An Action Plan for Women's Health in Manitoba and Saskatchewan

Why an Action Plan?

Just as it was important for women earlier this century to communicate the conditions of their daily lives, their health concerns and their visions to citizen organizations, political parties and policy-makers, so too are women voices needed today in the current debates over health care and health reform.[1]

Since the 1980's, women's health has appeared on the agenda of governments and policy makers with increased regularity. After more than four years of supporting gender-specific research on the social determinants of health, the Prairie Women's Health Centre of Excellence (PWHCE) can make recommendations to improve the health of women.

There is still much research to be done and many gaps to fill. Meanwhile the PWHCE along with other women, researchers and policy-makers have identified changes for the improvement of women's health. The Action Plan uses current literature and research, and women's voices to provide direction to government and community policy makers on women's health in Manitoba and Saskatchewan.

Limitations

This document is intended to be a source document which can be used to stimulate discussion and provide an agenda for change, both for advocates for women's health and for decision-makers at the provincial, regional or district levels. The Action Plan may be used in its entirety by provincial, district and regional health planners. Community organizations may wish to focus on one or more priorities and issues and to use the Action Plan as a resource to strengthen a call for changes in health planning and policy formation, influence health services to women, their implementation and evaluation.

The Action Plan is not comprehensive. PWHCE recognizes that many women's voices were not part of the planning and shaping of this document. This is especially true for women who live in northern, rural and remote Manitoba and Saskatchewan. The cultural diversity of women in the Prairie provinces cannot be given full consideration in this short document. Furthermore, some issues (e.g. health and safety issues for women in the paid workplace) were beyond the scope of the discussion.

PWHCE is interested in research, education and policy change around gender and the social determinants of health. Consequently, the Action Plan focuses on the social factors that affect women's health. Improving women's health requires sharing knowledge with researchers and with persons examining biomedical issues in women's health.

Methods

A Draft Action Plan was developed in the Spring of 2000 by the Prairie Women's Health Centre of Excellence in consultation with women in Manitoba and Saskatchewan. Consultations were held in Winnipeg, Manitoba, and Regina and Saskatoon, Saskatchewan.

Separate consultations were held with Aboriginal women in Winnipeg, Manitoba and Fort Qu'Appelle, Saskatoon to provide an opportunity to explore the particular cultural context of Aboriginal women's health issues and recognize the role that Aboriginal cultural diversity may have on how issues are approached. The consultations included Aboriginal women's thoughts on the historical effects of contact with colonizing peoples. This experience which resulted in primarily enforced systemic dependency and segregation of Aboriginal peoples has had great impact on the health and well-being of Aboriginal peoples, their communities, and their nations. The vision of Aboriginal peoples today remains one of regaining control over their lives. This includes

[1] Willson, K., and Howard, J. *Missing Links: The Effects of Health Care Privatization on Women in Manitoba and Saskatchewan* (Winnipeg: PWHCE, 2000).

redesigning health and social programs and services within a cultural context that respects the diversity of Aboriginal peoples. The Aboriginal concept of health views each person as a whole person whose well-being is determined by the interconnectedness of their spiritual, emotional, physical, and mental aspects of being. Within this concept of health is the person's ability to achieve a balance and function as a healthy individual within the family, the community, and the nation. This element of interconnectedness permeates Aboriginal peoples' concept of health that is quite different from the established health system. It also has "implications for the design and delivery of medical and social services" for Aboriginal peoples.[2]

The Draft Action Plan was presented to over 200 women from across the Prairies and across Canada at the Prairie Women's Health Centre of Excellence conference in Winnipeg, October 12-14, 2000, "Our Health in Our Hands". We are grateful for the knowledge and experience they could share with us; their suggestions and comments were invaluable to this final version. Following the conference, the Action Plan was rewritten to provide greater clarity, a broader understanding of cultural context, and to highlight the recommendations.

[2] *Report of the Royal Commission on Aboriginal Peoples, Volume 3, Gathering Strength,* 1996.

BACKGROUND

A PROFILE OF WOMEN IN THE PRAIRIE PROVINCES OF SASKATCHEWAN AND MANITOBA

According to 1996 Census data, women comprise slightly over half of the population in Saskatchewan and Manitoba.[3] In both provinces, girls under the age of fifteen are fewer in number than boys in the same age category.[4] There are greater numbers of senior women in the Prairie Provinces than there are men.[5]

Senior Women

Manitoba and Saskatchewan have higher proportions of women over age 65, and especially over age 80, than does the rest of Canada. Women live longer than men, with nearly 6 years greater life expectancy at birth, 4 years more than men at age 65, and 2 years more at age 80.[6] While the ratio of females to males has declined, it is anticipated there will be 137 females for every 100 males age 65 and over, and 225 females for every 100 males age 85 and over in 2001.[7] Older Manitoba women are three times more likely than older men to be widowed, and more than twice as likely to live alone.

[3] Statistics Canada, Cat. No. 95-189-XPB, *Profiles*, Table 1: Selected Characteristics for Census Divisions and Census Subdivisions, 1996 Census. Women in Saskatchewan and Manitoba comprise 50.1% of the total population of each province. This is consistent with national figures. See: Statistics Canada, *Women in Canada 2000, A Gender Based Statistical Report*, Catalogue No. 89-503-XPE.

[4] In Manitoba, there are 125,360 boys under the age of 15 or 11.3 % of the provincial population of 1,113, 900 and 119, 250 girls under the age of 15 or 10.7% of the provincial population. In Saskatchewan there are 117,105 boys under 15 or 11.8 % percent of a provincial population of 990, 235 and 111, 490 girls under 15 or 11.2% of the population.

[5] Statistics Canada, supra footnote 4.

[6] Moore and Rosenberg 1997.*Growing Old in Canada: Demographic and Geographic Perspectives.* Statistics Canada and ITP Nelson, Toronto

[7] Centre on Aging 1996. *Manitoba Fact Book on Aging.* University of Manitoba.

Immigrant and Refugee Women in Saskatchewan and Manitoba

Immigration has a long tradition in Canadian history and is consciously supported by government as a strong component of the nation's economic and social development policy[8]. Canada also receives an increasing number of refugees from different parts of the world. Immigrants and refugees constitute 17% of the Canadian population[9]. The immigrant and refugee population continues to grow, with an average yearly intake of around 3,800 to Manitoba and 1,800 to Saskatchewan[10]. According to the 1996 Census, immigrants and refugees make up 12% of Manitobans and 5% of Saskatchewan residents, and over 50% of them are women[11]. Increasing immigration, coupled with a change in where the new immigrants come from, means that the cultural composition of the population of Manitoba and Saskatchewan, and Canada as a whole, continues to grow in diversity and complexity.[12]

Another group of women at a continuous risk of being marginalized are the so-called "Visible Minority" group[13]. Visible minorities continue to be among the lowest income populations.[14]

Profile and Health of Aboriginal Women

Manitoba and Saskatchewan are also home to more Aboriginal people than Canada as a whole. Less than 3% of Canada's population is Aboriginal. According to 1996 Census data, 12% of the residents of Manitoba and Saskatchewan are Aboriginal. As a result, 30% of the Aboriginal people in Canada reside in the two Prairie provinces.[15]

Aboriginal women's health requires particular attention and urgent action. The statistics are alarming. Aboriginal women have shorter life expectancies than Canadian women as a whole. From 1989 to 1993 registered Indian women and girls were 2.8 times more likely than all Canadian women to die of violence. Their suicide rate was more than three times that of all Canadian women and girls. Aboriginal women also develop chronic conditions earlier in life. Even among young women aged 15-29, over one third of First Nations and Inuit women surveyed reported at least one chronic condition, including respiratory and vascular problems, arthritis and diabetes. For women 55 years and over, 87% described themselves as having at least one chronic condition.

Rural Women in Saskatchewan and Manitoba

Women in Manitoba and Saskatchewan are more likely than other Canadian women to live in rural areas. While 22% of the total Canadian population live outside of cities, 28% of Manitobans and 37% of Saskatchewan residents are rural dwellers.[16]

[8] Manitoba Rural Development Institute Report Series, 1994-8
[9] Statistics Canada *Profiles of Census Divisions and Sub-Divisions*, 1996 Census
[10] Citizenship and Immigration Canada, Immigration Statistics, 1995 - 1999.
[11] Statistics Canada, *Ibid*
[12] Bowen, S. *Community Based Programs for a Multicultural Society. A Guidebook for Service Providers*. Planned Parenthood Manitoba, Immigrant /Refugee Health Program, 1993..
[13] Federal, Provincial, and Territorial Committee on Population Health, *Toward a Healthy Future*, Second Report on the health of Canadians, 1999.
[14] *Ibid*.

[15] Statistics Canada, *The Nation Series*. A discussion of the limitations of Census data in understanding the situation of Aboriginal people is beyond the scope of this Action Plan.
[16] Statistics Canada, *A National Overview, Population and Dwelling Counts, Statistical Profile of Canadians, 1996.*

WOMEN AND HEALTH

The World Health Organization defines health as a "state of complete physical, mental and social well-being."[17] This interpretation has received wide acceptance from health organizations and policy makers because it acknowledges the influence of the social environment on well-being. The women's health movement maintains that the achievement of well-being is challenged by sex and gender.[18]

Acknowledging gender is important for the health of men and women because thoughtful explication of biological, social and economic differences can lead to effective policies and programs. Ignoring gender is particularly problematic for women because of:

- the systemic discrimination which women face in areas such as income and employment;
- societal expectations about women's role as caregivers in their families and in the community;
- women's greater vulnerability to violence;
- the lack of understanding of diversity among women, and the greater risks of ill health faced by women who are marginalized from mainstream society including Aboriginal women, visible minority women, women with disabilities, lesbian women, senior women, teenagers, and new immigrants;
- biases in the health system, including:
- a narrow definition of women's health as diseases or conditions specific to women (such as cervical cancer and pregnancy) or those more common to women (such as breast cancer). However, we must remain vigilant to ensure that the services to prevent and treat these conditions are both available and accessible;
- the under representation of women in senior decision-making positions and the over-representation of women in low paid jobs in the health sector;
- applying the results of research conducted only on men to women as well, for example in the diagnosis and treatment of cardiovascular disease;
- the over-medicalization of normal aspects of women's lives including pregnancy, childbirth and menopause;
- making treatment decisions based on stereotypical notions that women complain more about illness than do men.

WOMEN'S HEALTH AS A HUMAN RIGHT

The achievement of health is a high priority among nations. In the international context, health is recognized as a human right. **The World Health Organization declared:**

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition[19].

