MARITIME CENTRE of EXCELLENCE for WOMEN'S HEALTH

Promoting social change through policy-based research in women's health

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

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Contents

Executive Summary 4

Introduction 5

Bringing Women's Diverse Health Needs into Policy and Practice 5

Institutional Context 7

Mainstreaming Women's Participation 8

Training and Education 8

Accountability 9

Conclusion 11

References 12

Works Cited 13

Executive Summary

This paper reviews approaches to mainstreaming gender analysis in Canada, New Zealand, Australia and Western Europe and assesses their contribution to the development of policy, services and research that are responsive to women's health needs. It focusses on efforts to ensure "gender analysis" includes systematic attention to the needs and interests of diverse groups of women. Experience shows that it is difficult to weave 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 pursuing this important work. This approach involves a commitment to changing mainstream policy and services in equity-positive directions while ensuring 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 several ways to support these developments: (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 staff working in governments, health care facilities and educational institutions; and (b) incorporated systematically into the education of future staff; 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 *doing* gender analysis, but also for *making policy choices* 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.

INTRODUCTION[1]

Across Canada, diverse groups of women of colour, aboriginal women, women with a disability, lesbian women, and women living in poverty have argued for some time now that their experiences, needs and interests have not been adequately reflected in or taken up by the mainstream women's movement, by social service providers, by educational and research institutions or by governments. In the areas of health research and health policy, women from various communities have pointed to the need for relevant data disaggregated by gender, racial background, sexual orientation, disability and Aboriginal status (CACSW 1995: 34; Walters et al. 1995: 13; Grant-Cummings and Phillips n.d.: 3). They have noted that, all too often, health care providers assume that all women are heterosexual; health care facilities fail to develop culturally-appropriate services; and the health care workforce does not reflect the diversity of the population it serves. As a result, significant barriers to access are created to the detriment of women's health (Ramsay 1994; Tator 1996; BC Women's 1995). Government policies frequently do not respond to the health needs of diverse groups of women, or do so in ways which ignore the differences within particular communities of women (Simms 1996; Stout 1996). More generally, the health of all women – and particularly those from marginalized communities – is undermined by the failure of public policy to eliminate poverty, systemic discrimination, and violence from our lives. These circumstances raise important questions about whether and how initiatives to "mainstream gender analysis" can respond to diversity among women in a positive and productive way.

BRINGING WOMEN'S DIVERSE HEALTH NEEDS INTO POLICY AND PRACTICE

Mainstreaming is "an approach that recognizes that gender analysis is integral to the policy and program process and outcome and incorporates women's views and priorities into the core of policy decisions, institutional structures and resource allocations" (MCEWH 1999: 1). To implement it, women's policy agencies in Canadian governments and elsewhere have developed gender analysis documents that outline for policy staff throughout government how to take up gender in their work, and to persuade them of the importance of doing so.[2] These documents have generally emphasized that "gender analysis" is not just about addressing the policy-relevant differences *between women and men* but rather, by definition, requires the analysis of such differences *among various groups of women*. However, despite drawing attention to the specific circumstances of multiply-marginalized women, the focus in these documents tends to remain on "gender-in-general". How might they be further developed in order to support policy analysts' efforts to attend more fully to women's diversity and, in particular, to our health needs?

There are at least three possible complements to existing gender analysis documents: (1) policy analysis tools focussed on other dimensions of disadvantage; (2) health impact assessment tools; and (3) diversity analysis training. Each of these has both strengths and drawbacks. For example, in both B.C. and New Zealand, lenses for policy development and evaluation have been developed that address dimensions of diversity other than gender. In B.C. these include: (1) "Multiculturalism Assessment for Cabinet Submissions," produced by Multiculturalism BC (1995) which presents a list of questions for policy analysts to consider in preparing cabinet submissions; and (2) *The Disability Lens*, produced by the Office

of Disability Issues. Both are important for women, who comprise a significant proportion of each of the relevant groups. Nevertheless, attention to gender does not appear to have been incorporated into either of them in a significant fashion.[3]

The gender analysis document development by New Zealand's Ministry of Women's Affairs – *The Full Picture* – has also been supplemented. Building on the framework presented in *The Full Picture*, the Ministry of Pacific Island Affairs has developed a Pacific Islands framework for policy analysis (1998). This document is designed to facilitate consideration of the particular needs and interests of the diverse groups of Pacific peoples living in New Zealand by policy staff across government. However, as with the multicultural and disability documents in B.C., there is minimal attention in this framework to the specific interests of *women* within the various communities of Pacific Islanders. This suggests that the task of integrating gender must have multiple foci, that is, it needs to be directed at other lens strategies as well as at mainstream policy analysis, and that further work is needed to integrate the analysis developed in disability, multicultural and other lenses into both gender-based analysis and into the core business of government more generally.

