

Including Gender In Health Planning

A Guide For Regional Health Authorities

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PRAIRIE WOMEN'S HEALTH
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Introduction

WHY INCLUDE GENDER IN HEALTH PLANNING?

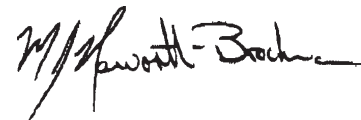
Because when it comes to health, sex and gender matter. By deliberately exploring the possible different needs, concerns and consequences of health plans for men and women, we can make health services more relevant and appropriate to both women and men in Manitoba.

This guide has been developed jointly by the Prairie Women's Health Centre of Excellence and Manitoba Health as part of the *Women's Health Strategy* endorsed by the Minister of Health and Minister Responsible for the Status of Women in 2000. Its primary purpose is to assist the Regional Health Authorities (RHAs) to incorporate gender in their upcoming Community Health Assessments and subsequent Health Plans. As well, the guide is a useful tool to Manitoba Health and others involved in gender & health planning.

When gender-based analysis is done successfully, gender becomes part of the entire regional health planning process including the Strategic Plan (vision, mission and values; environmental scan and strategic priorities) and the annual Operational Plan.

Regional Health Authorities are already taking action to include gender in health services. For example, South Eastman (RHA) has conducted a regional study to talk with women about their health. Assiniboine (RHA) runs a Women's Health Program to increase knowledge and understanding of women's health and needs in the region, support the provision of effective services to women, and promote good health through preventative measures. Interlake RHA has conducted focus groups on informal caregiving, a topic of great relevance to women. As well, in 2002, the Interlake region was recognized at a national conference for the successful work done by a multi-sectoral group (health, recreation, education, Aboriginal peoples) regarding health promotion initiatives to get girls and women active in the region.

This guide provides some background and history on gender-based analysis. Two case studies show the value of understanding the health of a population considering both females and males. Finally we provide brief checklists to assist you in considering men's and women's shared and differing needs. We hope you find this guide useful.



Margaret J. Haworth-Brockman
Executive Director
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What is Gender-based Analysis?

GENDER-BASED ANALYSIS (GBA) IS A TOOL TO HELP understand how the experiences of women and men are different, and how they are the same. In the case of health, GBA illuminates the differences in health status, health care utilization and health needs of men and women.

Health Canada defines Gender-based Analysis as:

“...an analytical tool applied to research, policies, program design, and evaluations to ensure that appropriate questions about both men and women yield sensitive and accurate analyses and programs.”¹

“Gender-based analysis helps to ensure that the differential economic, political, social and biological circumstances of both girls and boys, and women and men are taken into account. Gender-based analysis will render transparent

Gender-based analysis acts like a camera lens, filtering distortions and inaccuracies that are not immediately obvious.²

¹Health Canada, 2002, 1

²Health Canada, 1999, 35

issues such as the under-representation of women in decision-making or the absence of women in research. It may similarly highlight imbalances in addressing men's health issues.”³

Why Gender-Based Analysis?

When it comes to health, sex and gender matter. Research is increasingly alerting us to the ways that sex and gender interact to “create health conditions, situations and problems that are unique, more prevalent, more serious, or have different risk factors or interventions,” for women and men (Greaves et al., 1999:3)...Tailoring the health care system to meet the particular needs of women (and men) should lead to better use of resources.⁴

GBA allows us to consider the ways in which gender interacts with the other determinants of health to influence the health of women and men, boys and girls.

This is important because women and men are not all the same. We differ because of age, education, socio-economic status, culture, physical environments, etc.

Including GBA can be part of on-going programming and planning for health care delivery. Using GBA provides an idea of the wider breadth of the health issues that affect a regional population.

³Health Canada, 2002

⁴Ministry of Health Services, 2001

Gender can act in two ways to influence health.

Firstly, gender acts on its own. The most obvious example of this is reproductive health. But gender acts in other ways, that may not always be considered. For example the same drug can cause different reactions and different side effects in women and men.⁵

Secondly, gender works along with other determinants of health. For example, income is linked to health. Those with lowest incomes are at the greatest risk of ill health. The “gender gap” in incomes means that Manitoba women are more likely to be poor than are Manitoba men - almost 20% of adult women are poor compared with 13.5% of adult men.

GBA also includes an analysis of the diversity among people, recognizing that all women and all men are not the same. For example, senior women, especially senior women living on their own, women with disabilities and Aboriginal women of all ages are at even greater risk of poverty than their male counterparts.⁶

In Manitoba the health needs of Aboriginal women and men require particular attention. GBA shows how the situations of Aboriginal women and men are the same, and how they are different. It also shows how the situations of Aboriginal women and men compare to non-Aboriginal women and men.

GBA is a powerful tool for health planners and decision-makers who must allocate resources. GBA contributes to “evidence-based” decision making, because it broadens the scope of “evidence” used in the decisions.

⁵Health Canada, 2002, 6

⁶Donner, 2002, 1 - 3

Gender-based analysis (GBA) flows from a **population health** perspective. Manitoba Health's *Women's Health Strategy* recognizes gender as one of the important determinants of population health. The other determinants of health accepted by Health Canada are:

- income and social status
- social support networks
- education
- employment and working conditions
- social environments
- physical environments
- biology and genetic endowment
- personal health practices and coping skills
- healthy child development
- health services
- culture

Isn't Gender Just a Polite Way of Saying "Sex"?

IN ORDER TO UNDERTAKE GBA, IT IS IMPORTANT TO understand the concepts "sex" and "gender".

Sex refers to the biological differences between females and males. The health sector has focussed largely on reproductive differences, particularly maternity care, but physical distinctions between females and males shape a much broader range of health issues.

Gender refers to the array of socially constructed roles and relationships, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis. Gender is relational - gender roles and characteristics do not exist in isolation, but are defined in relation to one another...

Gender roles and responsibilities are rarely evenly balanced in any society. Women and men generally do not have equal access to resources such as money, information, power and influence...⁷

Without GBA, women and men may be treated the same way, when it is inappropriate to do so. Alternatively, they may be treated differently when it is inappropriate to do so, based on traditional, long-standing stereotypes. GBA helps to uncover both of these types of problems.

⁷Health Canada, 2000, 14

⁸Grant, 2002

Consider these examples:

- It is well-known that young men commit suicide much more frequently than young women. Looking at gender - and understanding the differences in the lives of young women and young men - will help in the development of prevention and intervention strategies to reduce suicides among both young women and young men. The first case study in this guide deals with this issue, as well as the related problem of self-inflicted injuries among women. In this example, treating women and men the same way is not appropriate.
- Canadian women live, on average, longer than Canadian men do. RHAs will therefore see more elderly women than men in hospital. Considering gender, and its many influences on the lives of senior women, will help to provide services that better meet the needs of these women. For example, their lower incomes mean that they are less able to purchase non-insured treatments such as certain prescription drugs, medical supplies and physiotherapy. Their caregiving roles may mean that senior women are themselves responsible for caring for others who are chronically ill. Again, in this case, treating women and men the same way is not appropriate.
- Health education messages designed to prevent unwanted pregnancies have primarily focussed on young women. This has reinforced the stereotype that places most of the burden of responsibility for birth control on women. In this case, it would be more appropriate and effective to target both women and men.