This acknowledgment is valuable because international human rights law plays a role in highlighting and moulding societal thinking about an issue. Human rights documents identify the parameters of state action and oblige states to achieve the ideals articulated in formal laws.[20]

Equity in health is promoted in numerous international documents. *The Convention on the Elimination of All Forms of Discrimination Against Women* clearly emphasized the importance of health initiatives in the achievement of equality.[21] Article 12 states*: State parties shall take all appropriate measures to eliminate the discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health services, including those related to family planning.*[22] Canada signed CEDAW on July 17, 1980, and ratified it on December 10, 1981.[23]

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[17] Preamble: *Constitution of the World Health Organization, Basic Documents*. Thirty-Ninth Edition. (Geneva: World Health Organization, 1992) pp. 1-2.

[18] For an example of a key background document outlining a perspective on women's health see: *Working Together for Women's Health: A Framework for the Development of Policies and Programs* (Federal/ Provincial/ Territorial Working Group, 1990) .

[19] *Supra footnote 7*.

[20] For a more complete discussion see: R. J. Cook, *Women's Health and Human Rights: The Promotion and Protection of Women's Health through International Human Rights Law*, World Health Organization.

[21] 18 Dec. 1979, U.N. GAOR Supp. 34th Sess., No.21 (A/34/46) at 193,U.N. Doc. A/RES/34/180 (entry into force 3 Sept.1981).

[22] *Ibid.*

[23] "Facts on CEDAW", http://www.pch.gc.ca/ddp-hrd/english/cedaw/dwfacts.htm ; Canada has prepared four reports on it's activities in relation to CEDAW. In the fourth report, the Governments of Manitoba and Saskatchewan provide a synopsis of health related initiatives - see *Canada's Fourth Report on the Elimination of All Forms of Discrimination Against Women;* http://www.pch.gc.ca/ddp-hard/english/cedaw/dw4toc.htm;

The 1995 *Beijing Declaration and Platform for Action*, confirm that action on health is essential to the achievement of equality.[24] The Platform document affirms women's right to physical, mental and social well-being. Paragraph 89 states, in part:

Women have the right to the enjoyment of the highest attainable standard of physical and mental health. The enjoyment of this right is vital to their life and well-being and their ability to participate in all areas of public and private life.[25]

Regardless of the importance of health and well-being to women's quality of life, it still eludes the majority of women.[26] Paragraph 90 states, in part:

A major barrier for women to the achievement of the highest attainable standard of health is inequality, both between men and women and among women. in different geographical regions, social classes and indigenous and ethnic groups . . . [27]

The Beijing Platform for Action calls on governments and institutions to create gender-sensitive health programs, including decentralized health services in cooperation with women and community-based organizations. The programs should *"address the needs of women throughout their lives and take into account their multiple roles and responsibilities, the demands on their time, the special needs of rural women and women with disabilities and the diversity of women's needs arising from age and socio-economic and cultural differences, among others."*[28] *Women should be included in the "identification and planning of health-care priorities and programmes."* States are encouraged to remove "*all barriers to women's health services and provide a broad range of health-care services."* [29] The United Nations confirmed the importance of these initiatives for eliminating health inequities in a follow-up document, *Further Actions and Initiatives to Implement the Beijing Declaration and the Platform for Action*. It calls for the implementation and full realization of the commitments stated in the Platform for Action.

Women continue to experience dramatic inequities even though commitments to equality in health are clearly stated in all these documents. The *State of the World Population Report*, 1999 found for example, that hundreds of millions of women around the globe continue to experience suffering related to gender-based violence, unwanted pregnancies, unsafe abortions and ill-health.[30] Arguably, women's inferior health status is a violation of international agreements. These documents can be used to push for greater equity in women's health.[31]

[24] *Beijing Declaration and Platform for Action,* Fourth World Conference on Women, 15 September 1995, A/CONF.177/20 (1995) and A/CONF.177/20/Add.1(1995).
[25] *Ibid.*
[26] *Ibid.*
[27] *Ibid.*
[28] *Ibid.*
[29] *Ibid.*

[30] *Lack of Choice Jeopardizes Women's Health,* News Feature, United Nations Population Fund, *http://www.unfpa.org/swp/1999/newsfeature3.htm*
[31] Cook, supra footnote 14.

THE CANADIAN CHARTER OF RIGHTS AND FREEDOMS

Canada's commitment to equality in laws, programs and policies, including those related to health, is found in the *Canadian Charter of Rights and Freedoms*. Section 15 (1) reads:

1. *Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular,without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.*[32]

Because the *Charter* clarifies that every individual in Canada is considered equal, governments are prohibited from discriminating on grounds listed in laws or programs. The courts have held that section 15 also protects equality on the basis of other characteristics, like sexual orientation, that are not specifically outlined.

Despite the *Charter's* statement on equality, women face systemic discrimination that has implications for their health. On average, women are poorer than men[33], are slightly less likely than men to have a university degree[34], and their employment activity is concentrated in areas traditionally dominated by women.[35] The connections between these factors and health status are well documented.[36] By incorporating gender sensitivity and analysis in health planning, programming, treatment, research and governance models, the provincial and federal governments can implement the societal equity mandated by the *Charter*.

THE WOMEN'S HEALTH STRATEGY

In recognition of its commitments on human rights and affirmation of the Beijing , the Canadian government introduced the *Women's Health Strategy* in 1999. This document emphasizes the federal government's role in ensuring that health services, programs and policies take the specific needs and diversity of women into account. The goal of the Strategy is: **to improve the health of women in Canada by making the health system more responsive to women and women's health.** Four objectives are specified:

- To ensure that Health Canada policies and programs are responsive to sex and gender differences and to women's health needs;
- To increase knowledge of women's health and women's health needs;
- To support the provision of effective health services to women;
- To promote good health through preventive measures and the reduction of risk factors that most imperil the health of women.

Despite Canada's commitment in national and international documents, women's health issues receive little attention in the debates and discussions on the health care system. Even in Manitoba, where women are now considered one of four priority populations by Manitoba Health since 1997/98, women's health issues are seen as peripheral to the issues of rising costs, staff shortages, bed shortages and insufficient resources, both in hospitals and in community based programs.

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[32] The Charter also allows for certain laws or programs that favour disadvantaged individuals or groups. For example, programs aimed at improving employment opportunities for women, Aboriginal peoples, visible minorities, or those with mental or physical disabilities are allowed under section 15(2).

[33] Statistics Canada, *Women in Canada 2000, A Gender Based Statistical Report*, Catalogue No. 89-503-XPE at 13.

[34] *Ibid p 11*.

[35] *Ibid*

[36] See: Towson, M., *Health and Wealth: How Social and Economic Factors Affect Our Well Being (*Ottawa: Canadian Centre for Policy Alternatives, 1999) and Canadian Public Health Association, *Health Impacts of Social and Economic Conditions: Implications for Public Policy (*Board of Directors Discussion Paper, March 1997).

POLICY FRAMEWORKS THAT SUPPORT WOMEN'S HEALTH

The Population Health Model

A recent development in the area of health policy is the adoption of a population health approach,[37] which "aims to improve the health of the entire population and to reduce health inequities among population groups."[38] This approach recognizes the central importance of health determinants, a variety of individual and collective characteristics and conditions that affect health status. Health determinants influence and interact with each other. Their combined influence determines health status.

Since 1996, Health Canada has recognized gender as a determinant of health. This was an important step forward. The other determinants are: income and social status, social support networks, education, employment and working conditions, social environments, physical environments, biological and genetic factors, personal health practices and coping skills, healthy child development, health services and culture.[39] Saskatchewan and Manitoba Health express a commitment to population health approaches and occasionally acknowledge gender as a health determinant in official publications.[40] More effort beyond these tentative first steps is needed to advance women's health at the provincial level.

Because the population health model encourages broad policy initiatives and actions related to health, it can be a strong tool for women's health advocacy and policy making. This approach is consistent with the Aboriginal concept of holistic health and the interconnectedness of life. Additional work is needed to fully address the additional risks of ill health faced by Aboriginal women, immigrant and refugee women, women with disabilities, young women and lesbian/bisexual women and senior women.

Health Canada has not recognized it as a health determinant, but the migration experience and women's specific immigration status in Canada constitute a major dimension affecting the health and socio-economic status of immigrant and refugee women in different ways. [41]

Health Promotion Frameworks

Health Promotion seeks to empower people to improve their own health by increasing their control over the determinants of health.[42] The goals of health promotion are equity, public participation and empowerment.[43] If interpreted from a feminist perspective, these objectives are consistent with the goals of the women's health movement. In order to be successful, health prevention and promotion programs for women must reflect the realities of women's lives and address societal expectations of women. Smoking prevention, reduction and cessation programs are more effective, for example, when gender related factors are taken into account in program design.

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37 While the term population health is relatively new, this policy initiative *"builds on a long tradition of public health and health promotion."* Population Health Approach - Health Canada, *http://www.hc-sc.gc.ca/hppb/phdd/approach/index.html*.

38 Health Canada, *ibid*.

39 For Thurston, the expanded view found in the population health model is useful because it "requires policy and program planners to consider the impact of determinants . . . and strategies such as advocating for healthy policies, strengthening communities, and reforming the health system." Thurston, W. *Health Promotion from a Feminist Perspective: A Framework For An Effective Health System Response to Woman Abuse*, Resources for Feminist Research, 26(3-4), Confronting Violence in Women's Lives, p 177.

40 Willson and Howard, supra footnote 1 p 7. The documents these researchers refer to are: *Saskatchewan Health, Annual Report, 1991-92, p. iii;* Saskatchewan Health, *Population Health Promotion Model: A Resource Binder*, 1999 revisions; *Manitoba Health, A Planning Framework to Promote, Preserve and Protect the Health of Manitobans*, Winnipeg: Queen's Printer, 1996. On page 7, the Manitoba Health's planning framework notes a need to focus "on broad determinants of health."

41 It should be noted at the outset that the experiences of **"Immigrants", or people who choose to migrate** to Canada vary from the experiences of **"Refugees", or people who are forced to flee their countries of origin** for various reasons. (see Glossary for definitions). These differences are also pronounced among the different 'Immigration Class Categories'. This includes the factors influencing the decision to emigrate, level of preparedness (financial, psychological, etc.), choice of country/location for settlement, length of stay and conditions encountered in transitional country, as well as the nature of support provided during the initial settlement and adjustment process in the new country.

42 Saskatchewan Health, *A Population Health Promotion Framework For Saskatchewan Health Districts, January 1999 p 5*.

43 *Ibid pp 13-14*.

POLICY INITIATIVES THAT THREATEN WOMEN'S HEALTH

Privatization and Health Care Reform

Over the last decade, provincial governments have been reforming the health system in an attempt to reduce costs, to ensure that services are cost-effective and to expand community-based health services. The direction and shape of the reform process has been extensively debated. Health reform has been detrimental to women's well-being.[44] Key pieces of health reform which affect women in particular are:

- reducing hospitalization and institutional care affects women as both patients and health care providers.