In addition to these "generic" instruments, there are also health-specific policy analysis tools. For example, in 1995 the B.C. Ministry of Health produced *Health Impact Assessment Guidelines* to assist those involved in the development and delivery of programs and services to "analyze your program's impact on the factors that affect human health and well-being" (p. 3). One of the nine factors identified for consideration is "equity of access to services and program, and opportunities to participate" for "First Nations people, cultural and linguistic groups; women, children, youth, seniors; gays and lesbians; people with disabilities, illiteracy, or mental health problems; people who rely on public transit, cycling, and walking" (pp. 5-6). Although noting the importance of responding to the specific needs of these groups, the document offers little direction to staff wanting to undertake such an analysis but unsure of where to start or how best to proceed.[4]

This fragmentation of attention to various dimensions of disadvantage across different government agencies and policy areas suggests that a more integrated approach to inclusive policy analysis might be preferable. Building on knowledge and experience gained in working with their gender-analysis document, *The Gender Lens* (MWE 1997), staff in B.C.'s Ministry of Women's Equality developed a proposal for "diversity lens training" across the provincial public service (MWE 1998). Such training would bring together the insights developed in *The Gender Lens*, *The Disability Lens*, and the multicultural impact assessment requirement with the *Health Impact Assessment Guidelines*. The proposal usefully highlights the need to integrate the various approaches to lens-based policy work, but it does have its own limitations. For example, "the training is designed primarily to focus on the groups for which specific lenses have been developed" (MWE 1998: 6). As a result, there is a significant risk that the interests of women also belonging to groups for whom lenses do not exist (for example, aboriginal women or lesbians) will continue to be marginalized. The development of such lenses (e.g., aboriginal and lesbian) and their full integration into diversity training, could be supportive of the efforts of staff to adopt an inclusive approach to their work.

There are other approaches to mainstreaming diversity that may prove useful:

- Require all government departments to produce a statement outlining their

spending (if any) targeted specifically at women and analysing the impact of *all* their expenditures on women (the "women's budget process"). This approach, developed and used extensively in Australia during the 1980s and 1990s, could be adapted to analyse the budget's impact on other equity-seeking groups and on groups of women that are multiply marginalized (Sharp and Broomhill 1990).[5]

- Bring a gender analysis to bear on developments that take place in the arena of federal-provincial negotiations. This might be accomplished through advisory groups to policy-specific committees and/or the inclusion of gender specific performance indicators in agreements developed at this level (Sawer 1998a, 1998b). Given the impact of federal-provincial negotiations and decisions on a wide-range of policies affecting the quality of health and health care available to diverse groups of women, and the persistent lack of transparency surrounding these processes, this is an important suggestion to consider.
- Explore the potential use of gender analysis approaches in non-governmental contexts relevant to the delivery of woman-positive health care. These could include service delivery institutions (BC Women's 1995); the guiding principles and codes of ethics of professional associations (Hills and Mullett 1998); and the education of policy analysts and health care providers.

INSTITUTIONAL CONTEXT

Arguments about the importance of mainstreaming gender have been driven, at least in part, by a perception that the "ghettoization" of women's concerns in separate institutional structures has had a number of harmful impacts: (1) the scope of work appropriate for such units becomes confined to narrowly-defined "women's issues"; (2) such units' work is under-resourced, despite expectations that their staff will nevertheless be able to intervene authoritatively on all relevant issues; (3) staff in other branches of the organization continue to believe that they are not responsible for addressing gender in their work, since "that's the job of the women's unit" (Carriere 1996; Moser 1993). Similar concerns have been expressed in discussions of how best to respond to the interests of other marginalized groups, such as aboriginal people or people with a disability (New Directions 1995: 5).

However, mainstreaming can pose dangers of its own: the argument that "mainstreaming is underway" has led to reductions in the resources available for targeted equity initiatives (Commission 1998) and been used to support claims that women-specific units are no longer needed. In the absence of adequate knowledge, skills and commitment to gender equity elsewhere in the organization, these developments may result in the disappearance of equity issues from the organization's agenda altogether (Outshoorn 1997, 1998; Rees 1998).

