lack of social justice in health can be seen as a risk factor for increased illness, disease (morbidity) and mortality. Creating a health care system that is congruent with the goals of social justice appears to have the potential to contribute to the improvement of women's lives.
This paper examines the extent to which the Canadian health care sector protects and promotes social justice and in particular women's right to health. Gender barriers to physical and mental health are examined. Inequities and injustices that women experience in their interactions with the health care system are revealed. The paper also discusses why gender disparities persist and investigates what areas of the health care system need to be reformed to incorporate social justice into health for women. The author argues that framing women's health in the discourse of human rights is a prerequisite to social justice. However, in themselves, rights have no meaning if they are not promoted and protected. Recommendations are suggested for what improvements would be desirable both within the health care system and beyond its confines.

Olena Hankivsky
The Legal System and its Impact on Women's Health:
A Largely Uninvestigated Terrain

This paper considers the potential and limitations of the legal system in women's struggle for social justice. The argument put forward in the paper is that though rarely taken into account when examining women's health, the legal system is a key determinant of women's health. Law and the justice system govern nearly every facet of women's lives. Having the power to regulate both private and public activities, oversee the protection of rights that affect women's socio-economic status, the law - in all its dimensions has the potential to affect women's physical and mental health directly and indirectly. Women are affected when the legal system fails to adequately respond to the inequalities (ie. educational, economic and social) and harms (ie. violence, harassment, trafficking, sexual exploitation) which women suffer. And as a result of the system's shortcomings, women can *and do* suffer real physical and mental injuries.

Accordingly, the paper examines a selection of current issues in the legal system (ie. access, criminal law, civil law, family law) that impact directly and indirectly on women' s health. This overview, however, should only be considered a beginning in the process of understanding the extent to which the law impact on women's physical and mental health. Much more research, data collection, and evaluation are required to measure explicitly and fully the role of the legal system as a determinant of women's health.

One of the major developments to emerge in the study of women's health over the last decade in particular has been the recognition that health is influenced not only by biological mechanisms and medical models but by a range of socio-cultural, physical, and psychological factors (Cohen & Sinding, 1996). Broadly categorized as the multiple determinants of health, these factors can include such influences as income and social status, social support networks, education, employment and working conditions, physical and working environment, biology and genetic predisposition, personal health practices, healthy child development, gender, and culture (Cohen, 1998; Women's Health Strategy, 1999). When discussing the factors that affect health, it is necessary to recognize gender as a key social determinant. Although both women's and men's health is affected by social and economic factors, the interaction of gender with the other determinants of health creates different experiences of health and illness for women and men. The compounding and interconnected impacts of race, sexual orientation, gender, age, class, and disability influence social support networks, access to education, access to quality employment, risk of violence, and other resources affecting health. The following are several social factors affecting women's health. These reflect some themes common in the literature about women's health and from some of the interviews that I conducted with community group representatives, policy makers, and researchers in St. John's, Newfoundland:

Multiple Roles: Women tend to have many roles that can be stressful and physically demanding. Many work full-time jobs and also care for children and elderly parents. Many women are forced to leave paid work to care for others resulting in reduced social security benefits, pensions, and medical insurance. This in turn can have a deleterious effect on women's physical and mental health status.

Women's Work: Despite the multiple demands women face, work outside of the home tends to have positive effects of women's health. Work outside of the home can offer financial rewards, social support, and greater self-esteem (Walters, Lenton, & Mckeary, 1995)., Women, however tend to be concentrated in work environments that increase stress and decrease job satisfaction (Kaufert, 1996). Women can also face social problems such as discrimination and harassment, and physical problems, such as mal-adjusted equipment and poor working conditions, that influence health.

Income distribution: In all societies, including Canadian society, women constitute a larger proportion of the poor and they lag behind men in almost every social and economic status indicator (Cohen, 1998). Poverty also seems to be associated with a slough of chronic health conditions such as heart disease, arthritis, stomach ulcers, and migraines (Statistics Canada, 1994). Income affects lifestyle, quality of housing, and nutrition. Income can also determine to a large extent access to health care; for example treatment, medication, counselling and rehabilitation (The Working Group on Women's Health, Department of Health, Government of Newfoundland and Labrador, 1994).