- shifting from hospital care to home and formal/informal community- based care. Community based care is viewed positively by many women, particularly immigrant, refugee, and Aboriginal women, because it promotes services and approaches that expand the limits of the established medical model. There has been limited analysis of the additional burdens that it places on women, who are the majority of paid institutional health care workers, paid community care workers, and unpaid family caregivers. The assumption that women family members will unquestioningly take on the work involved with informal care reinforces traditional gender roles and can have a negative impact on both those needing care and those providing it.[45]

- establishing regional health authorities and district health boards where the voices of women are not usually well represented on Boards or in senior management. There is little evidence that health bodies in Saskatchewan and Manitoba have the knowledge or tools needed to identify and respond to women's health needs.[46]

Manitoba and Saskatchewan have not seen the privatization of the delivery of health services now underway in other provinces, notably Alberta. Alberta's *Health Care Protection Act*, allowing the establishment of private surgical facilities, could have an impact on other provinces. Canadians have been warned that American health care companies could use the provisions of the North American Free Trade Agreement (NAFTA) to sue provinces which prohibit them from entering the "marketplace."[47]

Decreased Federal Funding for Health Care

The federal government's decreasing commitment to health funding is a factor motivating privatization. The move to private funding appeals to the provinces that struggle to maintain the services and programs they previously cost-shared with the federal government. In 1977/78, the federal government paid for 27% of health care expenditures.[48] By 1999/2000, this was reduced to 13%.[49] At the same time, health care costs are increasing, so the provinces must look to other sources to maintain comparable levels of service.[50]

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[44] The Prairie Women's Health Centre of Excellence explored the effects of privitization on women in Scott C., et al. *The Differential Impact of Health Care Privatization on Women in Alberta* (Winnipeg: PWHCE, 2000) and *Missing Links: The Effects of Health Care Privatization on Women in Manitoba and Saskatchewan*

[45] *National Coordinating Group on Health Care Reform and Women, Women and Health Care Reform*, pp.4-5

[46] Horne, et al,, *Invisible Women: Gender and Health Planning in Manitoba and Saskatchewan and Models for Progress* (Winnipeg: PWHCE, 1999).

[47] Rachlis, M., *A Review of the Alberta Private Hospital Proposal*, page 6.

[48] *Provincial and Territorial Ministers of Health, Interim Report on Cost Drivers and Health System Sustainability*, June 2000 p 20.

[49] *Ibid.*

[50] Fuller, C., *Caring for Profit: How Corporations are Taking Over Canada's Health Care System* (Ottawa: Canadian Centre for Policy Alternatives, 1998) p 282.

Reduced federal funding and the trend towards private funding of health care are of concern to women. The preservation and strengthening of medicare is important to women's health because:

- women have lower incomes on average than do men; further, they are more likely to work in part-time and poorly paid jobs without private health care benefits;
- women receive more prescriptions per person, and spend more on prescriptions than do men; women who earn less must use a greater proportion of their income on prescription drugs[51]
- women use the health system more than do men.[52]

Because women have fewer economic resources, it is likely that they will be unable to access necessary care and services if health becomes an out-of-pocket rather than a public expense.

THE PRIORITIES FOR ACTION

Taking this background into consideration the Prairie Women's Health Centre of Excellence has identified twelve Priorities for Action. We propose actions for within the health services system, and follow with proposals for action in areas that have a significant effect on the health of women.

The Priorities for Action overlap and intersect and may be considered together rather than separately. Actions taken in one area can improve women's health in another.

[51] Saskatchewan Health. *Who Uses Prescription Dugs, Results from a Population-Wide Study in Saskatchewan,* 1992, p 29.

[52] See Mustard, C, et al. In 1994/95 Manitoba women used about 30% more health care services than did men. It is important to note that the authors found that when sex-specific conditions and care in the last year were excluded, that there was no difference in health care utilization between women and men.

PRIORITIES FOR ACTION

PRIORITY #1

REDUCE POVERTY AMONG WOMEN AND ADDRESS THE CONSEQUENCES OF POVERTY ON WOMEN'S HEALTH

Both current research and the women who were consulted in the drafting of this Action Plan identified income disparities, and women's lack of income, as key determinants of health. Since women are at greater risk of poverty than men, this must be addressed in any plan to improve women's health. **In order to be successful, anti-poverty measures must recognize that poverty is a structural problem, not an individual one**.

Consider the following:

- Prairie women working full-time, all year, earn on average only 73% of what men earn.[53]
- Women constitute 70% of part-time workers in Canada[54].
- Women workers tend to be segregated in low paying jobs, such as those in sales and service, clerical, administrative and secretarial work. Women also dominate the low paying jobs in the health care system.
- Women are more likely to live in poverty than are men. Almost 19% of adult women in Canada are poor - the highest rate of women's poverty in two decades.[55]

Some groups of women are particularly vulnerable to poverty, notably:

- **Aboriginal women** - 38% reported living in poverty in the 1996 Census of Canada[56]. Aboriginal women's income is considerably lower than that of Non-Aboriginal women. In 1995, the median annual income for Aboriginal women in Saskatchewan was $8,613 compared to $13,563 for other women.[57]
- **Visible minority women** - 37% of whom reported living in poverty in the 1996 Census of Canada[58]
- **Women with disabilities** - 66% of whom earned less than $25,000 per year while working full time in 1991[59].
- **Senior women** - 24% of whom lived in poverty in 1997. The risk of poverty is greatest for unattached senior women in Canada; that is those who are widowed, single, divorced or separated who had a 1997 poverty rate of 49%.[60] In 1997, 30% of Manitoba senior women in Manitoba lived in poverty, a rate more than twice that of Manitoba senior men, who had a poverty rate of 13%. In Saskatchewan, 20% of senior women lived in poverty, a rate 3.5 times that of their male counterparts, who had a poverty rate of 6%.[61]

Poverty is not limited to those on social assistance, or to single mothers. Most of those working full time at minimum wage also live in poverty. Both Manitoba and Saskatchewan currently have minimum wages of $6.00 per hour. A single mother working full time and supporting two children, at minimum wage in Winnipeg or Regina, would still be $9,280 or 43% below the poverty line. Even if that woman lived with a husband, and they both worked full time at minimum wage, they and their children would still be $7,278 or 23% below the poverty line.[62]

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[53] Donner, L., *Women, Poverty and Health in Manitoba: An Overview and Ideas for Action,* p 23.
[54] Status of Women in Canada, *Women and Men in Canada: A Statistical Glance,* p 15
[55] Townson, M.., *A Report Card on Women and Poverty*, page 1
[56] Donner *op. cit.* pp 7 to 10
[57] Saskatchewan Women's Secretariat, *Profile of Aboriginal Women in Saskatchewan*, page 29
[58] Donner, *op.cit,* page 14
[59] Fawcett, G., *Living with Disability in Canada: An Economic Portrait*, p 101
[60] Statistics Canada, *Low-Income Persons, 1980 to 1997*, Table 5
[61] *Ibid*
[62] Statistics Canada, *Low Income Cut Offs, January, 1998*

Women on social assistance have access to certain non-insured health benefits, such as dental and prescription drug coverage, which are not available to most people who work full-time at low-paying jobs.

Poverty means living in substandard housing, in neighbourhoods which are less safe and which have fewer community resources. Poverty limits educational opportunities for women and their children. It limits the ability to buy nutritious fresh fruits and vegetables. It means that most recreational programs are simply not affordable. It means working in jobs which are less likely to have the protections offered by a union. These are only a few of the many ways in which poverty contributes to ill health. Those designing and implementing health service programs need to take the time to hear what women in poverty have to say about what it means to be poor in Canada today. They should then to use that information to:

- design programs which meet the real needs of women living in poverty and
- use their influence with decision makers outside of the health care system.

Canada has been criticized internationally for the extra burden of poverty borne by women. The United Nations Committee on Human Rights has stated:

The Committee is concerned that many women have been disproportionately affected by poverty. In particular the very high poverty rate among single mothers leaves their children without the protection to which they are entitled under the Covenant (on Civil and Political Rights).[63]

Research in Canada and internationally has shown a connection between income and health. Higher income is associated with better health. That is, lower income is associated with poorer health. Research in Manitoba has shown that women with lower incomes use the health services system more than women with higher incomes. Low-income women therefore appear to bear a greater burden of illness than do high income women. Low-income women were more likely to use health care services for problems related to all body systems. There were two notable exceptions to these findings. Firstly, there was no difference by income for conditions of the breast and the genitourinary system. Secondly, for routine screening for cervical cancer (Pap smears) and breast cancer (mammograms), the trend was reversed and lower income women used less of these services than higher income women[64].

But income inequalities do not affect only poor women. **In both Canada and internationally, research has shown that there is a connection between income disparities and health for all socio-economic groups.**[65] Canadian research has shown that:

Poor health is not simply concentrated among those who are most deprived. Health status declines with each decline in socio-economic status and thus it is important to focus on the broader structure of social economic condition rather than on material deprivation alone, though the determinants of health may vary at different levels of socio-economic status.[66]

This is significant, because Canadian women live in a society in which the gap between rich and poor is increasing.

[63] United Nations Human Rights Committee, *Concluding Observations of the UN Human Rights Committee*, April 6,1999 and available at: http://www.povnet.web.net/UNdoc.html

[64] Donner, op. cit., page 35 to 57

[65] Macintyre, S .*Social Inequalities and Health* pp 31 - 32

[66] Denton, M. and Walters, V., *Gender differences in structural and behavioral determinants of health: an analysis of the social production of health* page 1222

A slippery slope: *Over the course of the 1990s, Canada's growing gap has become a slippery slope for a growing number of middle income families sliding towards the bottom of the income ladder.*

Instead of pulling us in two opposite directions - towards greater affluence or towards greater poverty - the developments of this decade took us in one direction only: the proportion of families at the richest end of the spectrum barely held their ground, while a growing proportion of middle income families lost ground...

By any definition of poverty, the poor are getting poorer and there are more poor families among us.[67]

Our plan to improve the health of Manitoba and Saskatchewan women must therefore address the relationship between gender and income inequalities.

Health Care System Actions:

- Consult with women living in poverty to determine how health care services can best meet their needs. Ensure that Aboriginal women, women with disabilities, immigrant and senior women are included in these consultation processes.
- Change health care programs and services to reflect the results of these consultations. Provide health care services in homes and in community based facilities that are already known to and trusted by low income women.
- Include vision care and dental care as insurable services under the Canada Health Act.
- Examine and change the barriers to low income women who require prescription medications.