A promising alternative is to reject altogether the need to choose between dedicated units and a mainstreaming strategy and, instead, pursue both simultaneously (Commission 1998; Eisenstein 1996; Rees 1998). In an Australian health service delivery context, this "dual strategy" has ensured that women-specific programs enjoyed "space and capacity for continuing innovation" in meeting women's needs, but avoided the dangers of ghettoization by allowing these targeted programs to operate as "catalysts and critics to keep pressure on the mainstream to develop gender appropriate services" (Draper 1991: 332). This general approach was also advocated by participants in

a 1995 Canadian symposium on women's health, who "stressed that there should be a 'both/and' approach to the integration of cultural sensitivity into mainstream institutions and the development of parallel community organizations. One need not preclude the other" (CACSW 1995: 40; see also Tator 1996). A dual strategy can also be pursued within government, for example in the operation of women's health bureaux within ministries of health, *alongside* the continued existence of women's policy agencies such as Status of Women Canada or the B.C. Ministry of Women's Equality.[6]

MAINSTREAMING WOMEN'S PARTICIPATION

Women have an invaluable contribution to make to research concerning their health and health needs (Ramsay 1994; Simms 1996; Stout 1996) and to all phases of the policy making process. Experience has highlighted the need for participatory processes in these arenas which take into account the particular circumstances of the lives of women, rather than simply offering us a place in "business as usual" (Wharf Higgins 1997; Saskatchewan 1998). There are a number of elements crucial to the development of genuinely participatory processes for women:[7]

- participation must be properly resourced, so that women and the organizations for which they work are not burdened by their willingness to contribute to research, curriculum development, improvements in service delivery, and the public policy process (CACSW 1995);
- timelines and established ways of operating must be adapted if genuine, rather than token, participation is the goal;
- ingrained and elitist attitudes regarding what constitutes "expertise" and who possesses it need to be revised so that the knowledge of service recipients and front-line workers about what works and what doesn't is acknowledged as valuable (Wharf and McKenzie 1998).

In addition to supporting collaborative work between women outside of bureaucratic institutions and women within them, it may also be useful to consider measures that would facilitate the direct recruitment of community-based women into positions into government. Where civil service hiring rules have permitted this practice, it has had a salutary effect on the ability of women's policy agencies to pursue a woman-positive agenda from inside (O'Regan 1992; Outshoorn 1997; Sawer 1996).

TRAINING AND EDUCATION

To be effective, training in gender/diversity analysis needs to undertaken on a systematic and routine basis (rather than through one-off, one-day workshops[8]) and must address the particulars of the policy area or service context within which staff are working (Saulnier et al. 1999: 9). Hiring women from various communities to contribute to the development and delivery of such training could also serve to: (1) model participatory processes; (2) facilitate mutual learning across institutional contexts; and (3) improve the policy process by ensuring that the knowledge and experience of community-based women is available to analysts within government. Community-based women might also be employed to collaborate with academics and/or staff in health care organizations to develop training designed for a variety of contexts (government, health care organizations, educational institutions). Persuading governments and other organizations to allocate the resources necessary to support such undertakings in the present context, where reduced expenditure remains a privileged organizational goal and "special interest groups" are frequently dismissed as illegitimate, is a difficult but important task.

These issues can also be addressed proactively in the professional training of the staff of the future. Researchers, health care providers, and policy analysts could be routinely taught about women's diverse health needs and concerns, about qualitative and participatory research methodologies, and about feminist, anti-racist and other critical approaches to analysis during the educational programs they undertake in preparation for employment. A "dual strategy" could be pursued by both developing courses specifically focussed on such material, as well as ensuring that it is mainstreamed into existing courses. As with the development of training for existing staff, it seems worth exploring the ways in which this educational work could be built on (resourced) collaborative relationships between community-based women, academics, health care providers, and existing government staff (BC Women's 1995: 54). As government and health care organizations come to be staffed by people who are familiar with, and open to, the contributions feminist and qualitative research have already made to our understanding of women's diverse health needs, the productive uptake of existing research should be vastly improved and the need to engage in on-the-job diversity training reduced.

Education and training are not enough to ensure that inclusive policy analysis will actually be done if there are no positive incentives to undertake it, and negative sanctions for doing so (McLaren 1995: 13; Saulnier et al. 1999: 8). In government, in service delivery contexts, and in educational and research communities, women fear (and experience) marginalization, career penalties and/or job loss if they are vocal on gender issues; gender-related work is often done in addition to already-heavy workloads without acknowledgement or reward. These circumstances also hold for members of other marginalized groups working on issues of racism, heterosexism or ablism within their organization. Framing the continuous development of knowledge that supports inclusive ways of working a professional responsibility with appropriate rewards for doing so may help address some of these barriers (McLaren 1995).

