SIGHTING GENDER BASED ANALYSIS: PHASE II OF INVISIBLE WOMEN

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With the assistance of Amanda Eisener, MA

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ABSTRACT

In 1999 the Prairie Women's Health Centre of Excellence (PWHCE) released a commissioned research report entitled: *Invisible Women: Gender and Health Planning in Manitoba and Saskatchewan and Models for Progress*. The report was based on an analysis of community health needs assessments and health planning documents, at a time when regionalized health care was relatively new. The report found very little evidence of gender analysis being used to inform health planning at the regional or district level. Upon the release of *Invisible Women*, both the province of Saskatchewan and the province of Manitoba expressed interest in developing greater emphasis on gender sensitivity in health planning.

The focus of this report is describing the process of Phase II of the *Invisible Women* project. Section I is a narrative and story of Phase II as it unfolded over several years. Section II is an analysis using frameworks of policy analysis. Using the frameworks illuminates why early conceptions of the Phase II project were such a challenge, particularly given the complexity of health policy and planning in decentralized policy networks. It is important to successful policy processes that Policy Formulation activities (e.g. discussing various solutions) not be confused with Implementation activities (e.g. workbooks, guidelines, training). The work of the PWHCE in building good relationships with members of the policy community is important to achieving the Centre's long-term goals and should be valued as such. In the long-run, this project, combined with other activities, may build policy networks that will benefit women's health.

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PREFACE

This report is necessarily the responsibility of the author, however, it would not have been possible without the direct assistance of several people. Firstly, Amanda Eisener conducted and analyzed interviews and assisted through offering insightful questions and pointing to gaps in information. She drafted the first part of this report, the narrative of the project. Tammy Horne and Lissa Donner provided background information on *Invisible Women: Phase I*, read drafts of this report and provided additional feedback. The PWHCE staff, Kay Willson and Margaret Haworth-Brockman provided copies of correspondence regarding Phase I, participated in interviews and also provided feedback. Other people were also interviewed, but to protect confidentiality they will not be named.

I believe two issues are important to acknowledge at the forefront: potential bias arising from my previous relationship to *Invisible Women, Phases I and II* and the focus of this report. I was a co-investigator on Phase I. I also began as a co-participant in Phase II, with the plan that I would lead on evaluative research while Tammy Horne and Lissa Donner would lead on design and implementation. I participated in the first meetings around Phase II and several teleconferences. Over time I became increasingly frustrated with the project and the lack of an opportunity to do evaluative research. I even questioned whether this was an appropriate activity for a Centre of Excellence in Women's Health. At the same time I maintained my respect for the expertise of the consultants and the PWHCE staff and their commitment to and ability to create positive change. I am convinced that the PWHCE, being part of Canada's Centres of Excellence in Women's Health Program, is very important and making a substantial contribution to women's health research and policy in Canada; therefore, I was excited to have the opportunity to undertake this review.

The focus of this report is describing the process of Phase II. I began using a program evaluation framework that constructed Phase II as an intervention for which processes and outcomes could be assessed. I teach health program planning and evaluation and am involved in evaluations that usually involve a program, defined as a set of activities intended to achieve specified outcomes (Casebeer & Thurston, 1995; Thurston, Vollman, & Burgess, 2002; Thurston & Potvin, 2002b; Thurston, Graham, & Hatfield, 2002). During the process of analyzing the data and as a result of other work underway, however, I began to view Phase II not as program but as an attempt to change health policy. Specifically, I began to see links to the work I was doing on public participation in health policy development (Wiebe, MacKean, & Thurston, 1998; Thurston, Scott, & Crow, 1997). This was a major shift in orientation and was significant in terms of making sense of my own experience with the project and the data.

I view this report as akin to a third phase for *Invisible Women*, rather than as an external judgment of past work. I believe that being an insider increased my ability to describe and assess Phase II (Patton, 1997; Guba & Lincoln, 1989). Triangulation of the data and validation by participants increased transferability and credibility (Creswell, 1998), as did having a research assistant who had no previous knowledge of the project.

However, the accounts that follow can only be partial and "depend on the values, assumptions, presuppositions and political motivations of the one doing the evaluating" (Bacchi, 1999).

Produced from a variety of sources representing various perspectives, this narrative serves as an analysis of the process of a project that tried to facilitate working in partnership with provincial partners to implement gender analysis in health authorities and health districts in Manitoba and Saskatchewan. Narratives written by consultants, interviews with key individuals, meeting minutes, e-mails and other documents are combined (in some cases verbatim) to form a history of the project in detail. In analyzing the ways in which Phase II unfolded, issues are identified in a way that does not try to ascribe blame for any perceived failures or cause harm to any participants. Hopefully, the findings will be helpful to others who might try to accomplish similar goals in other projects.