Advocate Outside of the Health Services System For:

- Decision makers in the health determining sectors such as housing, education, transportation, communication and finance, to consider the impact of their decisions on the health of low-income women;
- Minimum wages at least equivalent to the Statistics Canada Low Income Cut-Off for a family of two;
- Safe, affordable, housing for all;
- Increased earned income exemptions for social assistance recipients.

[67] Yalnizyan, Armine, *Canada's Great Divide: The politics of the growing gap between rich and poor in the 1990s*, page ii

PRIORITY #2

IMPROVE CONDITIONS FOR FORMAL AND INFORMAL CAREGIVERS

The work of paid and unpaid caregiving is mainly done by women. Caregivers face some similar dilemmas, whether they work for pay or provide unpaid care to family members and loved ones. They are both performing tasks considered an extension of women's natural role. Because these tasks are done for little or no pay, caregivers subsidize the health system. They reduce the demand for hospital beds, long term care beds and lessen institutional admissions when care is provided at home and in the community.

Consider the following[68]

- Two-thirds of unpaid Canadian caregivers work outside the home. 20% of these caregivers report health effects, and 40% incur personal expenses.
- The costs to caregivers also affect employers in the form of absence from work, high employee turnover rates, and emotional and physical strains that affect the caregiver's performance on the job.
- Caregivers are not always looking after only one person. Caregivers who juggle paid employment and other family work including caregiving and childcare are typically in their middle and later years. This places women in triple jeopardy – losing access to wages, lifetime earnings, and long-term financial security.
- Employees who care for loved ones can suffer career and financial losses, fewer opportunities for workplace advancement and loss of benefits and pensions.
- There are additional costs to families including out-of-pocket expenses to hire respite workers, mental and physical fatigue, social isolation and family stress and breakdown[69].

The issues relating to caregiving are complex. Paid caregiving has traditionally served as a source of stable employment for women. Under health reform, however, the working conditions of women employed in the health system have deteriorated.[70] There is pressure to perform a greater number of tasks with fewer staff in workplaces characterized by stress and uncertainty. This pressure is exacerbated by the demands of balancing work in the paid labour force with unpaid work in the home.

One of the ways that women have addressed this issue is by hiring other women to perform household tasks. In 1999, 3,259 persons came to Canada under the Live-In Caregiver program that allows primarily women to enter the country if they meet official criteria and agree to full-time, live in employment providing care in private households for children, the elderly or persons with disabilities.[71] Live-In Caregivers can apply for open employment after two years. [72] Because the majority of these women are immigrants it raises issues of class and race discrimination in the caregiving professions. Paid caregivers are more likely to be visible minority women, especially recent immigrants. These low-paying jobs provide few opportunities for career advancement.

The issues relating to unpaid caregivers are also many-fold. Our society relies on the "labour and love" of informal caregivers to provide care within the home to family members who live with illness and/or disability. Yet informal caregivers lack the services and support they need. In addition, their work as caregivers makes them more vulnerable to poverty, isolation and declining health[73].

Women's responsibilities as paid and unpaid caregivers have been accentuated under health reform:

Shifting care into the home is recognized as a health reform strategy in Manitoba and

[68] Canadian Women's Health Network

[69] *Caregiving Still in Women's Job Description,* http://www.cwhn.ca/network-reseau/1-3/spare.html 11/26/00

[70] Fuller, C, *Reformed or Rerouted? Women and Change in the Health Care System* (Vancouver: British Columbia Centre of Excellence for Women's Health, 1999) see Chapter VI: Health Reform and Health Care Jobs in British Columbia.

[71] Citizenship and Immigration Canada, *Immigration by Levels, Principal Applicants and Dependents*. For a description of the Live-In Caregiver program see: Foreign Workers: Live-In Caregivers, Human Resources and Development Canada, http://www.hrdc-drhc.gc.ca/hrib/lmd-dmt/fw-te/common/aide_care.shtml) 28/11/2000/

[72] *Ibid.*

[73] Janzen, B. 1998

Saskatchewan designed to reduce health care expenditures. This shift in caring responsibility is built on women's traditional gender roles as caregivers. Often the women engaged in this caring work are unpaid, informal caregivers acting in their capacity as spouses, family members and friends. Paid caregivers are also overwhelmingly women.[74]

Saskatchewan research has shown that **after only 18 months of continuous caregiving, the health of 60% of unpaid caregivers begins to deteriorate.**[75] Caregivers often sacrifice their own health due to their commitment to maintaining or improving another's quality of life.[76]

The women we consulted with encouraged the creation of new community-based caregiving models that do not depend on assumed roles for women. They stated that **the care of children, the elderly and infirm is a societal problem which demands social solutions rather than answers that depend on the work of individual women.**

[74] Willson and Howard p 30.
[75] National Film Board of Canada, *Until the Day Comes*, 1990
[76] Canadian Women's Health Network.

Health Care System Actions:

- Home care services should be part of the medicare system, with all necessary services provided at no cost to all those who require them. This should include the direct costs of caregiving, as well as other costs, such as medical equipment, supplies and special meals, which would be absorbed by government if the recipient were admitted to a hospital.

- Home care policies and policies relating to admissions, discharge and all forms of care should not assume or require informal caregiving from family members. Service providers should be sensitive to issues of gender, race and class when dealing with the recipients of care and caregivers.

- Home care services and publicly funded attendant care should be available on an equitable basis in rural and northern areas.

- Consult with women of all ages, including women with disabilities, Aboriginal women, who use formal and informal home care services, to determine how the services can be improved to meet their needs for care, independence and support. Develop consultative mechanisms to ensure that the input of diverse groups of women is obtained.

- Caregiving services to children and adults with disabilities should foster their independence and integration at home, school, work and in all societal institutions.

- Caregivers, both paid and unpaid, should be provided with the training necessary to provide safe, effective care to those in their care.

- Recognize the work of paid caregiving as important employment providing an adequate salary, benefits, job security and opportunities for training and advancement so that paid caregivers are not impoverished.

- Universal, publicly funded respite care should be provided to reduce the burden on unpaid caregivers.

Advocate Outside the Health System For:

- Leave from employment with no loss of seniority or benefits to those providing informal care.

- The active inclusion of women with disabilities, and the consideration of gender issues, in the development of programs and services for people with disabilities.

- Review of policies and procedures, including immigration policies and procedures, to ensure that immigrant and refugee women are encouraged to participate in a broad range of employment activities. The Live-In Caregiver program should be reviewed to ensure that women are provided adequate wages and that the provisions of provincial employment standards legislation outlining appropriate working conditions are upheld.

PRIORITY #3

ADDRESS THE SPECIFIC HEALTH NEEDS OF ABORIGINAL WOMEN

The health issues and needs of Aboriginal women are embedded in the historical context of Aboriginal peoples' colonization experience. The effects of colonization include systemic dependency, no clear jurisdiction and fiduciary responsibility, and a general lack of cultural understanding of Aboriginal people's world-view. The situation is further compounded by the fact that the word "Aboriginal" peoples does not capture the diversity of cultures within indigenous nations. Service approaches for Aboriginal people are compartmentalized and based on a western model. They often do not recognize the links between services that are critical to addressing the well-being of the whole individual. All of these factors continue to affect the health and well-being of Aboriginal peoples who are over-represented in the numbers of people with chronic diseases and other health issues.

The key to addressing these issues lies within the diversity of Aboriginal communities, within the cultural context of the nations that encompass Aboriginal peoples, and within an appreciation for the cultural value of gender balance. Health service delivery models, programming design and approaches to well-being for Aboriginal peoples should be flexible to accommodate various cultural based approaches and traditions of First Nations, Metis and Inuit. Such models will include strategies for blending traditional and contemporary Aboriginal approaches, as well as demonstrating how traditional and western health philosophies and approaches to well-being can be actualized in community-based health care.

The Aboriginal concept of health views each person as a whole, whose well-being is determined by interconnected spiritual, emotional, physical, and mental aspects. Within this concept of health is the person's ability to achieve a balance and function as a healthy individual within the family, the community, and the nation. This element of interconnectedness permeates Aboriginal peoples' concept of health that is quite different from the mainstream. It also has "implications for the design and delivery of medical and social services" for Aboriginal peoples.[77]

- Some of the major issues for Aboriginal people with respect to the policy development process in health care are related to:

- The need to develop a common language to promote mutual understanding of concepts. Terms like culturally appropriate, culturally-based, culturally relevant, and holistic need to be defined in terms that are commonly understood and used by Aboriginal people.

- The need to acknowledge cultural diversity among Aboriginal people. For example, Metis people of mixed European/Aboriginal ancestry have their own distinct culture with a language (Michif), history, lifestyle, traditions, and practices. First Nations also have distinct cultures within their nations and language groups.

- The need to acknowledge Aboriginal peoples' historical involvement in the government policy-making process, a process plagued with misunderstanding, mistrust and only more recently approached from the government perspective of "consultation" and "partnership". Any policy concerning Aboriginal people needs to directly involve Aboriginal peoples to ensure that their needs are firstly understood, secondly articulated appropriately, and thirdly addressed appropriately.

Aboriginal women have less access to health services than other Canadian women. They are "socially, economically and politically marginalized from actively participating in addressing and advocating for their own health challenges".[78]

Actions that are founded within the cultural framework of Aboriginal peoples will be an important ingredient for success in beginning to address Aboriginal womens' issues.

[77] Report of the Royal Commission on Aboriginal Peoples, Volume 3, *Gathering Strength*, 1996.

[78] Stout, M. D. *Aboriginal Canada: Women and Health by Madeline Dion Stout*, Health Canada

Health Care System Actions:

- Recognize and use the expertise of Aboriginal women in building healthy public policies and health services.
- Provide access to traditional Aboriginal healing through the medicare system.
- Provide services which are culturally competent and culturally based, which focus on healing rather than treatment, which recognize that individual health and well-being is linked to community wellness, and which support a holistic approach to treating the whole person rather than just the disease.
- Ensure that health services for Aboriginal people are accountable to the Aboriginal community.
- Ensure that capacity building is a fundamental component of all services developed, delivered and intended for Aboriginal peoples.
- Support opportunities for Aboriginal women to address their own health issues at all levels within their particular Aboriginal nations cultural context (Indian, Metis, Inuit) of concepts, values, beliefs, and practices.
- Support Aboriginal women's community health care initiatives by recognizing the value of the community's expertise in designing, delivering, and being accountable for their own community-based health care systems.

Advocate Outside of the Health Services System For:

- Provincial employment equity legislation to improve the socio-economic status of Aboriginal women.
- Employment equity as a condition of provincial funding and procurement contracts.
- Housing and community supports for elder Aboriginal women, beginning at age 55.
- Woman-centred, culturally based health services for Aboriginal women in prison.