Social Support: According to a recent report considering gender as a health determinant, there is considerable evidence that social support influences health status, health behaviour, and the utilization of health services (Davidson, Holderby, Stewart, vanRoosemalen, Poirier, Bentley, and Kirkland, 1997). Although quality interpersonal relationships are vital, the supports found in the larger community are also important (Walters, Lenton & Mckeary, 1995). The extreme opposite of supportive environments and relationships is the violence that many women are faced with in inter-personal relationships and in the workplace. Women with low incomes, immigrant women, and

Aboriginal women have rates of physical abuse higher than the national average. Women with disabilities are also vulnerable to abuse (Nova Scotia Advisory Council on the Status of Women, 1995).

Geographic Isolation: Women in rural areas may not have access to appropriate health services such as counselling, mammography, and abortion. When coping with a disease, such as breast cancer, women living in geographically isolated areas may not have access to the support of other breast cancer patients.

Community Health: To improve health and well-being, it is important to examine the context of women's lives. Women are part of families and larger communities. When those families and communities suffer because of inadequate health services, economic depression, and lack of social support, women's health suffers as well. This does not negate the fact that women may have specific needs within families and communities or that certain women who are socially or economically disadvantaged may be more vulnerable to violence, discrimination, and isolation – factors that can contribute to ill health. It is also important not to "over-professionalize" support. Often it is possible to use community resources to cope with change or difficulties in the community.

Linking with other Groups: Linking with groups in other sectors is important because it combines a variety of skills and strengths to create effective and innovative projects that benefit women's health.

Recommendations:

Finding # 1	Recommendation # 1
There is some concern that shifts from acute care to community care will not be accompanied by appropriate shifts in resources and that women will be required to provide "free" caregiving that will negatively impact their mental and physical health.	Caregiving by should be recognized as "real" work and should be financially compensated. In places where community organizations or informal networks are expected to participate in care-giving, appropriate resources must be available to those doing such work.

Finding # 2	Recommendation # 2
Women's health does not occur in a vacuum. Women are part of families and communities. When communities suffer, women's health usually deteriorates.	Job creation, nutrition, housing, and health promotion programs need to be accessible to all members of the community. Care must be taken that the special needs of certain groups, for example, women, persons women disabilities, older people, and aboriginal people are taken into consideration.

Finding # 3	Recommendation # 4
Many of the skills and resources needed to cope with change and difficult situations are already in the community.	Although it is important that people have access to counselling services and social workers, it is equally important that lay people work with others in their community who are going through difficult times.

Finding # 4	Recommendation # 4
Although access to services, hospital beds, and quality health care can influence health, poverty and lack of jobs is a major health determinant.	It is necessary for policy makers, community workers, researchers, and service providers to examine and treat the root of problems that exist in their communities. It is not enough to provide "band-aid" solutions that only treat problems such as stress, anxiety, and depression that may be symptomatic of larger- scale problems such as poverty.

Finding # 5	Recommendation # 5
Women living in rural and geographically isolated areas often do not have access to counsellors, support groups, mammograms, breast screening, and abortion services.	Governments should strive toward making equal access to services and health care a reality, regardless of geographical location. Efforts should be made to bring these services to remote communities and to bring people living in remote communities to these services.

Finding # 5	Recommendation # 5
The availability of social support seems to play a pivotal role in health and well-being. Informal and free services and the development of support networks are vital to the health of all women and men. Community organizations provide many free support services and help for people who have nowhere else to turn. A move away from core funding to project based funding necessitates that many community based organizations spend hours of valuable time looking for funding and does not recognize or validate work such as giving referrals, peer counselling, organizing support groups, etc.	Community based organizations must have the option of applying for operational and core funding that will support vital services such as giving referrals, peer counselling, organizing support groups, etc.

Karen Messing
Building Alliamces to Improve Women's Occupational Health

Women suffer many problems related to their work: musculoskeletal problems; stress leading to heart disease and psychological distress; sexual and sexist harassment; job demands incompatible with pregnancy, nursing and family life; cancers, skin disease and toxic effects of chemical exposures; difficult work schedules; violence from clients and co-workers; eyestrain from meticulous work and exhaustion from overwork, inadequate rest breaks and repetitive work.