This report is in two sections. The first contains a story of *Invisible Women Phase II*. The second is an analysis using frameworks of policy analysis.

SECTION I: THE STORY OF INVISIBLE WOMEN PHASE II

Background

The Prairie Women's Health Centre of Excellence (PWHCE) is funded by the Women's Health Bureau, Health Canada, to compile information, support research and develop policy advice which will enable the health system to become more responsive to women's health needs in Manitoba and Saskatchewan, partnering with other Centres of Excellence in a national program. In November 1999, the PWHCE released a research report entitled *Invisible Women: Gender and Health Planning in Manitoba and Saskatchewan and Models for Progress*, by Tammy Horne, Lissa Donner, and Wilfreda Thurston. The report was based on an analysis of community health needs assessments and health planning documents developed at the regional or district level, as well as interviews with representatives of health districts (Saskatchewan) and regional health authorities (Manitoba). Regionalization was relatively new when *Invisible Women* was commissioned. The documents and the interviews analyzed in this study revealed very little evidence of gender analysis being used to inform health planning at the regional or district level. Information on health needs was rarely disaggregated by sex, and consultations with women's groups were the exception rather than the rule. When women's health needs were identified, they were often focused somewhat narrowly on women's reproductive health or women's assumed responsibility for the health and care of their families. The research report also contained information about gender-sensitive health planning efforts in other jurisdictions, to provide models for regional health planners who want to find ways to incorporate gender analysis into their work.

The lack of attention to identifying and planning for women's health needs contradicts international, federal, and provincial commitments to employ gender-based analysis in public policies and programs. While both Saskatchewan Health and Manitoba Health now recognize gender as an important determinant of health, this recognition had not yet been reflected in practice though regional and district health planning processes.

From the beginning of Phase II, evaluation was considered an integral component to assess the usefulness of approaches taken to implement gender analysis in health planning. As the project progressed, and the prospect of having an intervention or project to evaluate diminished, the need to record the many challenges faced in the process of this project became apparent. This need became

even more pressing in mid-winter of 2001/2002 when there was uncertainty over future funding for the Centres of Excellence. Rather than lose all opportunity to record the many challenges of this project, the PWHCE Executive Director, using funds set aside in the 2001/2002 fiscal year, commissioned this narrative.

Initiating Invisible Women: Phase II

In the Winter of 1999, PWHCE staff initiated contact with key individuals in both Manitoba and Saskatchewan to discuss their reactions to the Phase I report and to explore the possibility of working with them towards implementing some form of gender-sensitive health planning in their respective departments. Through discussions, a pilot project was proposed and envisioned as a way to develop practical tools to assist regions and districts in including gender issues in their health planning and community health assessments. It was believed that beginning work on a smaller scale at the district or health authority level would demonstrate both the feasibility and the benefits of gender analysis in health planning. The timeline of events for Phase II are described in Table 1. This illustrates the complexity of a bi-provincial project.

Table 1: Timeline of Events

Timeline	*Manitoba*	*Saskatchewan*
November 1999	Invisible Women Released	Invisible Women Released
November 15, 1999		PWHCE Meets with ministers and government representatives
November 17, 1999	PWHCE Meets with ministers and government representatives.	
December 17, 1999		Meeting with PWHCE, SK Women's Secretariat, and Saskatchewan Health
January 2000		PWHCE representative attends dialogue on health planning
January 4, 2000	PWHCE Director meets with MB Health & Women's Directorate	
January 17, 2000	CAHR submitted	CAHR submitted
March 2000	PWHCE draft framework	PWHCE draft framework
March 2000		Presentation to the Health Evaluation Network
March? 2000		2 versions of pilot drafted
August 2000		Touchwood Qu'Appelle RHD withdraws from project
September 2000	MB Minister of Health commits money	
September 22, 2000	Bi-Provincial Meeting	Bi-Provincial Meeting
October 2000	MB announces Women's Health Strategy	
November 2000		Planning Meeting
November 2000		SK Touchwood-Qu'Appelle comes back in
January 2001		Teleconference to discuss developments

Continued...

Timeline	*Manitoba*	*Saskatchewan*
January 2001	Decision to proceed with "workbook"	
March 2001		Saskatchewan Women's Secretariat commits $10,000
April 2001		SK Touchwood Qu'Appelle withdraws from project second time
October 15, 2001		2001Gender-Based Analysis and Health Planning Workshop held in Regina

The government infrastructure involved in planning Phase II varied between provinces. Reporting to the Saskatchewan Minister Responsible for the Status of Women, the Saskatchewan Women's Secretariat has a mandate to promote gender-based analysis of public policies.[1] Saskatchewan Health has a mandate to provide information and support to enable health districts to assess community health needs and develop appropriate plans for the delivery of health services. The District Management Services Branch of Saskatchewan Health communicates and facilitates an understanding of government priorities and policies, supports and assists districts in implementing initiatives to address government and district priorities, and monitors the progress of districts in meeting provincial health system objectives.