PRIORITY #4

ADDRESS VIOLENCE AGAINST WOMEN

Violence against women can be physical, sexual, and/or verbal/psychological, as well as stalking. It affects women of all ages, of all races and ethnocultural backgrounds, across all socio-economic lines; lesbian women, as well as heterosexual women, can be victims of abuse. Young women, women with disabilities, Aboriginal women, and women living in isolated regions are particularly vulnerable to violence. In Canada, 29% of women have been assaulted by a spouse[79].

Immigrant and refugee women are at an increasing risk of being entrapped in violence or abusive relationships due to a number of factors. First, these women may come from cultures where violence and abuse are perpetuated by inherent society practices, or where violence is perceived and dealt with in ways that are different from Canadians. Language and other barriers can prevent immigrant and refugee women from accessing and benefiting from existing support services. Many of these women want to maintain family unity with their children and spouses for reasons of social security. Other women are affected by fear of government institutions, including the police, due to experiences from the countries of origin. Many of the immigrant and refugee women are not able to find good paying jobs and are forced to live with their abusive partners in order to maintain a certain level of financial security.

Many Aboriginal women are victims of sexual, physical and emotional abuse at the hands of their husbands, boyfriends and male relatives[80]. A range of complex factors including the effects of colonization, community stress, racism, changing gender roles and alcohol abuse, among other factors, contribute to a high incidence of family violence within Aboriginal households[81]. Aboriginal women who participated in the Action Plan consultations emphasized the importance of using cultural community-based, holistic approaches to addressing violence against Aboriginal women.

Obvious health consequences of violence against women include death or permanent disability, and injuries including bruising, cuts, scratches, burns, broken bones, fractures, and internal injuries. Women who have experienced physical or sexual abuse are at greater risk of chronic pain, gastrointestinal disorders, anxiety and clinical depression. Violence also undermines health by increasing self-destructive behaviors, such as smoking and substance abuse.[82]

Over their lifetimes, survivors of abuse average more surgeries, physician and pharmacy visits, hospital stays, and mental health consultations than other women, even after accounting for other factors affecting health care use, and discounting emergency room visits.[83] In addition, women who have been sexually assaulted and/or battered are more likely than other women to commit suicide[84].

Violence against women affects society through increased costs to health, social services, criminal justice, and lost employment days. A recent Canadian study estimated that the annual health-related costs of violence against women and children are approximately $1.5 billion[85] Children who witness violence against their mothers are significantly more likely to develop aggressive behaviour, emotional difficulties, criminal activity, and have poor social and academic development. Statistics Canada reports that the majority of inmates in federal prisons who had committed some violence against family members, witnessed violence as children[86].

Both the Manitoba and Saskatchewan governments have developed policies and programs regarding violence against women.

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[79] Statistics Canada, *Family Violence in Canada*, Ottawa: Ministry of Industry, 1999, p.18.

[80] Research findings suggest that between 33% (Hamilton and Sinclair, 1991) to 80% (Ontario Native Women's Association, 1989) of Aboriginal women are affected by violence.

[81] Stout, M., and Kipling, G., *Aboriginal Women in Canada: Strategic Research Directions for Policy Development*, Status of Women Canada (1998), p. 17

[82] Fillmore, Del and The Elizabeth Fry Society of Manitoba, *Prairie Women, Violence and Self-harm* in press.

[83] Heise, L. Ellsberg, M., Gottmoeller, M. *Ending Violence Against Women*, Population Reports, Series L. no. 11. Baltimore, John Hopkins University School of Public Health, Population Information Program, Dec. 1999.

[84] *Ibid.*

[85] Day, T. *The Health Related Costs of Violence Against Women in Canada: The Tip of the Iceberg*, quoted in Health Canada, *A Report from Consultations on a Framework for Sexual and Reproductive Health*, p.iii.

[86] Statistics Canada, *Family Violence in Canada*, Ottawa: Minister of Industry, 1999, p. 31; Martz, D. and Sarauer, D., *Domestic Violence and the Experiences of Rural Women in East Central Saskatchewan*, 2000, p. 13

Presently, the Manitoba government spends more per capita on violence programming than any other province. Although Manitoba and Saskatchewan governments have developed a wide range of policies and programs on this issue it is important to note that these initiatives reflect a family services and/or justice perspective and fail to integrate a perspective from women's health.

> *... there [has not] been a recognition of the gendered structure of women's lives as placing them in positions that make them more vulnerable to abuse, or a recognition of how men's socialization places them in an offending position, or the gender differences in manifestations of abuse. Private violence is still conceptualized in terms of relationship issues and is less connected with the social position of the sexes.*[87]

The Manitoba and Saskatchewan governments offer a continuum of services ranging from crisis shelters and phone lines, to second stage housing and women's resource centres. However, there are gaps in the programmes:

- a lack of programs for girls only,
- insufficient aboriginal-specific services, particularly for northern women, and
- insufficient immigrant-women specific services[88]
- the lack of accessibility of services in rural and northern areas continues to be an issue for women since transportation to shelters outside of home communities can act as a barrier to women leaving abusive situations.
- there is a significant lack of programs for men and boys who abuse, especially those who are not criminally convicted of abusive behavior.
- school teachers are given curricula on violence for a range of ages and are offered professional development sessions on domestic violence, but it is important to note that participation in these sessions are not mandatory.
- training sessions and awareness information are available for professionals in Manitoba and Saskatchewan but are not mandatory. The police department, crown attorney's office, provincial court judges, teachers, health workers, workers from housing and social assistance, union members, day care workers, court workers, personal care home workers, and many other professional groups do not receive mandatory regular training sessions on violence against women.
- undergraduate students in Medicine and Nursing receive some education about family violence, and further professional development is available through staff education presentations and the distribution of information on available resources to nurses and doctors. However, there is no ongoing or mandatory training program/session on the dynamics of family violence.

[87] Gorkoff, K. in UNPAC (Manitoba), *Initial Review of Manitoba's Implementation of the United Nations Platform for Action*, January 2000, p.3.
[88] Final Report, UNPAC (Manitoba), Beijing Plus Five, June, 2000; pers. comm. RESOLVE (Saskatchewan), December 5, 2000

Health Care System Actions:

- Recognize violence against women as a public health issue that has roots in the unequal power between men and women, perpetuated by social attitudes.
- Develop gender-sensitive training programs for physicians, nurses, as well as other health care workers to enable them to recognize gender-based violence and to care for girls and women who have experienced violence.
- Consult with Aboriginal women, older women, women with disabilities, and new immigrant women to address the impact of violence in their lives and to implement appropriate, effective services to meet their needs.
- Promote a community development approach, emphasizing the important role and training of multicultural health workers to address violence against women within the communities they serve.
- Advocate with and train women in the mainstream health system to provide appropriate and culturally sensitive care to abused women.
- Sensitize all health care providers to the needs of immigrant and refugee women and ensure that access to services is not impeded by cultural barriers and racism.
- Advocate for increased funding to multicultural organizations to support projects for training and sensitizing professionals.

Advocate Outside of the Health Services System For:

- Sustained, global funding to organizations including crisis shelters, second stage shelters, women's resource centres, community health clinics, and transition centres which provide preventative and support services to women
- Community-based programs to promote the prevention of violence against young women and services to assist young women who are victims of violence
- Policies and programs dealing with violence against women which proceed from a gender analysis and which recognize that violence against women has its roots in the unequal power relationships between men and women and is perpetuated by social attitudes
- Specific programming for women from immigrant and refugee communities, as well as senior women and young women who experience violence.
- Safe homes and small-scale shelters in smaller communities for rural and northern women
- Mandatory, comprehensive and consistent training regarding violence against women for police, prosecutors, judges and other justice system workers. This training should take into account the gender roots of violence against women.
- Comprehensive anti-violence curriculum for all grade levels in public and private schools. The curriculum can include anti-racism/ sexism/ homophobia education, as well as conflict resolution and mediation skills. Anti-harassment policies in schools should be consistently enforced.
- A society in which violence against women and girls is unacceptable.

PRIORITY #5

DEVELOP AND SUPPORT BEST PRACTICES & KNOWLEDGE IN WOMEN'S HEALTH

Over the last two decades, advocates have encouraged gender sensitive policies, programs and services to maximize women's opportunities to achieve good health. Generally, women-centred care is "holistic, accessible, flexible, and responsive, supportive and accountable."[89] It incorporates an understanding of women's lives and acknowledges the relationship between inequality and health. This is important because:

Women's health is inextricably linked to their lives. Thus, any strategy aimed at improving women's health must incorporate a socio-ecological approach that includes such health determinants as the social, economic and physical environment, personal health choices, individual capacity, coping skills and health services. Inherent in this approach is the commitment to reduce the inequalities that arise from all forms of social stratification, such as class, race, and gender. Too often, however, the health consequences of inequality remain invisible.[90]

Some jurisdictions have developed health centres and programs to deliver services that are sensitive to women's lives and needs.[91] In our consultations, women praised two Canadian examples of women-centred programming. The Women's Health Clinic in Winnipeg, started in 1981, is a feminist, community-based health centre offering a range of services to women from teens to elders. The Clinic emphasizes prevention, education and action. It offers:

- health and wellness services which are women-centred non-judgmental and fully confidential;
- advocacy and research on issues of concern to women's health;
- health education to community and professional groups;
- resources and information as well as training for students and volunteers.[92]

The Vancouver/Richmond Health Board is a also a leader, at the policy level, with the release of the Women's Health Planning Project, Final Report in January 2000.[93] The report included recommendations to make gender based health strategies and women-centred care an important objective in the Vancouver/Richmond region.

Women who participated in the Action Plan consultations stressed the importance of providing access and coverage for a full range of health services, including complimentary health practices. They called on all health care providers to deliver gender-sensitive care services developed in accordance with sound policies. Because women are in frequent contact with the health system, health providers are "in a prime position to have a major impact on the lives of women." [94] In 2001, the Prairie Women's Health Centre of Excellence will publish an overview of women-centred care in Saskatchewan and Manitoba. The report will highlight example of services that are responsive to women.[95]

The women consulted on the Action Plan also articulated a need for centres of expertise in women's health care with a mandate to share knowledge and resources with health care providers.

[89] *Ibid* p 5.

[90] *Ibid* p. 3.

[91] Horne et al. outline "Models of Gender-Inclusive Health Planning" in *Invisible Women: Gender and Health Planning in Manitoba and Saskatchewan and Models for Progress* pp 72 - 97. They cite American, Scottish and Canadian examples.

[92] Women's Health Clinic, http://www.pangea.ca/whc/ .

[93] Vancouver/Richmond Health Board, Women's Health Planning Project (available at http://www.vcn.bc.ca/vrhb/Women's Health%20Plan.htm).

[94] Hills, M. and Mullett, J. Women-Centred Care: Working Collaboratively to Develop Gender Inclusive Health Policy, Final Report, August 1998, Women's Health Bureau, Victoria p. 3.