Women with health problems face obstacles at two levels: recognition of their problems and ability to organise to prevent problems.

The relative lack of progress in **recognition** can be attributed to:

- A perception, relatively impervious to evidence, that women's issues will be appropriately dealt with by gender-neutral research
- Pressure to deal with "real" issues of mortality and defined and compensated morbidity; ignorance of women's occupational health issues
- Lack of gender-identified data from governments and other sources
- The multidisciplinary nature of research in women's occupational health
- Feminists do not hold positions of power in scientific institutions

The relative lack of progress in **prevention** can be attributed to:

- Reluctance of employers and government to widen the definitions of the purview of occupational health and safety efforts to include issues in women's jobs, with consequent pressure on those active in health and safety to concentrate on "real" problems resulting in death or visible injury
- Relative absence of women and absence of people representing the issues in women's jobs from decision-making positions in occupational health and safety
- Relative absence (although progress is being made) of women from positions of power in unions
- A perception by health and safety practitioners, relatively impervious to evidence, that the interests of all workers are well served by gender-neutral interventions in health and safety
- Invisibility of problems for women workers, leading to a belief that their jobs are safe

Women workers, resource people and scientists have been involved in change at all levels. This has happened through unions, governments and community groups, although feminist health organisations have been little involved. In order to progress to action on these problems, concerted efforts among feminist health advocates, representatives of women workers, decision-makers and researchers will be necessary. A detailed action plan, available in French and English, has been drawn up by a Canada-wide group of researchers and practitioners.

Key Findings

- Working women are subject to many occupational health problems, but these may be invisible or met with skepticism from those charged with protecting occupational health and compensating for damage.
- Feminist health advocates have been little involved with occupational health.
- Women, particularly non-unionised women, making claims or asking for changes in their working conditions need support groups and help from outside the workplace.
- The scientific community has not been helpful in identifying women's occupational health problems.
- No Canadian research in occupational health (and very little elsewhere) has considered the impact of racism on women's occupational health.

Key Policy Recommendations

In order to progress to action on these problems, concerted efforts among feminist health advocates, representatives of women workers, decision-makers and researchers will be necessary.

- Data, gathered in a gender-sensitive way, should be made available on occurrence of and risks for women's occupational accidents and illnesses, at provincial and federal levels. These should include workplace factors that impinge particularly on women, such as risks for health arising from schedules incompatible with family responsibilities.
- Working conditions typical of women's work in the service sector should be included in standard-setting: prolonged standing; protection from abuse; restrictions on the variability of work schedules, etc.
- Those women and men charged with decision-making in occupational health should receive training to remove bias in treatment of reports and claims from women workers. Rehabilitation and retraining programmes should offer women a wide range of occupational options.
- Researchers in occupational health should be required to show gender-sensitivity and involve inputs from women workers at all stages of research.

Marika Morris
Shaping Women's Health Research: Scope and Methodologies

This paper reviews important issues pertaining to women's health research questions, design, ethical reviews, analysis, presentation and dissemination of results, and the possibilities for resulting action and policy changes. Power and perspective even in feminist participatory action research are examined. Best cases are presented in Appendix A, gender analysis tools for women's health research in Appendix C. The paper also takes a brief look at the current women's health research environment, the emerging Canadian Institutes of Health Research, and the ongoing problem of the dearth of meaningful research for lesbians, Aboriginal women, women of racial, ethnic and linguistic minority backgrounds, women with disabilities, young women and women over 65. The paper makes recommendations on each of these issues.

Plain language translation:

I wrote a paper on what women's health research is all about, from:

- deciding what to study;
- how to study it;
- whether or not the women being studied get a say, and how much of a say;
- what to do with the research afterwards - how to make sure the right people see it, from women who can use it to change their lives, to decision-makers who can change the system.

It matters who the researchers are, what their background is, what they think. There are ways of making sure your own ideas don't end up being the research - to let women speak for themselves. This paper gives examples of good research at the back after the bibliography. You'll also find there some talk about books and things for researchers on how to pay attention to women in their research.