In Manitoba, the Minister Responsible for the Status of Women works with the Manitoba Women's Directorate and the Manitoba Women's Advisory Council to represent the interests of women living in Manitoba. Among the Women's Directorate's long range plans are the goals to, "raise awareness of women's health issues and advocate for recognition of women's needs in public health policy," and to, "promote the routine use of gender-inclusive analysis in government decision-making, policies and programs".[2] The Women's Health Unit of Manitoba Health has a mandate to ensure that the health status of women in Manitoba is addressed in a coordinated, sustainable, equitable, and gender-sensitive manner.

PWHCE sought top-down support for Phase II. It was hoped that, with support from the Health Departments in both provinces, RHA/HDs could carry out their existing health planning duties using gender-based analysis. This information would then work its way back to the Health Departments, which could then use gender sensitive information in their provincial health planning strategies. The people in Districts and Authorities who were contacts for Phase II varied in actual position and most were assigned or, in a few cases, had voluntarily taken on this project in addition to their other responsibilities.

On November 15, 1999, PWHCE representatives and a member of the research team met with Saskatchewan officials including the Hon. Judy Junor, Saskatchewan

[1] The Saskatchewan Women's Secretariat was disbanded and enfolded in other government departments in April 2003.

[2] From the Manitoba Women's Directorate website, http://www.gov.mb.ca/wd/

Associate Minister of Health, the Hon. Joanne Crofford, Saskatchewan Minister Responsible for the Status of Women, and officials of the Saskatchewan Women's Secretariat and Saskatchewan Health, to present and discuss the findings of the *Invisible Women* report. The Ministers responded positively to the PWHCE's proposal for a second phase of the project and committed to establish a partnership with the PWHCE, health districts, Saskatchewan Health and the Women's Secretariat to develop practical strategies for implementation of gender-based analysis. The Women's Secretariat offered the use of some of their existing resources.[3] As a result of subsequent discussions with PWHCE staff, three health districts (Regina, Touchwood-Qu'Appelle, and Midwest) also expressed interest in participating in this project.

On November 17, 1999, PWHCE representatives and a member of the PWHCE research team met with officials in Manitoba including the Hon. Diane McGifford, Minister Responsible for the Status of Women; Sue Hicks, Associate Deputy Minister of Health; the Assistant Deputy Minister of Health; the Special Assistant to the Minister of Health (representing the Minister of Health); and the Assistant Deputy Minister Responsible for the Manitoba Women's Directorate. The response to both the report and the proposed second phase pilot project was positive and there was agreement that Manitoba Health and the Women's Directorate would explore how the ministries and regional health authorities could work together to plan and implement the second phase pilot project.[4] As a result of subsequent discussions with PWHCE staff, two Regional Health Authorities in Manitoba, South Eastman Health/Santé Sud-Est Inc. and South Westman Regional Health Authority Inc., also expressed an interest in working with PWHCE to develop more gender-sensitive health planning tools and processes.

Beyond the Ministerial level, feedback from other departmental and district staff was not entirely positive. Some individuals felt that the work that they were already doing in gender analysis was not being adequately acknowledged. For example, Saskatchewan Health recently updated the Population Health Resource Binder to include more discussion of gender as a determinant of health. Despite the initial negative reaction, there was an expressed an interest in working with PWHCE to increase the use of gender-based analysis in health planning.

Given the limited human and financial resources of this project, the PWHCE sought to coordinate activities through a bi-provincial model thus reducing the amount of staff time and administrative resources needed while pooling ideas and strategies from both provinces. In March 2000, PWHCE staff drafted a framework discussion paper for a bi-provincial gender and health-planning project to facilitate this planning process and as a means of working towards a consensus of the project components.

[3] From meeting minutes, Women's Secretariat, Regina, December 17, 1999.

[4] PWHCE "Gender in Health Planning Pilot Project - Background," distributed as part of the Meeting Minutes and Notes from the September 22, 2000 bi-provincial meeting.

Linda DuBick, Executive Director of PWHCE at that time, was committed to a bi-provincial project on gender and health planning and proposed that the next step was a bi-provincial planning meeting among the partners. Some partners suggested that the provincial differences might be more adequately addressed through two separate projects. Nevertheless, representatives of Saskatchewan Health, Saskatchewan Women's Secretariat, and the Regina Health District agreed to travel to Winnipeg for a bi-provincial planning meeting. The difficulties encountered in planning provincial components of the project, and in setting up this first bi-provincial meeting (first planned for Spring 2000 and then postponed to September 2000) were in many ways indicative of problems encountered later.