[95] White, S., et al. *Proposal to Prairie Women's Health Centre of Excellence for An Overview and Discussion of Current Models of Women-centred Care,* May 2000.

Health Care System Actions:

1. Develop Women's Health Strategies in Manitoba and Saskatchewan which:

- recognize women's health as multi-faceted
- advocate for policies and programs based on a population health model that recognizes gender as a determinant of health and also as a factor that bears on the other determinants;
- recognize the additional risks of ill-health faced by women marginalized from mainstream society including Aboriginal women, immigrants, refugees, women with disabilities, young women and lesbian/ bisexual women;
- the existing knowledge and expertise of organizations working in women's health;
- the need for the active inclusion of a gender perspective at all points in the health care process, from needs assessment, to health planning, to program design, implementation and evaluation;

2. Develop implementation plans for the Women's Health Strategies which include:

- Women's Health Units, with the ability to exercise authority and influence policy, within each provincial Department of Health;
- regional and district implementation strategies, screened and approved by the Women's Unit for gender sensitivity and inclusiveness;
- Use Gender Based Analysis (GBA) to ensure that current and proposed health programs and services are sensitive to the needs of women and men, boys and girls and to provide insight into ways the needs of these populations either differ or correspond;
- Use GBA in the design, development, implementation and evaluation of all health services;
- Ensure that GBA tools are used to respect the diversity among women and are sensitive to issues of age, culture, race, Aboriginal status, disability and sexual orientation;
- Recognize and use the expertise in women's advocacy organizations to design and apply GBA tools.
- Provide adequate funding for women's health research and ensure that the health research conducted looks beyond traditional concepts of women's health and takes into account physical, social, and economic factors.
- Fund the development and implementation of women centred models of care, such as the Winnipeg Women's Health Clinic, the Vancouver/Richmond Health Board's Framework for Women-Centred Health and the forthcoming research by Prairie Women's Health Centre of Excellence;
- Make health care services available and for diverse groups of women in rural and urban regions.

Advocate Outside the Health System For:

- Gender Based Analysis in the design, development, implementation and evaluation of government programs and services to ensure that the services meet the needs of women and men of all ages.

PRIORITY #6

RECOGNIZE THE IMPORTANCE OF WOMEN AS DECISION MAKERS

Generally speaking, women exercise limited decision making authority within the health system. According to Health Canada:

Women are under-represented as policy makers, decision-makers and educators in many segments of the health sector. Certain groups of women are doubly disadvantaged in these respects, because of their ethnicity or sexual orientation or because they have a disability and are less likely to be included in key roles and areas of the health system.[96]

In the health professions, women's functions vary from home care workers, nurses and doctors to members of boards and commissions. Their ability to exercise authority and influence outcomes is, however, limited. According to Health Canada:

Where women's representation is high within a profession, that profession tends to be less valued than one where men predominate. Generally, women are over-represented in nursing and under-represented in most fields of medical specialization - the gatekeepers and decision-making disciplines of medicine.[97]

The lack of women in leadership roles in health policy making and governance is of concern. Their absence lessens the likelihood that policies, programs and planning exercises will take women's needs into account. Decentralized decision making by health boards and authorities could provide governments with an opportunity to ensure that women serve in leadership roles in the governance of health. In Saskatchewan, women comprised half of those serving on district health boards in 1999.[98] While gender parity is important, more effort is required to ensure that women have the necessary information and supports to ensure that policies and programs include a focus on women's health issues.

In Manitoba, women are under-represented on the government appointed regional health authorities.[99]

The absence of women means that equity strategies are needed to ensure women's participation on provincial health bodies.

Health Care System Actions:

- Ensure that women and men are equally appointed as members of regional and district health governing bodies. Ensure that those appointed reflect the diversity of women and that the women serving have the financial, technical and personal supports, including child care, to make their participation effective and meaningful.
- Require that regional and district health bodies develop equity plans that promote the hiring of women in management positions. The plans should give particular attention to the hiring of Aboriginal women, immigrant and refugee women as well as disabled and lesbian/bisexual women. Health bodies should report annually on their progress towards gender equity.
- Ensure gender equity in all appointments made by the Minister of Health. Provide the technical, financial and personal supports to ensure that women are able to participate meaningfully and effectively.

Advocate Outside the Health Services System For:

- Gender equity in appointments to all government bodies, including external agencies, boards and commissions. Ensure that appointments accurately reflect the diversity of the people they serve.

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[96] Health Canada, *Women's Health Strategy*, 1999 p 15.
[97] *Ibid*.
[98] Willson and Howard p 9.
[99] *Ibid.*

PRIORITY #7

ACT TO IMPROVE WOMEN'S MENTAL HEALTH

Women's mental health was consistently identified as an area of concern in our consultations. Women are poorly served within the current system, and holistic, bio-pyscho-social approaches are needed.[100] Women call for gender to be considered in the delivery and design of mental health services because available programs are frequently inadequate:

The socially disadvantaged position of women, coupled with the tendency of some mental health professionals to stereotype women's problems with little reference to the context of their lives, has led to a situation where some services available to women are inadequate and inappropriate.[101]

Improvements to the mental health and well-being of Canadian women are dependent on the elimination of inequities and the adoption of strategies that reflect women's lived experience and their mental health needs.[102] Because mental health issues reflect women's disadvantaged position in society, policy development and treatment related to mental illness must take the determinants of health into account to be effective.

Reports of mental illness in Saskatchewan suggest that women are the main users of outpatient mental health services.[103] Women are more likely than men to experience emotional disturbances, like depression and anxiety disorders.[104] Other common diagnoses include "borderline" personality disorders, and eating disorders.[105] Women's mental health status is influenced by the fact that they are more likely than men to be victims of physical and sexual abuse.

Mental health system reforms moved individual care from institutions into the community. This has placed considerable strain on families, particularly women, who face the challenge of providing care in the home. Again, women are faced with a societal expectation that they will perform these tasks as a labour of love, with little pay, support or recognition. **A women-centred approach to mental health reform would incorporate "consumer participation, inter-sectoral partnerships, and community-focused resources."**[106]

[100] The "bio-psycho-social" model, recognized by the BC Mental Health Plan, examines physical factors as well as environmental ones that influence mental health. M. Morrow with M. Chappell, *Hearing Women's Voices, Mental Health Care for Women* (Vancouver: B. C. Centre of Excellence for Women's Health, 1999).

[101] *Working Together for Women's Health,: A Framework for the Development of Policies and Programs.* The Federal/Provincial/ Territorial Working Group on Women's Health, 1993 p 3.

[102] *Ibid.*

[103] Janzen, B.L. *A Profile of Women in the Saskatchewan Mental Health System: A Discussion Paper Prepared for the Women's Mental Health Agenda Project* (Health and Welfare Canada: Health Promotion and Social Development Office, January 1994).

[104] *Ibid.*

[105] *Ibid* p 5.

[106] *Ibid* p 5.

Health Care System Actions:

- Educate health professionals and staff on mental health issues among women and on the use and development of appropriate treatments and services and to understand the importance of gender in mental health.

- Develop gender and culturally sensitive mental health services based on holistic concepts of women's health and that incorporate strategies for individual and societal empowerment are accessible in all geographic areas, including women's prisons.

- Engage in a consultation process to better understand the needs of women - including young women, senior women, lesbian/bisexual women, Aboriginal women, immigrant and refugee women - with mental health problems and addictions and women survivors of sexual and physical abuse. Implement women-only programs and services to meet these needs.

- Adopt the recommendations for mental health in *Working Together for Women's Mental Health: A Framework for the Development of Policies and Programs*, prepared by the Federal/ Provincial/ Territorial Working Group on Women's Health, March 1993.

- Ensure that adequate supports are provided for the families of women suffering from mental illness and that the move to community care does not rely on women providing unpaid caregiving services.

Advocate Outside of the Health Services System For:

- Curricula for educators and students on the implications of childhood sexual abuse, sexual assault and violence on women's health. Integrate this curriculum into the regular program of studies of all students in health care related fields including, medicine, nursing and dentistry.

- Cooperation between departments of education and organizations that serve young women to develop programs that promote self-esteem and empowerment among young women.

PRIORITY #8

ACT TO IMPROVE WOMEN'S SEXUAL & REPRODUCTIVE HEALTH

Sexuality is a part of every woman's life. Some women choose never to be sexually active but most women explore their sexual desires in some way, at some point in their lives. Sexual health for women includes the freedom to choose how and how not to express themselves sexually, understanding their bodies and sexual desires, and becoming knowledgeable enough to make healthy personal choices about sexual relationships, protecting against sexually transmitted diseases, and choosing if and when to become pregnant.

Healthy societal values and attitudes about sexuality and reproduction, family and community networks and supports, educational and economic opportunities, a healthy physical environment, and access to effective services all enable sexual and reproductive health throughout life. Investing in policies, programs and initiatives to positively influence these conditions will offer excellent returns, now and far into the future.

In Canada, we have unacceptably high levels of sexual and reproductive health problems. Prevention of these problems, and effective care and support for those affected, must be a priority. Examples are rates of teen pregnancy that are higher than in many other developed countries, unacceptably high rates of low birth weight babies, large numbers of young people affected by sexually transmitted diseases (STDs) including HIV and AIDS, infertility experienced by about 7% of couples, often resulting from earlier untreated STDs, and unacceptable rates of sexual abuse and family violence[107]*.*

While women's health is much more than sexual and reproductive health care, we cannot ignore this important aspect of women's lives. Women's sexual health is part of their health over the entire lifetime and particularly from the years of puberty on. It includes sexuality education, contraception, desired and undesired pregnancies, the prevention and treatment of sexually transmitted diseases, including HIV/AIDS, menopause, sexuality throughout the life span (including women's comfort with their sexuality) and cancers of the reproductive system, especially cervical, uterine and ovarian cancers.

Access to age and culturally appropriate, gender-sensitive services and education is essential for women for each of these issues.

[107] Health Canada. *A Report from Constulations on a Framework for Sexual and Reproductive Health*, p ii

Health Care System Actions:

- Ensure access to a full range of reproductive health services for women, including abortion services as part of the universal medicare system. Ensure free access to abortions for women in rural and remote areas. Support accessibility for both medical and surgical abortions.

- Implement midwifery in Saskatchewan, based on the current system in place in Manitoba and using the framework specified in the *Action Plan for the Implementation of Midwifery in Saskatchewan.*[108]

- Employ midwives in all regions and health districts. In the short-term, while the numbers of registered midwives remains small, enable midwives to provide care to women beyond the geographical restrictions of health districts and regional health authorities.

- Address the particular reproductive health needs of Aboriginal women, women with disabilities, immigrant and refugee women and lesbian women. Take the necessary steps to ensure that these groups of traditionally under-served women have equitable access to services. Fund organizations that provide education and services which are available in culturally and language appropriate formats.