Accountability

Much of the discussion concerning how best to implement gender analysis mainstreaming has focussed on the potential benefits of working through organizational "accountability frameworks" to achieve this goal (MWA 1996a, 1996b; CIDA 1999; McLaren 1995). This involves establishing formal expectations about the adoption of inclusive policy analysis and the achievement of equity goals as part of the organization's routine business, ensuring that job definitions include clear statements regarding responsibilities for undertaking this work, and using these components of the accountability framework to evaluate progress on a regular basis. Many support this approach because: (1) it communicates the sense of commitment and leadership from the top that staff indicate encourages them to take gender analysis seriously; (2) it relieves women's policy agencies (or units organized around the interests of other marginalized groups) of the responsibility for being the sole monitor of mainstreaming initiatives across the organization – an impossible task; and (3) it is more transparent than Cabinet submissions processes, which are generally not open to public scrutiny (Saulnier et al. 1999: 3).

However, critics have argued that accountability frameworks, and the performance or outcome indicators developed within them, cannot easily capture aspects of social service delivery and policy development which are crucial from the point of view of marginalized communities. Anna Yeatman, considering the Australian context, has argued:

> This ... can be seen in the example of an Aboriginal community health service ... The trust relations established between the service and the community it serves, the educational impact of the service, and much of its actual health work cannot be turned into activities measurable by performance indicators (1990: 22-23; see also Eisenstein 1996: 191).

This suggests that accountability frameworks should include attention to the processes through which services and policy are developed and evaluated.[9]

But attention to process is not sufficient. However carefully gender-based analysis is conducted or a women's budget statement constructed, however nuanced the gender equality indicators that are developed, these may nevertheless have virtually no positive impact on the policy and service-delivery decisions which are actually taken (Moser 1993: 104-7; Schalkwyk et al. 1996).[10] Therefore, in addition to mechanisms for ensuring the technical accountability of bureaucratic staff for the implementation of inclusive policy analysis, it is important to develop strategies for holding government decision-makers *politically* accountable for the extent to which their policy choices support equitable outcomes for women.

Indeed, most discussions of gender analysis mainstreaming stress the crucial importance of political will in ensuring that it gets done, as well as in ensuring that it is converted into policies and programs that will benefit diverse groups of women. Women's activism in a wide variety of contexts has an important role to play here. Community-based women's groups, health care practitioners, and academics are all members of an interested public that can communicate to politicians that they will be held politically accountable for implementing gender-based analysis and for making equity-oriented decisions based on it. How might such groups be supported in this task? Relevant information should be made available in an accessible form for use by women in communities, individually and collectively (Walters et al. 1995: 55), For example, internal performance reviews of progress on gender analysis mainstreaming need to be "translated" into meaningful documents for assessment outside of government.

There is certainly a lesson to be learned here from Australian feminists. They have suggested that one of the main shortcomings of the women's budget process was that the extensive information that it produced was not made accessible to women's groups in the community. These groups could have used it to good effect in holding the government to account for the impact of its spending decisions on women and in lobbying for needed policy changes (Eisenstein 1996: 59-60; Sharp and Broomhill 1990: 10-11).[11] This is an important insight in light of the comments by feminist bureaucrats in a number of contexts indicating that pressure exerted by community-based women's groups has served as an important strategic resource on which they can draw in their efforts to generate change from within (McKinlay 1990; Sawer 1996; see also Skinner 1998).

Obviously, women's groups need adequate resources in order to undertake the task of holding bureaucrats and politicians accountable for both gender analysis mainstreaming and for the other commitments Canada has undertaken as a signatory to various international agreements (Roberts 1996). Any number of activities toward this end could be undertaken. A key question is whether governments are committed enough to the implementation of diversity analysis, and to improving women's health, to provide meaningful support for public scrutiny of their progress with respect to these goals.

Conclusion

As many commentators have noted, gender analysis mainstreaming is a project which generates stiff political resistance (Moser 1993; Schalkwyk et al. 1996). This fact helps us understand why one might conclude that one of the "factors that will influence the future extent of use of gender-based analysis" is "success in promoting the concept that gender-based analysis is not designed to be used only to serve women's interests" ("Thematic Summary" 1998: 75). Unfortunately, this assessment is probably accurate, and reflects a political climate hostile to the argument that equity for women and other marginalized groups is a valued goal in and of itself. While working to change this overall climate, we need also to proceed as best we can guided by the knowledge that experience and research can convey to us. Compiling and sharing the success stories that policy and service delivery practitioners have to tell about their efforts to work in an inclusive fashion is of practical use, and can also offer needed inspiration in a context that can otherwise be discouraging. In the short term, we need to focus on the realm of the possible in the world as it exists, and to value the progress that has been achieved.