Assumptions and Resources Behind Phase II

From the outset, PWHCE wanted to develop a project that would both move gender analysis in health forward and would include regional health authorities (including both Manitoba Regional Health Authorities and Saskatchewan Health Districts) and government departmental staff in the design, implementation and evaluation of the project, thus demonstrating that this type of co-operation was both possible and beneficial.

The specific components of the pilot project were to be developed in consultation with the partners according to their identified needs. Overall, the pilot project was to be designed to build capacity in gender analysis in the design of health needs assessments and health planning processes while respecting the diversity within, and the individuality of, participating regional health bodies.

Key assumptions surrounding this project included:

1. The partner organizations share a recognition that gender is one of several important factors determining the health of individuals and communities.

2. The partner organizations are committed to the development of public policies and programs which will help to maintain and improve the health of Saskatchewan and Manitoba residents.

3. The partner organizations agree that gender-based analysis of community health needs is an important component of health planning which can contribute useful information to help the health system become more responsive to women's and men's health needs.

4. It is essential for the pilot project to be feasible and strategic - that is, the project will be designed in a manner that is sensitive to the pressures confronting all the partners, particularly the pressure of financial and human resource management, and will emphasize practical approaches.

5. The pilot project will recognize that the level of support provided by each partner will be subject to negotiation that will consider respective needs and priorities, and limited resources.

6. The pilot project will be a collaborative initiative among the partners. Each will be a full participant in the design, implementation and review of the project. [5]

As a means to secure additional funding for this project, a Letter of Intent proposing an expanded gender and health research program through a Community Alliance for Health Research (CAHR) was submitted to the Social Science and Humanities Research Council (SSHRC) on January 17, 2000. The Letter of Intent outlined the research design and emphasized the collaborative intent of this project. Letters of support accompanied this submission from partners representing Saskatchewan Health, the Saskatchewan Women's Secretariat, the Saskatchewan Population Health and Evaluation Research Unit, Regina Health District (SK), Touchwood-Qu'Appelle Health District (SK), and the Midwest Health District (SK), as well as Manitoba Health, the Manitoba Women's Directorate, South Eastman Health/Santé Sud-Est Inc. (MB), South Westman Regional Health Authority Inc.(MB), and the Women's Health Clinic in Winnipeg.[6] This application was unsuccessful but it provided an opportunity for communications and consolidating relationships among the partners in the proposed Phase II.

The PWHCE committed $20,000[7] over two years to continue work in the area of gender and health planning in the two provinces. The PWHCE also contributed administrative support to the project, including project coordination services, and items such as long-distance teleconferencing and photocopying costs. The PWHCE staff and the members of the *Invisible Women* research team were available to contribute their expertise on gender and health planning, and to help coordinate a pilot project. In return, project partners were asked to contribute to project costs by means of in-kind contributions (e.g., sex-disaggregated data, staff release time, etc.) and financial contributions towards the costs of the project (e.g., team fees, travel costs for the purpose of project planning and steering committee meetings, etc.).[8] In September 2000, Manitoba Health made a two-year commitment of $20,000 towards their part of this project. The Saskatchewan Women's Secretariat committed $10,000 in February 2001.

We will next briefly describe the planning processes that took place in each province prior to the bi-provincial planning meeting. We will then describe by province the Phase II activities that followed the bi-provincial meeting.

Planning in Saskatchewan

Shortly after the PWHCE meeting with ministers, on December 17, 1999 and January 12, 2000, representatives from Saskatchewan

[5] These assumptions were presented in a document produced by PWHCE, "Gender in Health Planning Pilot Project - Framework Discussion Paper, March 29, 2000."

[6] PWHCE, "Gender in Health Planning Pilot Project - Framework Discussion Paper", March 29, 2000.

[7] This amount represents 10% of the PWHCE's research budget in each of 2000/01 and 2001/2.

[8] PWHCE, "Gender in Health Planning Pilot Project - Framework Discussion Paper", March 29, 2000.

Health and the Saskatchewan Women's Secretariat met with PWHCE Saskatchewan Program Coordinators to initiate a follow-up collaboration. They identified two major areas of future work: to arrange opportunities for further dissemination and discussion of the *Invisible Women* report findings, and to begin planning a pilot project on gender and health planning in partnership with two or three health districts in Saskatchewan.[9]

In January 2000 it was decided that PWHCE staff would consult with the health districts that had expressed an interest in the pilot project to get a clearer idea of their expectations and to clarify the project design. Three districts in Saskatchewan (Regina, Touchwood-Qu'Appelle, and Midwest) had expressed an interest in working with the PWHCE to develop more gender-sensitive health planning tools and processes. Work in a northern health district was also recognized as being important but not considered feasible without additional sources of funding.[10] Two versions of the pilot project in Saskatchewan were then to be drafted: one with limited resources, and a version with substantial external funding (in hopes of a successful SSHRC-CAHR grant).[11] With a clear framework in hand, it was hoped that feedback and commitments could be made and then used to brief other project partners.