- Fund retraining and education for midwives to increase the number of practising midwives.
- Prepare physicians and nurses to provide appropriate care to women with genital mutilation.

Advocate Outside of the Health Services System For:

- Environments and workplaces which are free of reproductive health hazards.

- Comprehensive approaches which address the high pregnancy rate among young women:

    - Work with young women to design and deliver school and community based programs for teenage women and boys to provide them with the information which they need to make healthy choices about when and if to have children;

    - Work with young women to design and deliver school and community based programs to provide free and low cost birth control supplies;

- Fund Aboriginally based and culturally sensitive programs and services for young Aboriginal women.

[108]Midwives Association of Saskatchewan et al, *Action Plan for the Implementation of Midwifery in Saskatchewan*, June, 2000

PRIORITY #9

ADDRESS THE HEALTH NEEDS OF OLDER WOMEN

Older women are likely to be widowed, living alone, unable to access transportation, concerned about issues of personal safety, and both the caregivers for other people and traditionally dependent on other people[109]. Abuse is also a concern for older women. Over 80% of cases reported to the Winnipeg Elder Abuse Resource Centre between 1990 and 1995 were from women, with the highest percentages among those age 65-74. In nearly 40% of all cases reported, the abuser was the spouse.[110]

Women's tendency to outlive male partners and other family members, and their traditional social roles, contribute to isolation and loneliness in older age. Older women may be described as more socially isolated than older men, and a greater proportion expressed higher levels of social loneliness. Both conditions significantly relate to poor health and an increased use of health services[111]. Many older women live with multiple chronic health conditions that can limit mobility and thus further restrict the capacity to socialize.

- In Canada, women are consistently poorer than men. The gap is largest among older people[112]: 48% of unattached women over 65 (compared to 35% of unattached men over 65), have before taxes incomes that are below the Statistics Canada low income cut-off.[113],[114] Of women age 65+ in 1991, 25% never worked outside the home for pay. [115] Among those who did work outside the home, most worked in the clerical and service industries – jobs less likely than traditional male occupations to have provided private pensions or to result in payment from CPP. Poverty is even more extreme for some senior women, especially visible minority or Aboriginal women.[116]

Although older women generally report they are in good health and most live and function independently, health concerns of older women include a greater tendency to increased chronic illness and functional restrictions than is the case for older men.[117]

- Older women are more likely to experience disability which limits everyday activities than do men at all ages. Forty-four percent of the women in the Aging in Manitoba Study (compared to 28% of men) required assistance with functional tasks such as moving about, bathing, dressing and eating. More than 40% of the women reported up to 4 chronic health problems, in particular arthritis (66% of women), vision problems (44%) and heart trouble (37%), all of which tend to restrict mobility.

- Because of women's greater life expectancy compared to men, they tend to experience disabilities for a longer time, often without a spouse or other adequate resources to help maintain independence.[118] And while older women have higher needs, they are less likely to have the income to buy resources to allow them to remain independent.

Services for older people in the community are often inappropriate for the particular needs of women. For instance, because of the traditional gender-based division of household tasks, services tend to focus more on meal preparation and housecleaning , while overlooking older women's need for help with home repairs, home maintenance, yard work, snow removal and other tasks requiring strength and mobility.[119]

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[109] Hall and Havens 1999. *The Effect of Social Isolation and loneliness on the Health of Older Women.*

[110] Centre on Aging 1996.

[111] Havens and Hall

[112] Brotman, S. 1998, *The Incidence of Poverty Among Seniros in Canada: Exploring the Impact of Gender, Ethnicity and Race.* Cdn. J. Aging 17(2): 166-185. Moore, E. and Rosenberg, M. 1997. *Growing old in Canada: Demographic and geographic perspectives*. Statistics Canada and ITP Nelson: Toronto.

[113] Statistics Canada 2000.

[114] For example, among those age 72 and over who reported income information in the Aging in Manitoba Study, 80% of the women compared to 53% of the men reported annual incomes of less than $13,500. Unpublished 1996 data.

[115] Centre on Aging 1996, Table 21 p 53.

[116] Brotman, S. 1998. *Op cit.*

[117] Arber, S. and Cooper, H. 1999. *Gender differences in health in later life: the new paradox*? Social Sciences and Medicine, 4861-76.

[118] Maxwell, C. and Oakley , K.1998. *Editorial: older women's health issues.* Cdn J. Aging 17(2): i-ix.

[119] Groves, M.. 2000 *Gender differences in living alone.* Senior's Housing Update. March 8-9.

- Alzheimer's disease and related dementias tend to be more prevalent with age, suggesting again that women, with their advantage in life expectancy, are more likely to experience some form of cognitive impairment. As women are also more likely to be primary caregivers, they tend to experience the greatest burden in caring for a spouse with dementia. [120]

- Inactivity increases with age, and more older women than men are inactive[121]. Inactivity is more prevalent among those who are widowed, lived alone, who have less education, and had lower incomes, and are living with chronic illness and functional impairment. Group activities which combine light to moderate activities with socialization, may be more attractive to those at greater risk of inactivity, such as older widowed women and those with health problems[122]. Regular activities may prove to overcome barriers presented by demographic, geographic and socioeconomic conditions

Older women take more prescription medication and over-the-counter preparations than men of any age group. [123]

- Nearly 1/3 of older women receive psychotropic drugs, twice the rate of older men. Older women may often receive these prescriptions to help cope with bereavement when their spouse dies. [124]
- Multiple medication use is most prevalent among those with chronic conditions, particularly those taking medications for heart disease, diabetes, asthma and hypertension.[125] Information on the appropriate use of medications, especially multiple medications, may be less available to older people, possibly because older people may take the same medications for many years. This, coupled with the possibility of less retention of information generally as people grow older, produces a higher risk for adverse drug reactions. [126]

- Older people are more susceptible to medications that affect the central nervous system than younger people.[127] Older women experience a greater risk for adverse drug reactions which may result in disorientation, falls, and stomach problems, and a greater risk of hospital admission for adverse drug reactions than older men.[128]

Many older women are primary caregivers to family members, particularly spouses, and often grandchildren[129] . While caregiving can have both positive and negative results for older women[130] , it may limit social interaction. Older women often spend many years caring for an ill spouse, a full-time activity that forces them to withdraw from traditional social networks and restricts further opportunities for social interaction[131].

Research in the area of older women's issues is scarce, with the result that older women generally remain invisible in research. Data on women are often not reported by age, and research on elderly persons is not often available by gender. As a result, the issues for older women are often overlooked. The same is true with regard to ethnicity, as older women who are non-white or non-English-speaking are usually absent from research.

[120] Maxwell and Oakley 1998.
[121] Hall and Havens 1998
[122] Hall and Havens 1998
[123] Maxwell and Oakley 1998.
[124] *Ibid*.
[125] Millar,W. 1998. *Multiple medication use among seniors.* Health Reports 9(4): 11-17.
[126] *Ibid*.

[127] *Ibid*.
[128] Maxwell and Oakley 1998, Millar 1998.
[129] Arber and Ginn
[130] Janzen, B. 1998.
[131] Hall & Havens 1998

Health Care System Actions:

- Ensure that a full range of gender and age appropriate services are available to senior women, including health promotion, prevention, acute and chronic care services.
- Explore ways to motivate older women to be active; support opportunities for accessible, low-cost community-based exercise and social interaction activities.
- Provide greater availability of respite and other support programs for caregivers.
- Raise awareness among physicians and pharmacists to the risk of multiple medication use among older women, and the continuing need for education of all older people taking prescription and over-the-counter medications
- Determine risk factors for conditions affecting health of older women, and explore the effectiveness of health promotion, disability postponement and disease prevention activities at all ages
- Involve older women and their caregivers in all areas of decision-making, and mobilize seniors to work in their own interest
- Encourage effective research in the use and over-use of medications by older women, and the prescribing practices of physicians

Advocate Outside the Health System To:

- Address the differential rates of poverty in the population, particularly for older people, and the discrepancies between older men and women and among the diverse groups of older women
- Provide programs and services for older women appropriate to their needs and concerns, low in cost, and easily accessed
- Address issues of barriers to access in the community which may prohibit those with functional and mobility restrictions
- Provide appropriate low-cost services, including home maintenance and renovation, to assist older women to remain in their own homes
- Provide a range of supportive housing options, including congregate settings, with a wide variety of service and program options
- Urge strict regulation of all housing and long term care facilities to ensure appropriate service options and the availability of trained and knowledgeable staff
- Provide readily available, low-cost, door-to-door transportation to ensure the safety of older women
- Require the Canadian Institutes of Health Research to support research that specifies gender differences, and gender-based research that addresses the differential characteristics for older people and accounts for differences between the young-old (60's) and old-old (80's).

PRIORITY #10

ADDRESS THE SPECIFIC HEALTH NEEDS OF IMMIGRANT AND REFUGEE WOMEN

A few crucial issues and considerations are highlighted below:

- The immigrant and refugee population is diverse, with a great range of differences in geographical origin, ethnicity, culture, socio-economic status, political affiliation, religious orientation and many other factors. This diversity continues to grow by geometric proportions, with the shift in immigration from traditional source countries (largely European), to non-traditional source countries (Asian, Middle Eastern, African and Latin American). Immigrants and refugees from non-traditional source countries may hold concepts about health and health care behaviors that differ from the majority culture of North American society. Different cultural family dynamics, educational and language proficiency levels, and other factors affect health and health care behavior in different ways.

- Canada's Federal/Provincial/Territorial Advisory Committee on Population Health (ACPH) acknowledges that immigrants are generally in good health when they arrive Canada because *"immigration policies tend to favor immigrants who are in good health [and] secondly, many immigrants and refugees are young when they arrive."*[132] The same source also acknowledges that the prevalence of chronic conditions increases the longer immigrants stay in Canada. Although the reasons for this deteriorating tendency are not well understood, the ACPH attributes some of the factors to *"the normal aging process"* and *"the adoption of unhealthy lifestyle practices such as smoking"* after arrival in Canada. What the ACPH has failed to acknowledge is the link between the migration process and the health and socio-economic status of immigrants and refugees.

- Immigrant and refugee women face a variety of problems as a result of a combination of factors affecting health, including discrimination based on race, gender and immigration status.[133] Two Manitoba studies (1998[134] and 1999[135]) conclude that immigrant and refugee women bear the brunt of multiple access barriers to health and social services and to the labor market. This includes non-recognition of credentials and experiences from abroad, lack of appropriate training programs, and diminishing funding to agencies serving immigrants and refugees at a time when the social support network is considered an important health determinant.