Two Manitoba projects supported by Prairie Women's Health Centre of Excellence give insight into effective women's health planning and programming:

A Rural Women's Health Program: The Experience of the South Westman RHA, by Donner, L., 2002 and; *Women and Health: Experiences in a Rural Regional Health Authority* by Roberts, J., Falk, M., and South Eastman Health, 2002.

Did You Know...

Women and men do not receive the same (or similar) care, even for the same conditions. American studies show women are less likely to receive high-tech services, and tend to receive less aggressive care for conditions such as heart disease and cancer.⁸

What About Men's Health?

A gender inclusive approach includes men **and** women. When women's health is emphasized, it is because much more is already known about men's health. Most health research in the past has been conducted on men, by men. The results may then be applied to women, leading to inappropriate or ineffective interventions.

Gender-based analysis gives us an opportunity to ask questions based on health data which is already available. It also helps point out information which may be missing from current data.

Why is Gender Important in Health Planning?

GBA is about more than identifying and analyzing issues specific to women (like hysterectomy rates and Caesarean section rates) or men (like prostate cancer) or issues more common to women (like breast cancer). GBA is a tool to apply when analyzing all aspects of health, and all parts of the health care system, because gender affects all aspects of the lives of women and men - everything from income and education to family responsibilities, and social supports to occupational health.

Good health planning is about using the available resources to help obtain the best possible health outcomes for all. However, providing the same programs and treatments for everyone in a region (that is, treating them equally), may not produce results which are equitable. Different programs or treatments may be necessary for women and men, boys and girls, in order to

achieve the best possible results. **GBA will help to identify and give priority to those areas where gender-sensitive interventions will lead to improved health.**

Putting GBA to Work: Two Examples

The two case studies which follow are examples of GBA in action. These examples demonstrate how an understanding of gender can be practically applied to community health assessment and health planning work. They present some basic information and a series of questions for RHAs to consider when analyzing the influence of gender in their own communities.

Case Study #1

Three Issues in Mental Health: Depression, Self-Inflicted and Suicide

GENDER-BASED ANALYSIS CAN HELP RHAs TO identify ways to better meet the mental health needs of the women and men in their region.

This case study is limited to three issues in mental health - depression, self-inflicted injuries and suicide. The focus in this first case study is on the value of using data disaggregated according to sex as one of the foundations of GBA. This case study is not a comprehensive analysis of gender issues in mental health. It includes data for Manitoba as a whole. Some of this data is also available at the regional level.

Are the mental health needs of women and men different? Read on...

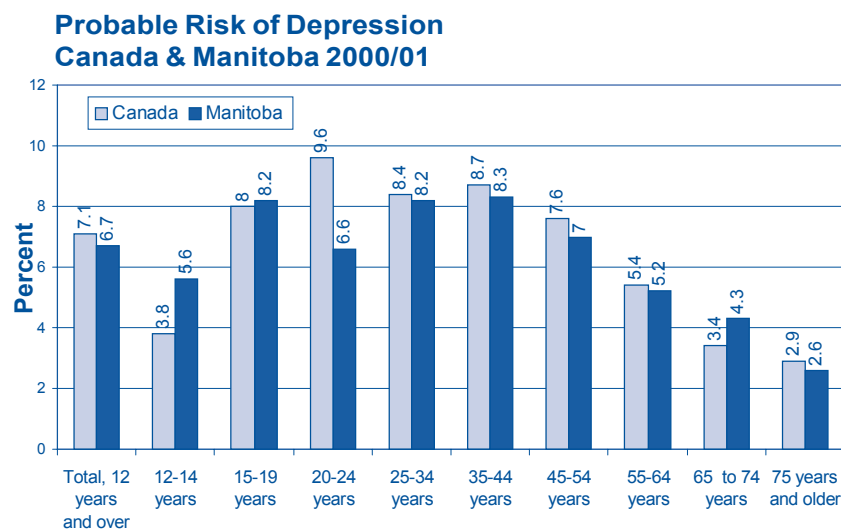
Depression

Here is a typical, gender-neutral analysis of some recent data about depression:

As illustrated by Figure 1 below, in 2000/01 **6.7%** of Manitobans were at probable risk of depression compared with **7.1%** of Canadians.

Young people were more likely to be depressed than older people. Manitobans between the ages of 15 to 19 and 35 to 44 had the highest probable risks of depression of (**8.2 to 8.3%**). By age 65, the risk of depression drops to **4.3%** and by age 75, it drops again to **2.6%**.⁹

Figure 1.



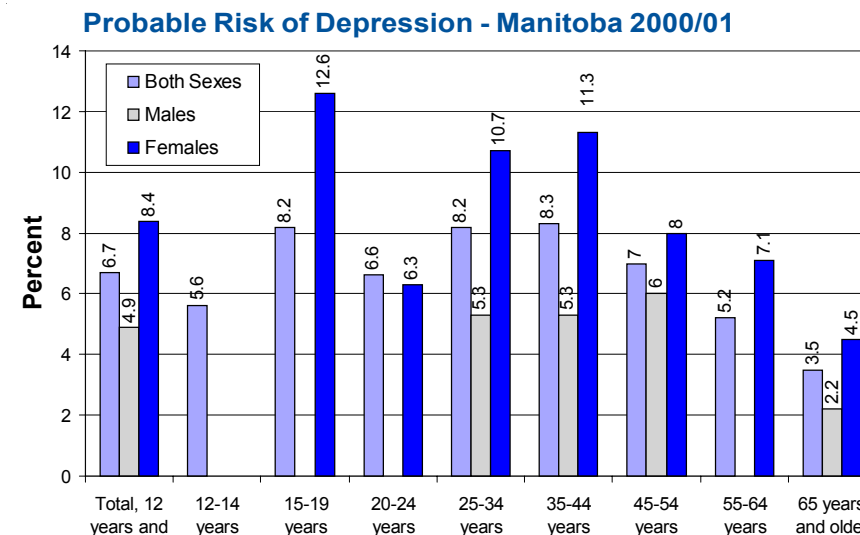
Source: Statistics Canada, *Health Indicators*

⁹ Statistics Canada, 2002

These data clearly point to the importance of a youth-focused strategy in dealing with depression.

What happens when gender is added as a consideration?

As Figure 2 illustrates, at every age and stage of life, women are at greater risk for depression than men. **This important information was lost when data about women and men were not considered separately.**



Source: Statistics Canada, *Health Indicators*.

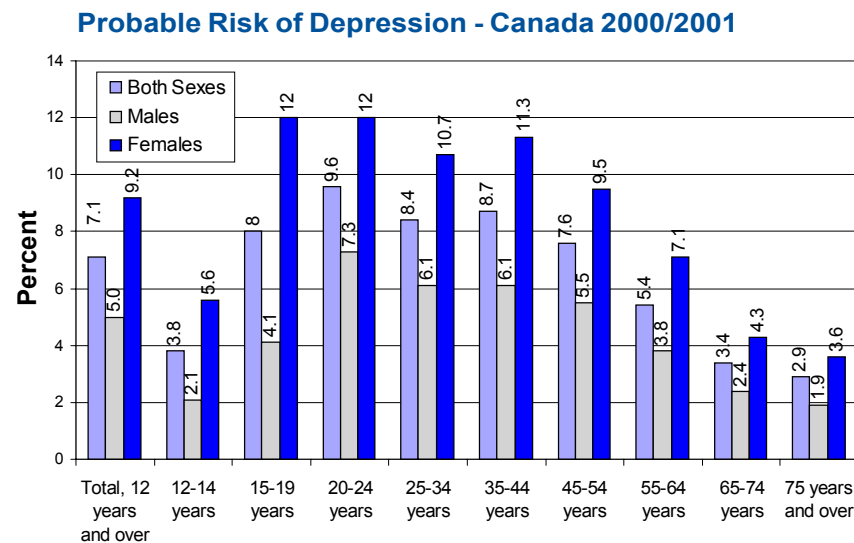
Where no bar appears, the data were too unreliable to be published.