Despite these drafts, Saskatchewan Health wanted more specific information on the extent of the information and analysis requirements before access to sex-disaggregated data could be made available. Saskatchewan Health reiterated that there would be no monetary resources to support this project and that any human resources involved would need to be clearly defined.

While the overall goal of incorporating gender-based analysis into health planning was clear and recognized as important, the specific actions, roles, and responsibilities individuals from both sides would take in this process and the resources these actions would require remained undefined.

It was suggested that a member of the *Invisible Women* research team or a representative from PWHCE meet with other members within Saskatchewan Health, namely the District Management Services Branch (DMSB), the CEOs Forum, or the Health Evaluation Network.[12] A PWHCE staff member gave a presentation on gender and health planning to a meeting of consultants within the District Management Services Branch and other Saskatchewan Health staff in January 2000. Two PWHCE staff members worked with a policy analyst from the Women's Secretariat to provide a workshop on gender and health planning for the Health Evaluation Network in March 2000. While these meetings provided opportunities to promote the inclusion of gender analysis in health planning, the participants in these meetings were not directly involved in efforts to shape a pilot project within the participating health districts.

Among the many ideas and suggestions

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9 "Gender and Health Planning Project (Saskatchewan): Follow-up to the Invisible Women Research Report, Draft Framework" February 2000.

10 Meeting minutes, December 17, 1999, Women's Secretariat, Regina SK.

11 Meeting minutes, January 12, 2000, Saskatchewan Health, Regina SK.

12 Meeting minutes, December 17, 1999, Women's Secretariat, Regina SK.

brought forward in these meetings was a repeated desire for training to increase senior management and district staff's understanding of the need for gender analysis in health planning. However, both the PWHCE and the Saskatchewan Women's Secretariat felt that a one-time workshop or training event on gender and health planning was not sufficient to meet the goals of the pilot project. As a compromise, efforts were made to respond to the expressed need for a training event or workshop that would also serve as a springboard to further work in a longer-term process that would include efforts to implement gender analysis in health planning done by the participating health districts. While tools for gender-based analysis were generally available (for example, documents addressing gender analysis prepared by the Women's Secretariat), there was an overall agreement that resource materials specifically focused on gender-based analysis of health needs, policies and programs should be further developed and presented at such a workshop.

PWHCE staff members and a Senior Policy Analyst from the Women's Secretariat were invited to give a presentation to the Health Evaluation Network in March 2000. Key issues emerging from this meeting included:

- A need to clarify what is meant by health planning in terms of the processes and levels of government involved.
- The need to be clear about departmental and jurisdiction boundaries and an identification of how health determinants are affected by the policies of different departments and jurisdictions.
- A need to understand the context in which regional health planning occurs in terms of such factors as the legal context of the Health Districts Act, and fiscal context of current funding arrangements, the planning process of the provinces, etc.[13]

In these initial meetings, key players accentuated the need for PWHCE to understand how the health systems they were working with operated. It was felt that the research/consultants on gender and health planning should provide more input on the kinds of services they would be able to offer. At the same time, it was hoped that project partners would share more of their knowledge of the systems in which they worked. The attempt to share knowledge proved to be one of the continuing challenges to the collaborative nature of the project design.

Planning in Manitoba

On January 4, 2000, the PWHCE Executive Director (Linda DuBick) met with representatives from Manitoba Health, the Manitoba Women's Directorate, and various staff members to initiate discussions surrounding Phase II and the SSHRC-CAHR program proposal. There was general agreement that the second phase pilot project would be explored, contingent on discussion with potential partners.[14]

The Women's Health Unit of Manitoba Health was actively supportive in

[13] Meeting minutes, January 12, 2000, Saskatchewan Health, Regina SK.
[14] PWHCE, "Gender in Health Planning Pilot Project - Framework Discussion Paper," March 29, 2000.

implementing the second phase of *Invisible Women*. In contrast to activities in Saskatchewan, Manitoba Health was preparing its *Women's Health Strategy*, thus providing both a framework and political commitments to pursue implementing recommendations outlined in *Invisible Women.* Working with PWHCE, the Women's Health Unit pursued an active role in identifying potential tools and strategies to assist in gender-based analysis in health planning at the Regional Health Authority level.