At the same time, it is important not to lose sight of the relationship between these incremental gains and the wider goals to which they contribute (Moser 1993). As a long run strategy, mainstreaming "seeks to tackle deeply rooted organisational cultures and practices within which inequalities are embedded"; it is an approach through which "the transformation of institutions becomes the agenda, rather than the continuing attempt to improve women's access to and performance within organisations and their hierarchies as they are" (Rees 1998: 47 and 41). This vision of mainstreaming can also work positive changes for groups marginalized on the basis of race, ability, sexual orientation or poverty. It is the direction in which we must continue to move.

References

1. I am grateful to the Social Sciences and Humanities Research Council of Canada for funding the research on which this paper is based. My thanks also to Colleen Kasting for superb research assistance and to Michael Prince for helpful comments on an earlier draft.

2. See Skinner (1998, Appendix B) for a description of gender-based analysis initiatives that have been undertaken by federal and provincial governments in Canada. These are generally aimed at integrating attention to gender into *all* stages of the policy process. By contrast, "gender impact assessment", developed in the Netherlands and Belgium, focuses primarily on a gender analysis of policy options *once they have been formulated*. See Meier (1998), Verloo and Roggeband (1996) and Woodward and Meier (1998) for discussion and critical assessment of this strategy.

3. Multiculturalism BC's one-page list of questions does not refer to gender at all. It does suggest, in a section on "Differences and Diversity," that policy analysts consider the potential impact of their recommendations on "various and diverse groups of immigrants"; however, the discussion here (as elsewhere in the document) makes reference only to genderless "people" and "groups". *The Disability Lens* does include passing reference to the need to attend to gender, along with a number of other dimensions of difference, in the various stages of the policy process. Unfortunately, it communicates little sense that gender might constitute a central category of analysis, and offers little practical guidance to policy analysts seeking to understand the difference that gender might make for women with disabilities.

4. New Zealand's experience with its health-specific documents suggests an additional source of potential difficulty with the use of such documents. Produced by the Ministry of Women's Affairs, *Think Women's Health: A Checklist for Area Health Board Members* (1989) and *Advance Women's Health: A Checklist for Regional Health Authorities and Crown Health Enterprises* (1995) were intended to assist policy analysts and service providers in developing a gender-inclusive approach to their work. However, the 1989 document had to be rewritten in response to a restructuring of the health care delivery system during the 1990s; the second document has not been replaced in the wake of a subsequent restructuring. Thus restructuring itself may constitute an important barrier to the cumulation of knowledge about, and experience with, gender analysis within particular contexts, thereby undermining opportunities for learning and progress.

5. The women's budget statement had been discontinued at both the national level and in most states by the late 1990s, with the Office of the Status of Women (the main women's policy agency in the Australian national government) arguing that "while [it] has been a valuable reporting mechanism" it has had "little impact on policy formulation" (OSW 1996: 1). See below for a discussion of ways in which the impact of this process might be enhanced.

6. The government of New Zealand provides an example of a dual strategy being used to mainstream other dimensions of diversity into work organized around gender. Within the Ministry of Women's Affairs there is both a Maori policy unit (Te Ohu Whakatupu), whose staff focus their work specifically on the interests of Maori (aboriginal) women, and a Policy Unit, which is responsible for attending to the interests of *all* the women of New Zealand, *including* the particular interests of Maori women, in its work. See Tahi (1995) for a discussion.

7. For a useful, and much more extensive discussion, of how to facilitate women's participation, see Saskatchewan Women's Secretariat (1998: 25-29).

8. This is especially important in contexts where there is significant turnover in staff, which can otherwise mean the recurring loss of any expertise in inclusive policy analysis that might have been developed through training (Outshoorn 1998: 118; Tahi 1995: 76).

9. Polster and Newson (1996) argue that it is unlikely that the disadvantages of the approach can be compensated for by ensuring that the indicators are "better" – either tapping valued dimensions of performance or measuring them in a more meaningful way. In their view, this is not a promising strategy.

10. For examples of the ways in which seeming attentiveness to women's interests can be used to justify policies that have a negative impact on women, see Armstrong (1996) and Grace (1997).

11. Marian Sawer has noted that other countries that have taken up the Australian women's budget approach "have improved on it, for example by the incorporation of parliamentary oversight (a parliamentary committee with some expert technical support) to ensure it remains a meaningful accountability exercise" (1998b: 4).

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