Figure 2.

In Manitoba, those at highest risk of depression were young women, aged 15 to 19 years, of whom 12.6% were at probable risk of depression. Depression among women reached its next

highest peak among women aged 35 to 44 years (11.3%), after which it declined steadily. The Manitoba Centre for Health Policy has reported that women are prescribed anti-depressant drugs twice as often as men from the mid-teenage years to age 65.¹⁰

Depression among men followed a similar age-related pattern, but their rates of depression were lower. Since Manitoba data for young men were not published, comparable Canadian data are presented in Figure 3 below. In all of Canada, women aged 15 - 19 were at highest probable risk of depression. Women in this age group were almost three times as likely as men to be at risk.



Source: Statistics Canada, *Health Indicators*

¹⁰ Manitoba Centre for Health Policy, 2000

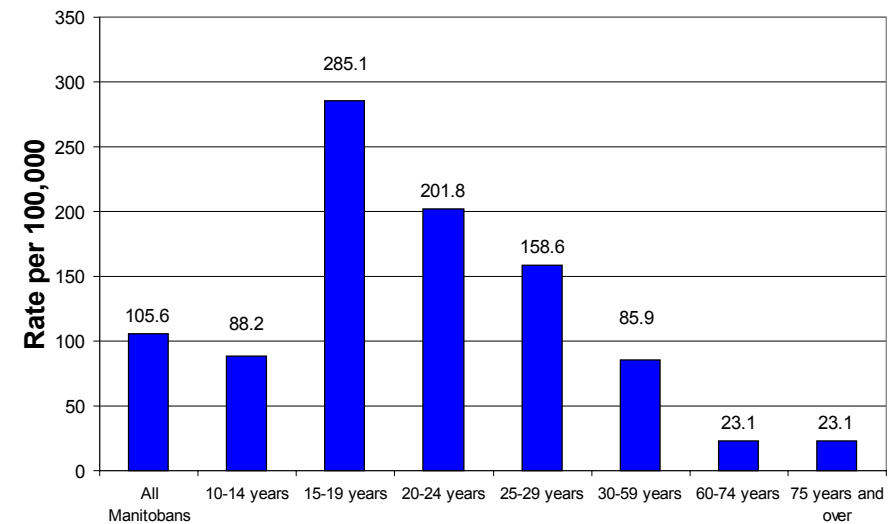
Self-Inflicted Injuries

Here is an analysis of recent Manitoba data about hospitalizations for self-inflicted injuries, which does not take gender into account.

In the ten years from 1990 to 1999, **106/100,000** Manitobans were hospitalized for self-inflicted injuries.

As with depression, hospitalization for self-inflicted injuries peak at age 15 to 19 (285/100,000) and declined with age to 23/100,000 for Manitobans 60 years and over.

Hospitalizations for Self-Inflicted Injuries Manitoba 1990 to 1999



Source: Epidemiology Unit, Manitoba Health

But presenting the data this way overlooks the very real and very important differences in the experiences of young women

Figure 3.

Figure 4.

and young men. Figure 5 below illustrates that women are at much greater risk than men for hospitalization due to self-inflicted injuries.

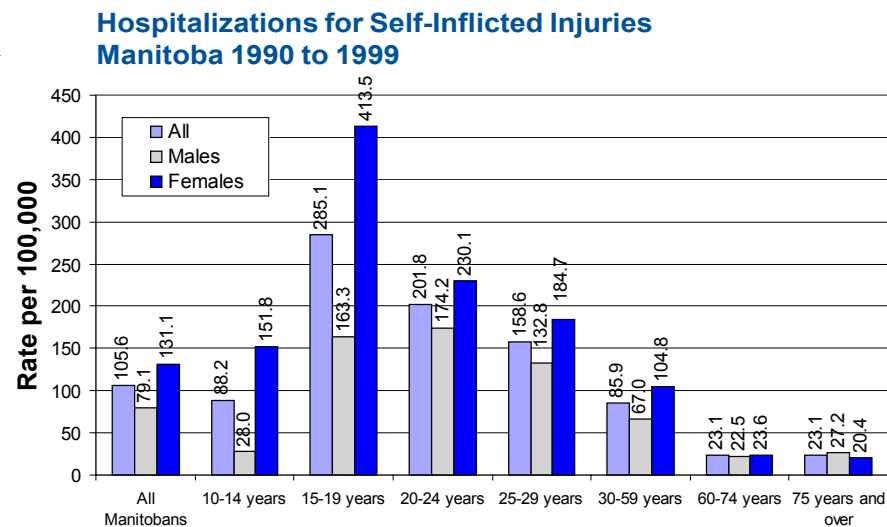


Figure 5.

Source: Epidemiology Unit, Manitoba Health

Young women aged 15 to 19 years are at highest risk of hospitalization for self-inflicted injuries. This is also the highest risk age group for Manitoba men. However, women aged 15 to 19 were more than 2.5 times as likely as their male counterparts and almost four times as likely as all Manitobans to have been hospitalized for self-inflicted injuries.

It is also important to look at differences among women and among men. These are illustrated by Figure 6, which compares the risk of self-inflicted injuries among First Nations* and non-First Nations women and men in Manitoba over a ten year period.

*First Nations Manitobans in this data set are those identified to MB Health as having treaty status.

Self Inflicted Injuries First Nations and Non First Nations Manitobans 1992 to 1999

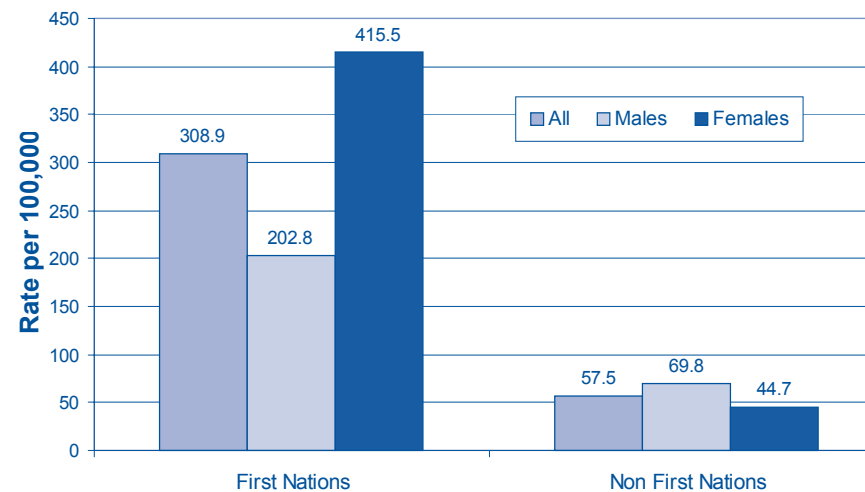


Figure 6.

Source: Manitoba Health, Injuries in Manitoba - A Ten Year Review, 2003, forthcoming.