The Bi-Provincial Meeting, September 22, 2000

The bi-provincial meeting was a significant event in the life of Phase II. It was scheduled to develop a realistic plan for a pilot project on gender and health planning in partnership with participating health districts, regional health authorities, Ministries of Health and Ministries Responsible for the Status of Women in Manitoba and Saskatchewan, and to establish a steering committee for the pilot project. The bi-provincial planning meeting was held in Winnipeg on September 22, 2000, six months later than originally hoped. Of the invited consultants and staff, eighteen women represented their organizations as partners in the pilot project as well as the newly appointed PWHCE Executive Director.

In preparation for the meeting, PWHCE staff and one of the authors of *Invisible Women*, drafted a Potential Outcomes document that included a menu of potential results for the pilot project in both provinces. Working from these various options, meeting participants were asked to define overall goals, objectives and potential outcomes for the pilot project as a whole, recognizing that the project would take shape differently in each district/region and province.[15]

As a result of discussions at the meeting on September 22, 2000, *process* oriented goals and objectives were rewritten towards more specific project *objectives* and specific potential outcomes. The evaluative component of the project was not included among these goals. The amendments are bolded below:

Goals:

a. To contribute to the development of a health system which is more aware of, and responsive to, women's (and men's) health needs;

b. To develop, implement and evaluate practical tools for gender-sensitive health planning and to increase the capacity of provincial and regional health bodies to incorporate gender analysis into their needs assessment and planning processes. **To increase the capacity of provincial health departments and health districts/regional health authorities to incorporate gender analysis into needs assessment and planning processes.**

Objectives:

a. Provide training in gender-sensitive health planning for regional and provincial health system personnel; **Regional/**

[15] PWHCE "Gender in Health Planning Pilot Project - Background," distributed as part of the Meeting Minutes and Notes from the September 22, 2000 bi-provincial meeting.

district and provincial health system personnel will demonstrate increased knowledge of the principles of, and strategies for, gender-sensitive health planning;

b. Work with personnel from regional health bodies to incorporate gender analysis into their needs assessment and health planning processes **Regional/district and provincial health personnel will have a strategy for the application of gender-sensitive health planning in their work;**

c. Develop tools and guidelines for gender-sensitive health planning; **Regional/ district and provincial health personnel will have a strategy for involvement of women and men in their communities in gender-sensitive health planning;**

d. Document the experience of the regional health bodies involved in the pilot project, and analyze the factors which facilitate or hinder their efforts to implement gender-sensitive health planning **Provincial departments will demonstrate support to the health district/regional health authorities for the project.**

From the options presented at the meeting, Saskatchewan representatives (including Saskatchewan Health, the Women's Secretariat, and the Regina Health District) continued to favor a training approach that would include ways to better use sex-disaggregated data from Saskatchewan Health in needs assessments and health plans. They also expressed a need for staff training on the importance of gender-based analysis and hoped to use PWHCE funds to do so. Manitoba Health continued to want "practical tools for gender analysis," which would, in the end, take the form of a workbook (discussed in more detail later).

There was some concern among the consultants over some of the suggestions made at the meeting. The provision of training on gender-based analysis was intended to support other potential outcomes, not serve as a replacement for them. The consultants were concerned that limited PWHCE funds would be used to train staff even though staff training is a core government responsibility. Further, successful staff training in itself does not address health planning. They argued that if training was the work to be done in Saskatchewan, the training should be targeted at Health District staff, not Departmental staff, and that one or more of the other potential outcomes be included as examples during the training and in follow-up after the training.[16]

These changes marked a permanent shift in focus from the collaborative efforts envisioned in *Invisible Women* towards material/products/tools to be developed and coordinated by the PWHCE. Recommendations made in *Invisible Women* envisioned a process whereby the Regional Health Authorities and Health Districts would be involved in the design, implementation and evaluation of the project. For the most part, these agencies or organizations did not provide sufficient human or financial resources for such an endeavor. RHA/HDs saw gender-based

[16] E-mail, "Follow up to planning meeting," September 25, 2000, Lissa Donner.

approaches as an addition to their already heavy workloads. They could not see this as being integrated into their existing work. The provisions of training and practical tools were thought by some partners to be realistic "first steps" towards the incorporation of gender-based analysis in future work.

Saskatchewan Health and the Women's Secretariat (SK) indicated that they had reservations about the bi-provincial structure outlined in the framework as they felt it was too cumbersome and would create unnecessary delays.[17] There was very little or no money for out-of-province travel and limited time to attend meetings in another province, and to some extent, a different region/district. Instead, it was felt that resources should be focused at the district level. There was an expressed interest in attending a bi-provincial meeting with Manitoba at the end of the project so that ideas could be shared between the two provinces.[18]

Partly as a result of discussions during the meeting and partly due to the decisions made by the new PWHCE Executive Director, it was decided that this initiative would not be implemented bi-provincially – each province would work towards their own set of goals and the end results and resource tools would be shared, not developed together. It was decided that one small central project steering committee with two provincial steering committees would be established in recognition of the different ways in which the project unfolded in the two provinces.