I let you know how women's health research fits into health research in general, like where the money comes from and what you have to do for it. I also talk about blocks to health research by and for lesbians, Native women, women of different races and backgrounds, poor women, disabled women, young girls and old ladies. The federal government is trying to make us buy this new idea of "Canadian Institutes for Health Research" - but I don't know if good ways of doing women's health research are going to make it into this thing unless we force them to do it. It's important because a lot of the money is going to come from there. I don't want to tell you folks what to do about all this, but hey, I did.

Research/Policy Fact Sheet
Maritime Centre of Excellence for Women's Health

Shaping Women's Health Research: Scope and Methodologies

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Research Finding #1: Even in health research done by and for women, there are imbalances in power and perspective. Major research gaps exist in the areas of lesbian health, First Nations, Inuit and Metis women, women of ethnic, racial and linguistic minorities, and women with disabilities, particularly research that reflects their priorities and needs.	**Policy Implication #1:** The Centres of Excellence and other agencies should seek out and support members of these communities to engage in particpatory action health research. Funding agencies should encourage other researchers to engage in team research with team members who reflect the diversity of the research population; establish research partnerships with community organizations; perform community-based research, which is directed by the community from choosing research topics to design to dissemination of results; and pilot the research with participants and use their feedback to make the research design more effective. Women's health researchers and agencies should work to ensure this policy direction is understood and adopted by mainstream health research funding agencies.
Research Finding #2: The emerging Canadian Institutes of Health Research show no signs so far of gender analysis or of building on what we know about women's health research, determinants of health, and participatory action methodologies.	**Policy Implication #2:** A cross-Canada network of women's health researchers should be formed to work with the Gender and Women's Health Research Working Group on the CIHR, to lobby the federal government and the CIHR to ensure gender-parity on the Governing Council, that Council members are brought up to speed on women's health research, gender analysis, and participatory action methodologies, and that gender issues and analysis form a part of funding criteria.
Research Finding #3: The findings of women's health research are not adequately being communicated to women, particularly those who are low-income, Aboriginal, members of ethnic, racial or linguistic minorities, and women with disabilities.	**Policy Implication #3:** Set a target of communicating women's health research findings to 100% of the affected group and develop and build in outreach strategies into the research project. Even if reaching the target may not be possible, simply setting the goal may lead to innovative strategies and the communication of the research findings to women who would not otherwise have had access to it.
Research Finding #4: There is a huge and increasing gap between health determinants	**Policy Implication #4:** One priority of women's health researchers and agencies should be to educate governments, finance ministers in particular, of the

research results and recommendations and government policy on income support and other social and economic policies.	links between their policies and their impact on women's health. This does not involve just performing the research, but to make appointments with senior officials to discuss the research findings and their implications.
Research Finding #5: Not all the recommendations of the 1995 National Symposium Women in Partnership: Working Towards Inclusive, Gender-sensitive Health Policies have been implemented.	**Policy Implication #5:** The Women's Health Bureau, Health Canada should fund an independent review of the Bureau's work toward implementing the recommendations, which would give specific steps the Bureau should take in implementing the remainder. The report should be made available to the public.

Rieky Stuart
Organizational Approaches to Building Gender Equity

This paper presents new concepts and strategies currently being applied in a number of organizations to build gender equity. Women and men working for gender equity have used a number of strategies. They began by naming the problem. Understanding that women's subordination was not 'natural' or 'divinely ordained' but socially created generated both anger and an imperative for change. In spite of efforts, change in the way organizations address or remedy gender-based inequality has been disappointingly slow, at least from the perspective of those who want to end it.

Efforts to analyse why change has been so slow led to the understanding that desire for change, knowledge of injustice, and even policies and training are necessary but insufficient for organizations to change. Independently, several groups of practitioners and academics have been developing new ways of working with organizations to become capable of creating greater equity both in the way they do their work and in their social impact.

The combination of insights from feminist theory and insights from organizational change theory and practice brings to the foreground useful and interesting ideas and potential approaches to gender equity issues in organizations. Four major dimensions of how organizations are gendered include: (a) valuing of heroic individualism, (b) splitting work and the rest of life, (c) construction of power by organizations, and (d) concept of mono-cultures and instrumentality. Reflecting on and changing these gendered dimensions of organizations as they are practiced in a particular context can lead to changes that enhance the organization's capacity to be effective, both internally for women and men staff, and externally, in achieving its goals with equity.