First Nations women were 2.1 times more likely than First Nations men to be hospitalized for self inflicted injuries. They were 9.2 times more likely to be hospitalized for self inflicted injuries than Non First Nations women.

Suicide

Here is a typical analysis of suicide data, without considering gender:

From 1990 to 1999, 1,280 Manitobans committed suicide. This is approximately 13/100,000 people. Suicide is age related. Younger people are much more likely to commit suicide than are older people.

These data on self-inflicted injuries are understated. It is important to note that the number of hospitalizations does not include visits to emergency rooms when a patient may not be admitted to a bed.

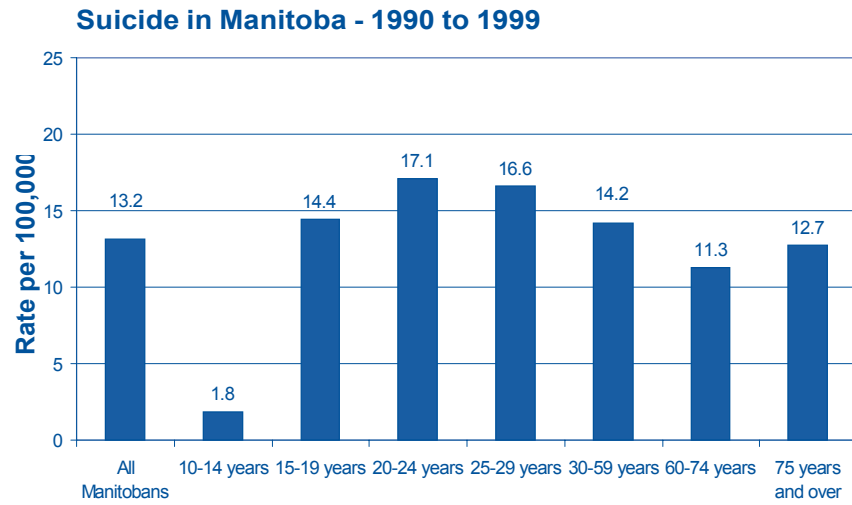


Figure 7.

Source: Epidemiology Unit, Manitoba Health

The data above show that the suicide rate was highest for those aged 20 to 24 years (17/100,000).

With the data presented here, an RHA would see the value of interventions to improve mental health among young people. **But in looking at the information this way, some important pieces to help design and deliver the most effective programs would be missed.**

There were significant gender differences among Manitobans who committed suicide during the ten years from 1990 to 1999. **At every age, men were more likely to commit suicide than women. Men aged 20 to 24 were most likely to commit suicide, at a rate 4.6 times greater than their female counterparts.**

For women, suicide risk declines with age. However, this is not true for men. **Elderly men, aged 75 years and over, ended**

years. Their suicide rate was 6.5 times that of women in the same age group.

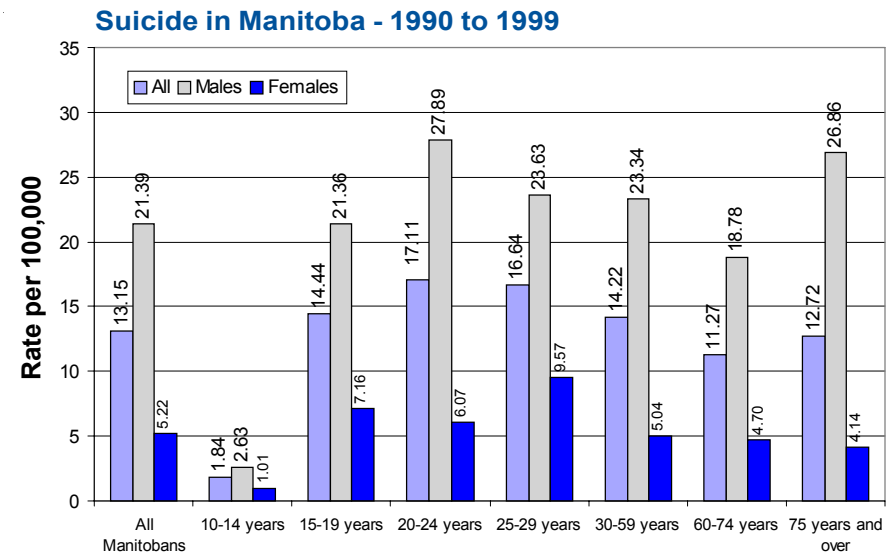


Figure 8.

Source: Epidemiology Unit, Manitoba Health

Going Beyond the Numbers

These data are useful because they illustrate the similarities and the differences between the situations of women and men and suggest some areas for further investigation and discussion. They are a useful starting point for gender-based analysis.

Did You Know... Men, young and old, are more likely to use lethal methods in their attempts at suicide...Females are more likely to take advantage of community suicide prevention services...even after initiating a suicide attempt.¹¹

¹¹ Suicide Information & Education Centre, 1998

Some questions for RHAs to consider are:

1. How does our regional data look when analyzed by gender? What do we know about depression, self-inflicted injuries and suicide among women and men in our area?
2. What do we know about the lives of women in our region that would place them at higher risk for depression and self-inflicted injuries? In particular, what do we know and what do we need to find out about the lives of young women? How can we find out more?
3. What do we know about the lives of men in our region that would place them at higher risk for suicide? In particular, what do we know and what do we need to find out about the lives of young men and elderly men? How can we find out more?
4. What resources are available to help us better understand the mental health needs of Aboriginal women and men? How can we find out more?
5. How can we use this information to guide our community health assessment process? How can we include those with knowledge of mental health issues for Aboriginal women and men in our community health assessment process? What steps can we take to ensure that the voices and experiences of young women and young men are included in our community health assessment process?
6. What resources are available to help us plan programs and services which address the different mental health needs of women and men in our region?

I know that young and elderly men have the highest rates of completed suicide. What I didn't realize was the remarkable differences in rate between men and women over 75 years old, with men being almost 6.5 times as likely to commit suicide. This has made me stop and think about what is going on in the lives of older men...Is this in response to widowhood, new medical diagnoses, feelings of isolation?

Gord Favelle, Former Director of Mental Health, Manitoba Health, and Board Member, Canadian Association of Suicide Prevention

Case Study #2 Diabetes

IN THIS SECOND CASE STUDY WE SEE HOW GENDER interacts with other health determinants. Again, this case study is not a detailed examination of a chronic disease, but an example of GBA. As in the first case study we use data from Manitoba as a whole. Regional Health Authorities can apply similar analysis to data from their own regions. Following the case study are some questions and ideas for RHAs to consider in planning gender-sensitive diabetes prevention and treatment programs.

A Gender-Based Analysis of Recent Manitoba Adult Diabetes Data

Diabetes Prevalence and Incidence

Diabetes is a major health concern in Manitoba. Manitoba Health reports that in 1999, there were 57,391 Manitobans living with diabetes. That represents 5.01% of the total population or 7.4% of adults 25 years and over. Of these, 29,850 were women and 27,541 were men.¹²

¹²Manitoba Health, 2002, 3, 11

In Canada as a whole, 4.4% of males and 3.9% of females have diabetes.¹³ This pattern is reversed in Manitoba, where more women than men live with the disease. The prevalence of diabetes (that is, the total number of cases) also continues to increase for both men and women in Manitoba. In 1999, the prevalence of diabetes among female Manitobans was 515 per 10,000 (5.2%) and the prevalence for male Manitobans was 487 per 10,000 (4.9%). This includes adults and children.