After September 22, 2000, follow-up meetings with the RHA/HDs in Saskatchewan and Manitoba were planned to identify possible projects. Although discussions worked towards the goals set out during the September 22 meeting, it was difficult for RHA/HDs to identify specific gender and health planning projects for their areas without first knowing what internal resources would be required to undertake the project. From the perspective of PWHCE, it was difficult to direct the consultants without first knowing details of the specific projects. Adding to this situation was that PWHCE projects had to be completed in time for the results to be disseminated prior to the end of their fiscal year, March 2002.[19] PWHCE tried to find different ways to approach the pilot project so that it could provide better direction to the RHA/HDs to result in meaningful outcomes.[20] In the end, despite best intentions, what the follow-up to *Invisible Women* was envisioned to be "amounted to very little," according to two key participants.

Implementation in Saskatchewan

A planning meeting of project partners in Saskatchewan was held on November 24, 2000. In this meeting and subsequent discussions, partners identified a number of challenges facing district personnel who wanted to incorporate gender analysis in their

[17] Meeting minutes (BT), June 9, 2000.

[18] June 9, 2000 meeting minutes provided by Tammy Horne and W.E. Thurston.

[19] March 2002 was scheduled to end the original, federally funded Centres of Excellence mandate.

[20] "Invisible Women - Phase 2: Gender and Health Planning — Draft Proposal for Project, (January 25, 2001)".

district health planning. Table 2 lists several of these challenges and the ideas offered by PWHCE as possible opportunities to meet these challenges:[21]

Table 2: Challenges to Gender Analysis Implementation

Challenges in Saskatchewan	*Opportunities Provided by PWHCE*
Health and district personnel have many other demands on their time.	Compilation of sex-disaggregated data could make it easier to find information about women's and men's health needs.
Health district personnel may be unfamiliar with gender-based analysis since health planning guidelines have often been gender-blind.	Consultants can provide introductory training and be available to provide guidance and advice on how to incorporate gender-based analysis in health planning.
Gender-based analysis tools have not been tailored to the specific requirements of district level health planning.	District personnel could work with consultants and project partners to ensure that the tools were adapted to be practical and meaningful in their specific situations.
Health district leadership may not see gender-sensitive health planning as a priority.	Consultants could present information on the importance and practical benefits of gender-sensitive health planning, as part of initial training.
District health planning can be quite complex and involve many people.	By focusing on planning for one or two priority areas, defined by each district, gender-sensitive planning can be thorough, meaningful and relevant to decision-makers.
Compiling information on women's (and men's) health needs does not automatically lead to more responsive services, and can, in fact lead to increased citizen/consumer frustration.	Compiling information from a variety of sources could engage more organizations in the development of more responsive services and provide opportunities to profile successful programs. However, governments and districts need to be prepared to make changes based on new evidence of community needs.

PWHCE developed a draft proposal for activities in Saskatchewan for discussion at a teleconference in January 2001. Specifically, it was proposed that PWHCE contract with a consultant from the *Invisible Women* team to provide the following services in Saskatchewan:

- Provide a training workshop for health district personnel to provide an introduction to gender analysis in health planning (including, but not limited to, community health needs assessments).
- Demonstrate how to use sex-disaggregated population health data and a variety of information sources to enhance gender analysis of health needs in each district.
- Consult with health district personnel to identify one or two planning processes that are district priorities.
- Provide practical advice and outline a strategy for incorporating gender analysis into the selected planning processes.
- Mentor district personnel as they attempt to incorporate gender analysis in their selected planning processes.
- Prepare material for inclusion in the *Gender and Health Planning Workbook*.[22]

[21] "Invisible Women - Phase 2: Gender and Health Planning - Saskatchewan Draft Proposal,(January 24, 2001".

[22] "Invisible Women - Phase 2: Gender and Health Planning - Saskatchewan Draft Proposal, (January 24, 2001)".

The Saskatchewan planning group worked with the consultant to plan a workshop to be held for interested personnel and senior managers in the participating health districts. It was hoped that the workshop might generate greater commitment or "buy-in" to the inclusion of gender analysis in district health planning processes. Buy-in from senior managers was seen as necessary to facilitate further involvement in the pilot project. The Women's Secretariat continued to provide resources and advice regarding the workshop process and materials.