Since the early 1990's there have been a number of experiments in Northern and Southern countries in applying the concepts described above to help organizations wanting to improve both their equity and their effectiveness. While each intervention is unique, there are significant commonalities in the methodologies and approaches. Each of them looks at key issues of concern to the organization and links them with gender equity issues through the use of the 'gendered lens' to explore and come to grips with aspects of the organization's deep structure. Each of them has three phases - a start-up or diagnostic phase, change experiments that are often based on an action-learning model, and an evaluation/validation/dissemination phase, in which learning is collected, assessed and entrenched in the organization. And finally, each intervention used continual feedback to the organization and to change agents to modify the interventions and learn from them.

Examples of how these ideas have been put into practice to help organizations to change toward greater gender equity are provided, and while it is possible to abstract the commonalities, the particularities of each case led to a very different look and feel on the ground. In any given situation it is important to examine what the issues are, how they relate to the work of the organization, where change should star and at what level, which strategies are most promising, and what needs to be negotiated with the various interests involved. These approaches require people to work together to create new ways of seeing and acting within organizations that will lead ultimately to gender equity. It is from these new ways of thinking about and being in organizations that the future emerges.

Katherine Teghtsoonian
Centring Women's Diverse Interests in Health Policy and Practice: A Comparative Discussion of Gender Analysis

This paper reviews a number of different approaches to mainstreaming gender analysis that have between undertaken in Canada, New Zealand, Australia and western Europe, in order to assess what they might contribute to the development of policy, services and research that are responsive to women's health needs. It focusses, in particular, on efforts to ensure that "gender analysis" includes systematic attention to the needs and interests of diverse groups of women. Experience to date has shown that it is difficult to weave together gender and other dimensions of diversity, such as race, sexual orientation and ability, into policy analysis, program development and institutional structure. The paper recommends a "dual strategy" for continuing to pursue this important work. This approach involves an ongoing commitment to changing mainstream policy and services in equity-positive directions while at the same time ensuring that adequately resourced programs and institutional structures organized specifically around the needs and interests of marginalized groups continue to model and catalyze such change. The paper identifies a number of ways in which these developments can be supported: (1) facilitating genuine and well-resourced participation by community-based women in collaborative working relationships with government staff, health care providers and academics; (2) ensuring that the knowledge and skills necessary to work in a diversity-inclusive fashion are (a) routinely made available to existing staff working in governments, health care facilities and educational institutions; and (b) incorporated systematically into the education of the staff of the future; and (3) developing accountability mechanisms which are transparent, routine, and ensure attention to both process and outcome.

Key Findings:

- Further work needs to be done to weave systematically into gender analysis a focus on race, sexual orientation and ability, and to weave gender into lens-based work focussed on other marginalized groups. We also need to consider how an enriched diversity analysis can inform health impact assessment guidelines, work in health care delivery contexts, and the education of relevant staff.

- A "dual strategy" allows organizations to avoid the potential disadvantages of, on the one hand, "ghettoizing" the interests of women (or other marginalized groups) in specific units and, on the other hand, eliminating such units in the name of "mainstreaming."

- The current need for on-the-job training in diversity analysis will be reduced if relevant material is routinely incorporated into the educational programs that produce health care providers, policy analysts, researchers and educators.

- It is important to ensure that governments (and other organizations) are held accountable not just for <u>doing</u> gender analysis, but also for <u>making policy choices</u> which support equitable outcomes for diverse communities of women.

Key Implications for Policy:

- Governments (and other organizations) should ensure that community-based women are resourced in ways that acknowledge appropriately the contributions they can make to training and education, policy development, and democratic process.

- Discussions between community-based women, government staff, service providers, and academics should be resourced by governments, universities, and other relevant institutions to explore the directions in which future lens-based work could usefully proceed.

- Governments, service delivery organizations, and educational institutions should consider ways in which they could implement a dual strategy.

- Governments and other organizations should ensure that progress on developing the processes and outcomes sought by mainstreaming diversity analysis is explicitly identified in their organizational goals and job expectations, and that performance and progress in these terms is routinely evaluated (by groups both internal and external to the organization) and rewarded where appropriate.