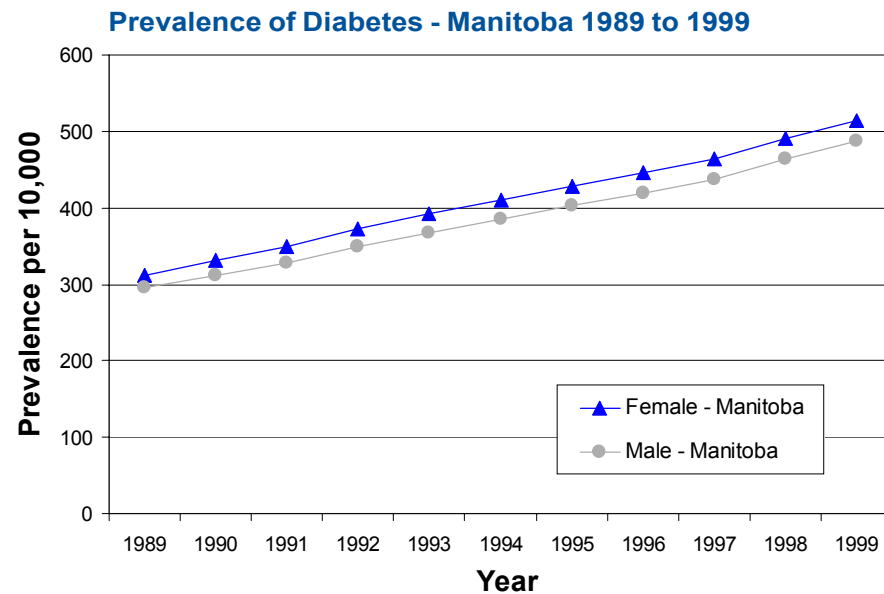
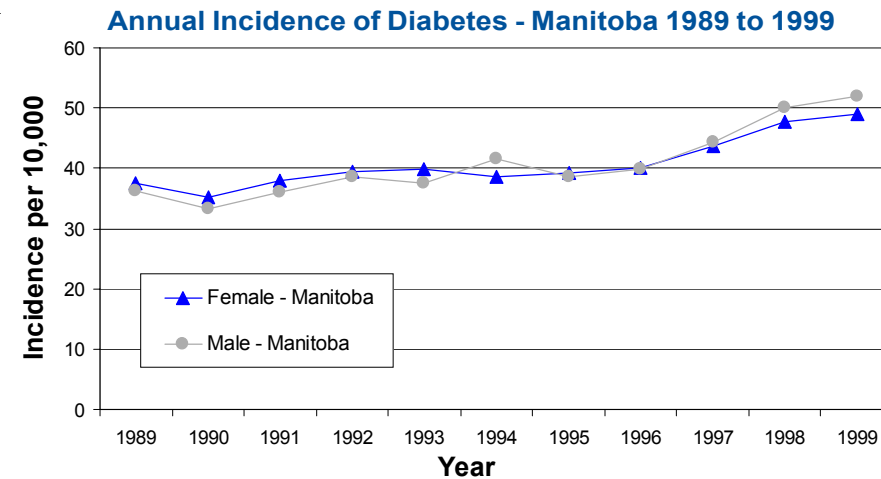


Figure 9.

Source: Epidemiology Unit and Chronic Disease Unit, Manitoba Health

The incidence of diabetes (the number of new cases diagnosed in a specified year) also continues to rise for both women and men. In the early 1990s and before, there were typically more Manitoba women than men diagnosed with diabetes each year.

While the rate of new cases has increased for both women and men since 1994, there have been more new cases reported annually among men. The annual incidence of diabetes for Manitoba men was 33.2 per 10,000 in 1990; by 1999 this had increased to 51.9 per 10,000, an increase of 56%. For women the annual incidence of diabetes had risen from 35.2 per 10,000 in 1990 to 49 per 10,000 in 1999, an increase of 39%.



Source: Epidemiology Unit and Chronic Disease Unit, Manitoba Health

Figure 10.

But looking at data by sex alone leaves out some important information. **Two other important factors to consider are age and Aboriginal ancestry.**

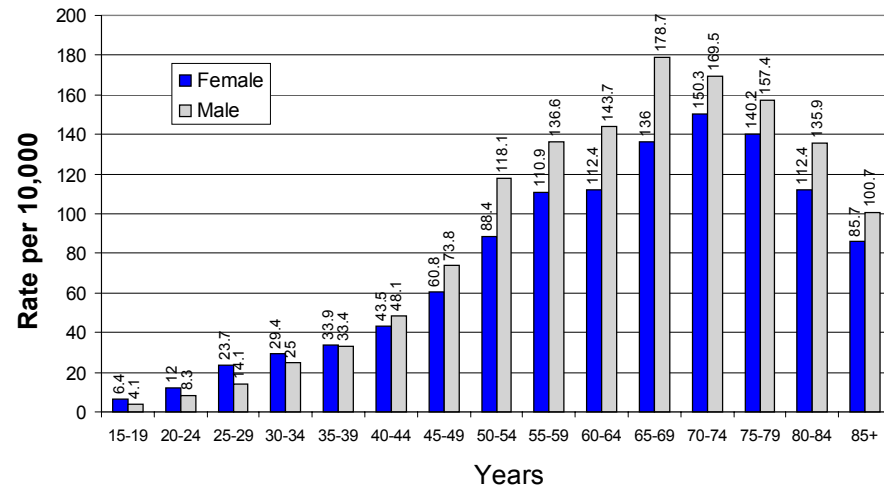
Age as a Factor in Diabetes

Let's now look at the same information taking both age and gender into consideration:

In Manitoba, women are more likely than men to be diagnosed with diabetes from ages 15 to 39. Those women who develop gestational diabetes during pregnancy are more likely than other women to later develop overt diabetes. *This is important because earlier onset of diabetes means an increased likelihood of developing complications later in life.*

Men are more likely to be diagnosed with diabetes from ages 40 and up.

Age Specific Incidence of Diabetes - Manitoba 1999



Source: Epidemiology Unit and Diabetes and Chronic Disease Unit, Manitoba Health

Figure 11.

Diabetes prevention, detection and treatment programs will, therefore be more effective if they are both gender and age sensitive in their approach.

Gender, Age and Aboriginal Ancestry

Aboriginal women and men bear a greater burden of illness than other Canadians. They are more likely to suffer from

chronic diseases including heart problems, hypertension, rheumatoid arthritis and diabetes.¹⁴ Aboriginal Manitobans are at much greater risk of developing diabetes than are other Manitobans.

There are more data available about diabetes among First Nations Manitobans* than for other Aboriginal people. In 1999, the incidence of new cases of diabetes among First Nations Manitobans was 74 cases per 10,000 compared with 49 per 10,000 for other Manitobans.