- Immigrant and refugee youth are highly affected by multiple and inter-related stresses with respect to school, family and ethnic identity. Fast acculturation among immigrant and refugee youth is associated with higher rates of smoking, abortions, violence and many inter-generational communication gaps.

- The health care system in Canada has not been designed to respond to the growing diversity of the Canadian population. Newcomers may be unfamiliar with differences in technology, physical structures of facilities, management and administration, costs, conceptual framework (e.g. concept of choice), and support systems.

By way of summary, barriers to immigrant and refugee women's health need to be considered from three levels of service delivery, and all three levels must be involved in providing an effective solution.[136] This includes consumers, implementing agencies and policy makers.

[132] Chen, J., Ng, E. Wilkins, R. *The Health of Canada's Immigrants in 1994-1995*. Statistics Canada. In *Toward a Healthy Future, Second Report on the Health of Canadians*, Advisory Committee on Population Health, 1999.

[133] Resources for Feminist Research (FRF/DRF), *Immigrant Women*, A Canadian journal for feminist scholarship, 16 (1), March 1987.

[134] Sharma, A., & Hakim, C., The Newcomers Entrepreneurial Training and Support (NETS) Project, A Research Initiative of Employment Projects for Women (EPW), Immigrant Women's Association of Manitoba and SEED Winnipeg (unpub. Report), 1998.

[135] Hakim, C., and Angom, G., *An Analysis of Barriers Facing Immigrant Women and their Families in Accessing Health and Social Services*. A Study Conducted for Immigrant Women's Association of Manitoba (unpub. report), 1999.

[136] *Ibid.*

Health Care System Actions:

- Encourage and involve immigrant and refugee women in all the different stages of the decision-making processes, including in the development of policies that affect their health.
- Advocate for continued policy level research and analysis to develop appropriate policies, design and plan appropriate programs for immigrant and refugee women's health. Advocate for creation of policies that recognize the credentials, skills, abilities/competencies, knowledge and experiences acquired prior to immigrating to Canada.
- Include the migration process as a determinant of health.
- Promote programs for continuous multicultural awareness at all levels.
- Advocate for appropriate funding to implement programs/services that respond to the specific health needs of immigrant and refugee women, including coordination of professional interpretation services and subsidies for cost of services.
- Develop clear plans of action for implementing equity policies, including diversification of the workforce. Promote and stimulate immigrant and refugee women's participation at all levels of program development.
- Develop and implement appropriate bridging and outreach programs.
- Work towards the inclusion of multi-cultural awareness in the educational curriculum for the schools of medicine, education, social work and nursing.
- Implement a Population Health approach that includes and goes beyond the 12 determinants of health as a basis for assessing the needs of immigrant and refugee women.
- Use community development, including popular education principles as a means to empower immigrant and refugee women to gain control of their health.
- Promote effective use of interpreters and appropriate language training to address some of the access barriers to health care system.

Advocate Outside of the Health Services System For:

- Increased funding to support the work of agencies serving immigrants and refugees.
- Promote multi-sectoral, holistic approaches to addressing the needs of immigrant and refugee women.
- More effective networking/partnership between mainstream, immigrant serving agencies and communities for an accountable and coordinated response to the plight of immigrant and refugee women.

PRIORITY #11

ADDRESS THE HEALTH NEEDS OF WOMEN WITH DISABILITIES

Women with disabilities are among the poorest of Canadians. They are systematically excluded from the labour market and experience high rates of unemployment. Their wages are lower, they are less able to access social programs and experience higher rates of poverty than their male counterparts. 137 Understandably, our consultations identified strategies to address poverty, employment, and housing issues as crucial.

One of the most pressing health issues for women with disabilities is the inaccessibility of services. While this factor varies with the disability, health and social services are generally difficult for women with disabilities to access.[138] Women have identified the need to build access to primary care in particular. They also wanted each health region or district to hire nurse educators and nurses with special knowledge of women with disabilities. Because there is enormous diversity among women with disabilities, policies and programs must also reflect this diversity.

Women with disabilities do not want society to automatically link poor health with disability. Women with disabilities are often described in negative terms that focus on their limitations rather than their abilities. This stereotyping detrimentally affects disabled women's life opportunities and self esteem. Women with disabilities are, for example, discouraged from having children by health care providers who fail to see their capabilities related to parenting tasks. Due to these restrictions, mental health issues described as common and of high concern among women with disabilities.

The women consulted saw education for physicians on disabilities, conditions and health issues as a crucial strategy for the improvement of the health of women with disabilities. Final issues related to genetic screening, selective abortion and euthanasia. This is not a new concern. In 1990, the Federal/ Provincial/ Territorial Working Group on Women's Health stated:

Some advocates for people with disabilities have argued for the emergence of prenatal diagnostic techniques such as ultrasound, amniocentesis and chorionic villi sampling is raising complex ethical issues about the value which we place on people with disabilities in our society.[139]

Further education is needed to ensure that the health needs of women with disabilities are identified, understood and addressed. The federal Office of Disabilities recently released the document ***In Unison: A Canadian Approach to Disability Issues.*** It promotes the full participation of persons with disabilities in Canadian Society. The document states:

The realization of the vision will allow persons with disabilities to maximize their independence and enhance their well-being through access to required supports and the elimination of barriers to prevent their full participation.

137 Fawcett, G. *Living with Disability in Canada.* Office for Disability Issues, Human Resources Development Canada, Minister of Supply and Services Canada, 1996, p. 151

138 Federal, Provincial, Territorial Working Group on Women's Health, *Working Together for Women's Health: A Framework for the Development of Policies and Programs,* April 1990.

139 *Ibid* p. 19. The Prairie Women's Health Centre of Excellence will publish research on prenatal diagnostic techniques in 2001.

Health Care System Actions:

- Consult women with disabilities to determine how health care services can best meet their needs. Include Aboriginal women, new immigrant women and young women.
- Change health care programs and services to reflect the results of these consultations.
- Include vision and dental care as insurable services under the Canada Health Act.
- Examine and remove barriers to women with disabilities who require prescription medications.
- Enhance training for health professionals to expand knowledge and expertise in caring for with women with disabilities.
- Enhance mental health services to include a particular focus on women with disabilities.

Advocate Outside of the Health Services System For:

- Decision makers in health determining sectors (e.g. housing, education, transportation, communication, finance) to consider the impact of their decisions on the health of women with disabilities.
- Enhanced employment opportunities for women with disabilities.
- Safe, affordable housing for all women with disabilities.
- Increases to the provincial disability allowance and to provincial/federal disability benefits.

PRIORITY #12

IMPROVE THE HEALTH OF WOMEN LIVING IN RURAL & REMOTE AREAS

Rural and farm women and women living in remote communities have limited access to health services. Fewer services and care givers are available to women who live outside the urban centres.

Women who farm are in a high-risk occupation (*Condition of Ag. Safety and Rural Health*). There are risks of injuries, as well as environmental risks from dusts and chemicals. Furthermore farm women may face a quadruple workload: unpaid on the farm, off the farm, in the home, and in the community. While there is evidence that rural women are increasingly elderly, data about the health of rural women is limited.

Women in remote communities must cope with greater distances to reach health care, particularly specialized care. Recruiting and retaining physicians is an on-going struggle for remote and rural communities; finding a female physician for care can be especially difficult. Some women find that physicians who are newcomers to Canada are not able to care for the women in an appropriate, culturally sensitive manner.

The introduction of regionalized health care has included new geographic barriers to some health care services. For example in Manitoba the newly regulated profession of midwifery is offered in some Regional Health Authorities but not in others. Midwives who are now employed by a particular RHA are no longer able to care for women who may live outside the geographical boundary of the RHA. Saskatchewan women report that the geographic boundaries differ for various services including mental health services and social support networks.

Health Care System Actions:

- Integrate and incorporate rural women's health needs in gender-sensitive health programs.
- Use sex-disaggregated health data to get a clear idea of the health of women in rural and remote communities.
- Develop and adequately support a rural women's health consultation mechanism so they have continued input in health programming and policy formulation.

Advocate Outside the Health Services System To:

- Address the issues which lead to poverty among rural and remote women
- Advocate for stabilized support for social programs for farm women
- Create mental/emotional health services which are accessible to women in rural and remote communities.
- Support safe houses for rural and remote women who are victims of violence
- Create services for child care and elder care which are available to women in local communities.

Conclusion

The PWHCE has prepared this Action Plan to stimulate discussion and promote actions to improve the health of women in Manitoba and Saskatchewan.

We hope that this plan will serve as a tool for health policy makers, women's health advocates, health service providers and others to measure and monitor changes in the health care system.

Glossary

Aboriginal peoples: refers to organic political and cultural entities that stem historically from the original peoples of North America, rather than collections of individuals united by so-called 'racial' characteristics. The term includes the Indian, Inuit and Metis peoples of Canada. *(Report on the Royal Commission of Aboriginal Peoples, Volume 1, Looking Forward, Looking Back, 1996)*

culturally-sensitive: a concept that respects and recognizes culture as a primary determinant in influencing a peoples way of thinking, interacting, and acting

culturally-based: an approach that is embedded in a people's cultural values, philosophy, bodies of knowledge and practices

gender: the array of society-determined roles, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis. Many health issues are a function of gender-based social status or roles. Women, for example are more vulnerable to gender-based sexual or physical violence, low income, lone parenthood, gender based causes of exposure to health risks and threats.

gender based analysis: "a process that assesses the differential impact of proposed and/or existing policies, program and legislation on women and men. It compares how and why women and men are affected by policy issues. It makes it possible for policy to be undertaken with an appreciation of gender differences, of the nature of relationships between women and men and their different social realities, life expectations and economic circumstances. It is a tool for understanding social processes and for responding with informed and equitable solutions." (adapted from Status of Women Canada, 1998).

health determinants: factors of human biology, cultural, physical and social environment; behaviour and lifestyle (including the health care delivery system)m and public policy that influence health.

(McLaren, J. 2000. *Evaluating Programs for Women: A Gender-specific Framework*)

holistic approach: is a concept that recognizes that all elements of life and living are interdependent, with equal emphasis to the physical, spiritual, mental and emotional aspects of a person. It is a concept that recognizes that well-being flows from balance and harmony among the elements of personal and collective life *(Report of the Royal Commission on Aboriginal Peoples, Volume 3, Gathering Strength, 1996)*

refugee: according to the UN: "any person, who by reasons of race, religion, nationality, membership in a particular social group or political opinion, (a) is outside the country of his/her nationality and is unable...to avail him/herself of the protection of that country, or (b) not having a country of nationality, is outside the country of his/her former habitual residence is unable ... to return to that country."

sex: the biological and genetic differentiation between male and female. The basic biology and organic make-up of the human body are a fundamental determinant of health

visible minority: refers to people other than Aboriginal peoples who are members of a race other than Caucasian.

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