Wendy Williams

Will the Canadian Government's commitment to use a gender based analysis result in public policies reflecting the diversity of women's lives?

For decades women have been analysing government policies and programmes and to see if they meet women's needs. Often they did not and women developed their own services.

Now the federal and some provincial governments have said they will change the way they work. They will ensure that their future policies and programmes will fit the needs of both women and men using a process they are calling gender based analysis.

In 1995, the Canadian government adopted a policy requiring federal departments and agencies to conduct gender-based analysis of future policies and legislation. The aim of this will be to produce policies et cetera that meet the range of women's and men's needs. The Women's Health Bureau in Health Canada has started this process.

At least three provincial governments have made commitments to a gender based analysis, British Columbia, Quebec and Newfoundland and Labrador. The BC government started their process in December 1993. Both federal and provincial governments have publications that describe their processes.

Women in government at the international, national and provincial levels are saying they need a process to help influence public policies. The suggestion that is being made is a gender based analysis. Speaking for women can be dangerous. Gender based analysis may be a safety net for women inside government bureaucracies working to include women's experience. There is an opportunity for governments to report where and how they have used gender based analysis to improve polices and programs for women and men.

Concerns about the process exist. Gender based analysis did not come from the activist community. Activists are unsure of what it is. Women do not talk about gender. They speak about their lives and experiences. Will women even know that a gender based analysis is about putting both women's and men's experience into the policy process? Who will be doing this work and what training will they have. The process needs to be evaluated.

Under the Canadian constitution there are two levels of government, the federal and the provincial or territorial. The responsibility for the delivery of health care services is with provincial governments. Many provinces have adopted a regional system of health care delivery. Thus, most health care delivery decisions are now made at the regional level in a regional board of health. This means that there are many levels to affect policy decisions in health care delivery.

No model of health care delivery in Canada is giving better service to women than men. When we are talk about the health care delivery system, we usually mean the system to treat illnesses and disease. It includes hospitals, cancer treatment centers, doctors offices and the many people who work in those agencies nurses, social workers, cleaners and administrators. Noting this system does not deliver health is important. Most of the resources go into treating illnesses and disease.

This is an important distinction. According to the determinants of health model, health is determined by one's income, education, social support networks, healthy child development, personal health practices, coping skills and working conditions and the health care delivery system. The role that the

health care delivery system plays in maintaining the health of women is smaller than these other factors.

There are many changes in the health care delivery system across Canada. Initiatives such as those following, may improve the delivery of health care services to women. It is too early in the process to know what the results will be. Several projects under way in British Columbia may produce health care services designed with women in mind. These projects need to be documented, shared and evaluated to see if services improve.

One goal of the women's movement is the improvement of the lives of women. Gender based analysis may be one tool to reach this goal. It is only one. Many women will not want to spend their time and energy discussing, evaluating or using this tool. They will be watching this process to see if it produces change.

Recommendations

1. The federal government must report annually on the use of a gender based analysis in its policy and programs development

2. As this is a new process the women's community need funds to pursue education and information about gender based analysis

3. The use of a gender based analysis must be monitored and evaluated using feminist indicators. The federal government must allocate funds for this monitoring and evaluation.

4. Changing the health care delivery system to meet women's needs is being tried. Funds must be allocated to document this process and to share the information with women across Canada.

5. Gender based analysis will be mainly done inside non feminists institutions. There needs to be much discussion on how to support the feminists working inside those institutions working for change, while holding the institutions accountable if the change is not happening. This discussion must take place in many places. Funds are needed to develop, to document and to share models to do this work.

Research Fact Sheet

Finding	Action
The Federal Government has made a decision to use a gender based analysis when developing policies and programs	The federal government must report on the use of this process across all departments and agencies.
Gender based analysis is new	The process must be explained to the women of Canada
Gender based analysis must be evaluated	The federal government must allocate monies for the development of feminist indicators to be used in the evaluation of the process
Changing the health care delivery system to meets women's needs is being tried	Document this process and share the information with women across Canada
Change in government policies requires people both inside and outside working together	This process of change must be one that holds people accountable for their actions while being respectful of them. Models for doing this must be documented, evaluated and shared.