Among Manitoba First Nations people 50 years and older, 36 to 44% of the population in each age group has already been diagnosed with diabetes.¹⁵

Data recently published by Manitoba Health, in co-operation with the Manitoba Métis Federation, showed that in 1997, the age-standardized prevalence of diabetes among Métis 15 years of age and older as of December 31, 1997 was 9.8% for males and 11.3% for females . This was substantially higher than the prevalence among the total Manitoba population (Males 6.1%, Females 5.7%).¹⁶

Aboriginal women in particular are believed to be prone to diabetes. Approximately two-thirds of the First Nations people diagnosed with diabetes are women. This means that Aboriginal women are

¹⁴ Donner, 2002

¹⁵ Manitoba Health, 2002, 15

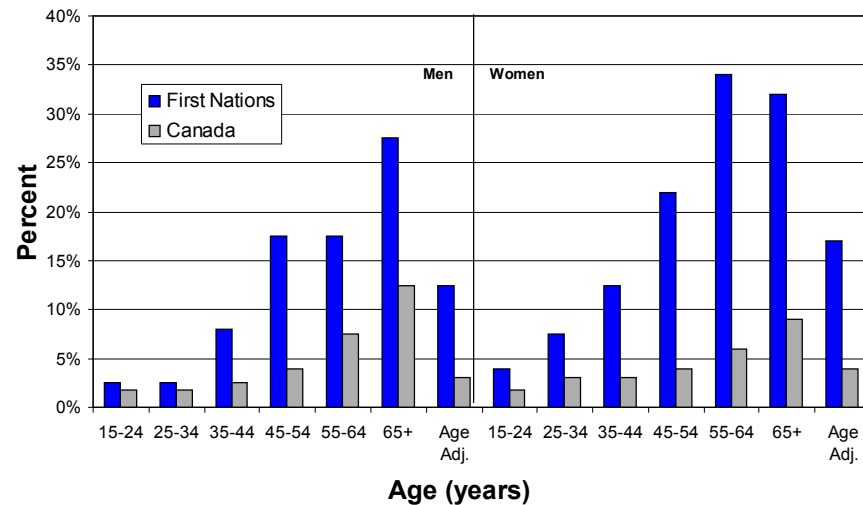
¹⁶ Kliewer, Mayer, and Wajda, 2002, 22

* First Nations Manitobans in this data set are those identified to MB Health as having treaty status.

contracting the disease at a rate roughly twice that of Aboriginal men...First Nations women have over 5 times the rate of diabetes compared to women in the general population.¹⁷

The figure below, reprinted from Health Canada, (*Diabetes Among Aboriginal People in Canada: The Evidence, 2000*) compares the risk of diabetes among First Nations people living on reserve with Canadians as a whole. It shows the greater burden of diabetes borne by First Nations people in general, and First Nations women in particular. **Note that in every age group, First Nations women have the highest rate of diabetes, compared to First Nations men and other Canadian women and men.**

Age-Sex Specific and Age Adjusted Prevalence of Self-reported Diabetes, First Nations On-Reserve and Canada



Source: First Nations and Inuit Regional Health Survey. National Report 1999

Figure 12.

¹⁷ Canadian Women’s Health Network, 2001/2002, 22

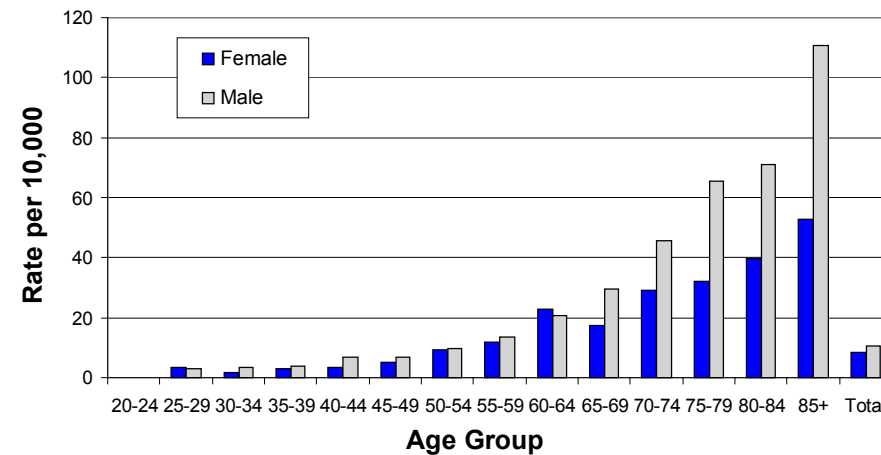
Therefore, in addition to being sensitive to age and gender, programs to prevent, detect and treat diabetes will be more effective if they are sensitive to the needs of women and men who are Aboriginal.

Complications of Diabetes

Those living with diabetes are also more at risk for long term complications of the disease which include heart disease, stroke, lower limb amputation, permanent vision loss and kidney (renal) failure. We know that the risk of complications such as these can be greatly reduced with proper control of blood glucose throughout the life of people who have diabetes.

Figures 13 and 14 show the rate of two of the most serious complications of diabetes – renal failure and lower limb amputations - among women and men.

Rate of Renal Failure - Manitoba 1999



Source: Epidemiology Unit and Diabetes and Chronic Disease Unit, Manitoba Health

Figure 13.

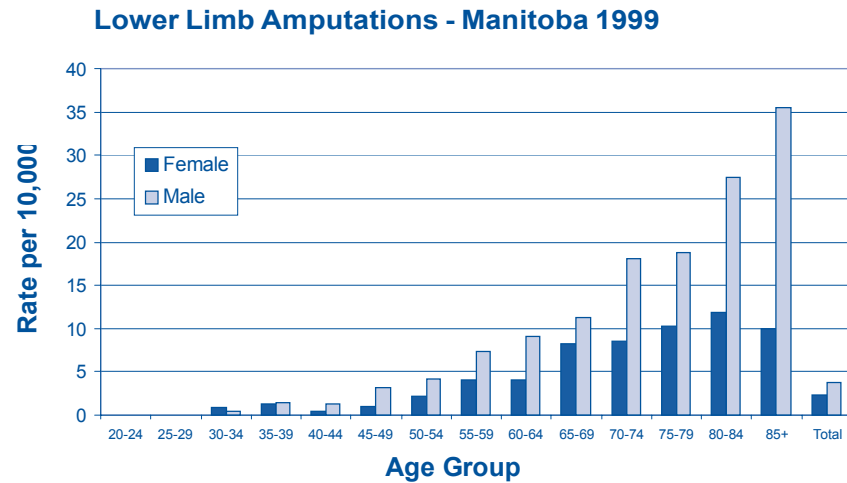


Figure 14.

Source: Epidemiology Unit and Chronic Disease Unit, Manitoba Health

Aboriginal people with diabetes have very high rates of complications of the disease. For example, in the First Nations population of Manitoba, persons with diabetes account for:

- 91% of limb amputations,
- 60% of hospitalizations for heart disease,
- 50% of hospitalizations for stroke,
- 41% of hospital days, and
- 30% of hospitalizations.¹⁸

Since men are at much greater risk of developing the complications of diabetes, a gender sensitive approach to their prevention is needed.

What happens when we also look at the differences among First Nations and non-First Nations women and men in Manitoba?

Just as First Nations Manitobans bear a much higher burden of diabetes, they also bear a higher burden of the complications of this disease. But here too, gender differences are significant.

¹⁸Manitoba Health, 1998

Renal Failure in Manitoba - 1989 to 1999

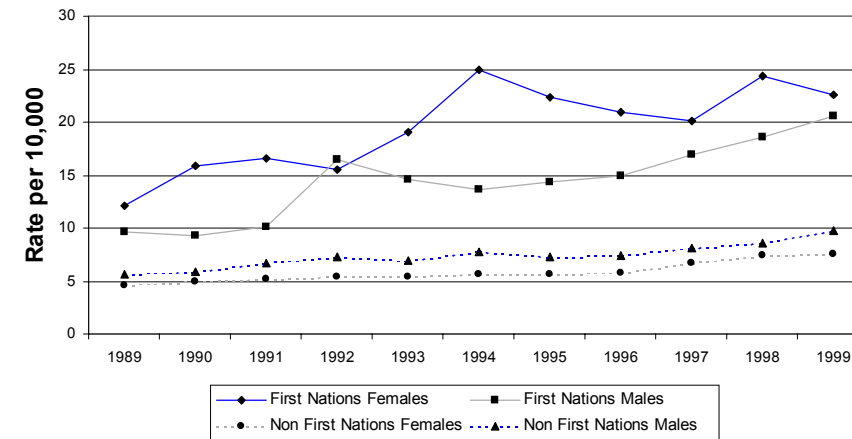


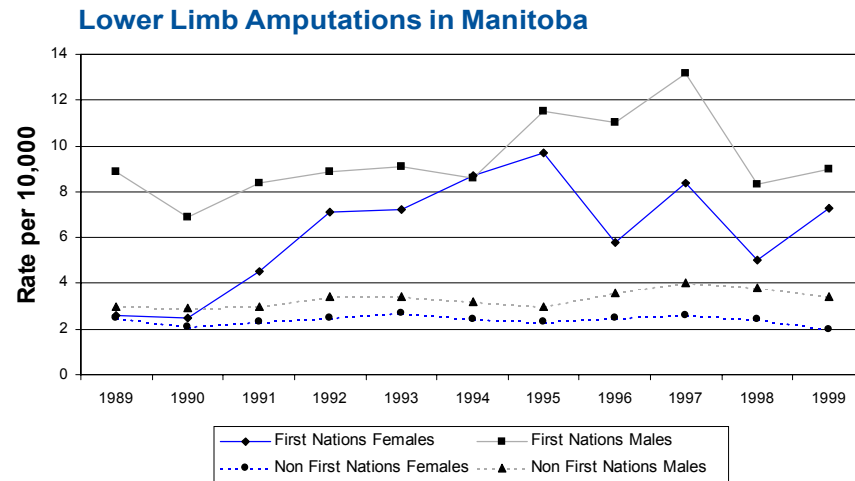
Figure 15.

Source: Epidemiology Unit and Diabetes and Chronic Disease Unit, Manitoba Health

Figure 15 shows that First Nations women are more likely to experience renal failure than either First Nations men or other Manitoba women or men. Looking only at the data by age and gender obscured this important fact.

The data for lower limb amputations also show the greater risk faced by First Nations Manitobans, but here it is First Nations men who are at greatest risk. Figure 16 also shows significant differences when compared annually. Explaining this is beyond the scope of this case study, but it might be related to access to surgical services, or referrals for surgery.

Figure 16.



Source: Epidemiology Unit and Diabetes and Chronic Disease Unit, Manitoba Health

But how will knowing this improve health planning?

In diabetes, prevention is critical to reducing the number of new cases and to lessening the burden of complications on those who live with diabetes, and on the health care system. Taking gender into consideration will enable health planners to design more successful prevention programs.

Incorporating Gender in Planning for Diabetes Prevention, Detection and Treatment

Typically, planning for diabetes treatment, detection and prevention has not taken gender into consideration. Even Manitoba Health’s 1998 publication *Diabetes: A Manitoba Strategy*, neither includes gender as a determinant of health, nor women and men as populations requiring special consideration. Health Canada’s 1999 *Diabetes in Canada* does

recognizes Aboriginal women as a population requiring special consideration because of their higher prevalence of diabetes, the risks of complications of pregnancy and the future risk for the child.

In 2001, Manitoba Health and the Manitoba Women’s Directorate jointly published Manitoba’s *Women’s Health Strategy*. The strategy acknowledges the role of gender as a determinant of population health. RHAs have the opportunity to take a leadership role in developing diabetes programming which incorporates the broader knowledge gained by using gender-based analysis.

Here are some points for RHAs to consider in planning diabetes programs for their regions.

1. Primary prevention of Type 2 diabetes focuses on modifiable risk factors. These are: obesity, physical inactivity and income adequacy.¹⁹

- What do we know about obesity and physical inactivity in our region?
- What factors contribute to physical inactivity and obesity among women and men? How are they different?
- How can we promote physical activity and healthy body weight among women in a way that supports and encourages healthy body images for women of all ages and sizes?

The Women’s Health Clinic in Winnipeg has launched an in-depth project dealing with the impact of income on the health of Manitoba women. For more information see <http://www.womenshealthclinic.org/advocacy.html#1>

¹⁹ Health Canada, 1999, 30 - 33. Health Canada considers income to be a modifiable risk factor. We understand this to mean that it is humanly constructed and can be changed at the societal level. Genetic endowment, for instance, is not modifiable.

Did You Know...

Violence is a major public health issue. Women (wives) are more likely than men (husbands) to be murdered; women are significantly more likely to be victims of sexual assault.²⁰

- How can we design programs to promote healthy body weight and physical activity which are accessible to, and appropriate for, Aboriginal women and men? With which Aboriginal organizations, federal and provincial departments should we consult?
 - In Canada and in Manitoba, women are more likely to be poor than men. Aboriginal women and senior women are among those most likely to be poor. What do we know about the income levels of the women and men in our region?
- 2. Secondary prevention of diabetes focuses on early detection through screening.** Manitoba Health recommends testing for Type 2 diabetes in individuals without risk factors every 3 years, beginning at age 45 and that individuals with risk factors should be tested more frequently and/or from an earlier age.²⁰
- How can we promote the appropriate use of screening for diabetes for women and men? Do we need different strategies to reach them? What would these be?
 - What kinds of strategies are needed to reach Aboriginal women and men in our region? What Aboriginal organizations and resources could assist us?
- 3. Tertiary prevention of diabetes focuses on preventing or delaying the complications of diabetes.** Tight glycemic control (keeping blood glucose levels in the desired range) reduces the rate of complications from diabetes. This in

²⁰Manitoba Health, 2002, 6

turn requires that those living with diabetes have the information necessary to manage their own condition.

- Do women and men need different types of diabetes education in order to successfully control their blood glucose levels? What would these be? How can we find out?
- How can we make our diabetes education programs most useful to Aboriginal women and men? With which Aboriginal organizations and resources can we consult and work? (Some resources may be available through Health Canada's *Aboriginal Diabetes Initiative*. See <<http://www.hc-sc.gc.ca/fnihb-dgspni/fnihb/chp/adi/index.htm>>)

These two case studies on suicide/self-inflicted injuries and diabetes show that, in addition to culture and age, looking at health data by sex provides a clearer picture of the impact of these serious health concerns on the Aboriginal population. It is important to note that suicide and diabetes are only two examples of serious health matters facing the Aboriginal population. In addition to the physiological symptoms of illness, the emotional trauma women carry is another factor affecting their wellness that needs consideration.

We need to ask further questions and explore the influence of gender, among other factors, as we work with Aboriginal communities to improve health outcomes and enhance promotion, prevention, education, treatment and support services.

Loretta Bayer
Director, Aboriginal Health Branch, Manitoba Health

Conclusions and Checklists

Using GBA to Improve Health Planning

GENDER-BASED ANALYSIS WILL ENRICH THE health planning process by providing RHAs with better information about the health status and health needs of the population. **By highlighting gender differences, planners can identify and give priority to those areas where gender-sensitive interventions will make a difference.**

The two case studies presented here are meant to provide a starting point for RHAs to improve their own capacity for gender based analysis. Other organizations, including the Prairie Women's Health Centre of Excellence, Manitoba Health's Women's Health Unit and the Winnipeg Women's Health Clinic are able to provide additional training and assistance. In addition, a list of written resources appears at the end of this workbook.

As we have seen from the case studies, "including gender" means much more than just presenting separate male and female data. **Here are a few questions to ask to help you to enhance GBA in your region.**

Did You Know... Women are the fastest growing risk group for HIV/AIDS, yet HIV/AIDS is mostly an invisible epidemic among women. The primary routes of transmission for women are heterosexual activity (64% of cases) and intravenous drug use (11% of cases). There is some evidence to suggest that gender factors may influence women's risk of the disease. There is also evidence to suggest that the efficacy of treatments may be affected by both sex (e.g., drug metabolism) and gender (e.g., lifestyles).²²

Questions to Ask When Analyzing Data

1. Are the data separated by sex (disaggregated)? Are they analyzed by sex? If not, how can we do that?
2. Were the data collected in a way that allowed for the full participation of women and men, boys and girls?
3. Have the data been analyzed considering gender both as a determinant of health and as an important influence on the other determinants of health?
4. Are women and men, boys and girls considered all together, or have differences in age and life-stage been considered? Has diversity been considered?
5. Do the data shed light on the situations of those women and men, boys and girls who carry a greater burden of illness, or whose health may be more vulnerable, including youth, seniors, those living on low incomes, people with disabilities, Aboriginal people, immigrants and refugees and those with different sexual orientations? What can the data tell us about the influence of gender on the health of women and men in these groups? For more information, see *Invisible Women*.²¹
6. Are the data available only at the household/family level, when the experiences and needs of women and men, girls and boys in the family may be different?
7. How can these data be used to help us to improve the health of the women and men, boys and girls in our region? How

²¹ Horne, Donner and Thurston, 2000, 30 - 41

²² Grant, 2002

can these data be used to help us to address gender inequities in the health of our population?

In summary, GBA has been incorporated into data analysis if:

- ✓ Sex disaggregated data are presented and analyzed;
- ✓ Women, girls, men and boys are fully represented in the data by sex and age, as appropriate;
- ✓ Data are available for individuals, not just for families;
- ✓ The effect of gender as a determinant of health has been considered;
- ✓ The influence of gender on other determinants has been considered;
- ✓ Data about diversity among women/girls and men/boys are presented and analyzed;
- ✓ Data about women/girls and men/boys who carry a greater burden of illness or whose health may be more vulnerable are presented and analyzed.

Questions to Ask in Program Planning

1. Was this program designed considering the similar and different needs of women and men, boys and girls? What resources exist locally and outside of our region to help to identify these needs?
2. Was the program designed considering what is already known about gender differences for this health issue?

²³ Grant, 2002

Did You Know... Men and women engage in different risk-taking behaviours related to their traditional gender roles, and as a result men have a greater propensity for risk-taking behaviours.²³

3. Have the views of women and girls, boys and men who will be using this program been included in its design? If not, how can we gain their input?
4. Are women and men, boys and girls considered all together, or have differences in age and life-stage been considered? Has the diversity of the population been considered?
5. Has this program been designed using the available information about the situations of those women and men who carry a greater burden of illness, or whose health may be more vulnerable, including youth and seniors, those living on low incomes, people with disabilities, Aboriginal people, immigrants and refugees and people with different sexual orientations? What do we know, and what can we find out, about the influence of gender on the health of women and men in these groups? Where can we go for additional information?
6. Does the design of this program perpetuate existing stereotypes about women and men, boys and girls?

In summary, GBA has been incorporated into program planning if the program was designed:

- ✓ Considering the similar and different needs of women, girls, men and boys;
- ✓ With input from the women/girls and men/boys who will use it;
- ✓ Using existing knowledge about gender differences;

- ✓ Considering diversity among women/girls and boys/men;
- ✓ Considering the particular needs of women/girls and boys/men who carry a greater burden of illness or whose health may be more vulnerable;
- ✓ To avoid perpetuating stereotypes about women/girls and boys/men.

Questions to Ask when Assessing the Health of the Community

1. Does the plan to gather information include women/girls and boys/men, as appropriate?
2. How will gender affect the ways in which women and men, boys and girls participate, or do not participate, in the project? How can we change the design of the project to encourage the equitable participation of both women, girls, men and boys?
3. Is the project designed so that we can collect information about the different needs and experiences of individual family members, rather than using the family as the basic unit of analysis? How do we include different types of families?
4. Has the project been designed with consideration of what is already known about gender differences for this health issue?
5. Is the project designed to gather information about the situations of those women/girls and men/boys who carry a greater burden of illness, or who may be more vulnerable? This could include youth and seniors, those living on low incomes, people with disabilities, Aboriginal people, immigrants and

Did You Know...

Poverty, a key determinant of health and longevity, is more common in women. It is associated with many of the leading causes of sickness, disability and death.²⁴

²⁴ Grant, 2002

refugees? What do we know, and what can we find out, about the influence of gender on the health of women and men in these groups? What resources exist locally and outside of our region to help us?

6. What other data about the health of our population is available, from either provincial or federal sources? Is it sex-disaggregated? Have I considered gender issues in analyzing this data?

In summary, gender-based analysis has been incorporated into the community health assessment projects if they:

- ✓ Appropriately include women/girls and men/boys as sources of information;
- ✓ Encourage the equitable participation of women/girls and men/boys;
- ✓ Collect information about the needs and experiences of individual family members, not just the family unit;
- ✓ Gather information about those women and girls, men and boys who carry a greater burden of illness or whose health may be more vulnerable;
- ✓ Use existing knowledge about gender differences;
- ✓ Include gender-based analysis in the analysis of other data which are included in the project.

References and Additional Resources

The list below is a sampling of some documents which may be helpful. It is not meant to be an exhaustive bibliography.

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A Checklist for Gender-based Analysis

Analyzing Data

- √ Present and analyze sex disaggregated data;
- √ Ensure that women, girls, men and boys are fully represented in the data, as appropriate;
- √ Present and analyze data for individuals, not just for families;
- √ Consider the effect of gender as a determinant of health;
- √ Present and analyze data about diversity among women, girls, men and boys;
- √ Present and analyze data about women, girls, men and boys who carry a greater burden of illness or whose health may be more vulnerable.

Program Planning

- √ Consider the similar and different needs of women, girls, men and boys;
- √ Design programs with input from women/girls and men/boys who will use them;
- √ Use existing knowledge about gender differences;
- √ Consider diversity among women, girls, men and boys;
- √ Consider the particular needs of women, girls, men and boys who carry a greater burden of illness or whose health may be more vulnerable;

Program Planning continued...

- √ Avoid perpetuating stereotypes about women, girls, boys and men.

Assessing the Health of the Community

- √ Include women, girls, men and boys as sources of information;
- √ Encourage the equitable participation of women and girls, men and boys;
- √ Gather information about the needs and experiences of individual family members, not just the family unit;
- √ Gather information about those women, girls, men and boys who carry a greater burden of illness or whose health may be more vulnerable;
- √ Use existing knowledge about gender differences;
- √ Include gender-based analysis in the analysis of other data which are included in the project.

Congratulations, you have just done a gender-based analysis.



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