This project was significantly hindered by changes to personnel and the lack of commitment of personnel to this project at the department and district levels. In mid-2000, some Saskatchewan Heath staff were assigned to work on the Commission on Medicare.[23] The representative to the planning group from Saskatchewan Health went on leave from the Department from April to November 2001 and her position on the project's planning group remained vacant despite requests for the Department to appoint other staff to work with PWHCE on this initiative. While she was away, the Director of her unit retired and a key contact in the District Management Services Branch left. Not having enough staff to devote to the project, and losing key contacts altogether, was common in other departments, districts and authorities in both provinces causing considerable delays in implementing this project.

By April, 2001, Touchwood-Qu'Appelle Health District withdrew from the project due to lack of resources and personnel shortages but the Regina Health District remained interested. The workshop, as the first part of the Saskatchewan draft framework, was planned for late Spring 2001 but was postponed because of a pending strike by health care workers in the Regina Health District. The workshop was rescheduled and eventually held on October 15, 2001. Other pieces of the framework would have to wait for more resources.

The Workshop

The *Gender-Based Analysis and Health Planning Workshop* was conceived of and actively promoted as a stepping-stone towards more sustained efforts to implement gender sensitive health planning. Organized by the consultant from the *Invisible Women* team, in collaboration with PWHCE staff, the Women's Secretariat and the Regina Health District's Women's Health Program, the goals of the workshops were:

1. To provide an introduction to gender sensitive health planning;
2. To increase understanding of gender-based analysis and its relevance to health policy makers and service providers; and
3. To increase understanding of ways to apply gender-based analysis in health planning.

[23] Commonly known as the "Fyke Commission," the commission was to identify challenges facing medicare, outline potential solutions and engage the public and health care providers in a discussion of new ideas. The Commission provided the first of its reports to the Premier in the Fall of 2000 on the challenges facing the people of Saskatchewan in reforming and improving Medicare. Its final report, on the future direction of health care in Saskatchewan, was released April 11, 2001.

A half-day session was organized for general awareness building and practical approaches to gender-sensitive health planning. A smaller number of participants were invited to an afternoon session to discuss specific strategies to implement gender-sensitive approaches and ways to continue this work over time. Invitations were primarily sent to managers, directors and interested personnel within the Regina Health District. Individuals from Saskatchewan Health Policy and Planning Branch and District Management Services Branch were also invited to attend.

Representatives from the Regina Health District felt that it was important to have someone from Saskatchewan Health speak at the workshop to reinforce the idea that gender analysis was important, especially to the Health Districts. The head of the Policy Branch within Saskatchewan Health was invited and agreed to give a brief presentation on the importance of gender-based analysis in health planning. However, at the last minute he was unable to attend and another representative from Saskatchewan Health delivered opening remarks at the workshop.

Although approximately thirty representatives were expected, only fifteen people attended the workshop. Though some people remember there being closer to 20 or 25 participants, everyone agreed that the numbers dwindled as the day progressed. Because of another pending health care strike in the Regina Health District, many senior managers did not attend the workshop. Overall, those who attended the full day were already supportive of gender-based analysis. Even though there was overall enthusiasm for the project, among those who attended, no one present was in a position to commit resources for next steps.

Following the gender-based analysis workshop in Regina, the representatives from the Regina Health District (the only remaining participating Health District) were unsure what their next steps would be. After the workshop, the Regina Health District could/would not commit any further resources to this project. Remaining funding would be used to adapt whatever "tools" emerged from the Manitoba project. In the end, it was obvious that in Saskatchewan, PWHCE was the driving force for further work on gender and health planning, supported by the Women's Secretariat, but with minimal buy-in from the health system decision makers themselves.

Implementation in Manitoba

As in Saskatchewan, the implementation of this initiative occurred within a larger health care environment. Although committed to improving women's health programs, the two remaining Regional Health Authorities (RHAs) in Manitoba saw gender-based analysis as an addition to their existing work. There were also important issues surrounding health funding from the provincial Health Department.

In the Fall of 2000, the Minister of Health and the Minister Responsible for the Status of Women formally stated that gender is a determinant of health and endorsed the

"Manitoba Women's Health Strategy".[24] The Women's Health Unit is responsible for taking the lead on and coordinating the Strategy, in conjunction with the Manitoba Women's Directorate. The strategy recognized a commitment to work in partnership with PWHCE and the regional health authorities to promote gender-based analysis and planning and awareness concerning women's health issues across the life cycle.[25] Most importantly, the formal recognition of a partnership between the Women's Health Unit and PWHCE gave this project legitimacy and support within Manitoba Health. This would prove instrumental in this initiative's perceived success in Manitoba.

In the initial stages of Phase II, it was the intention of PWHCE to work with all interested RHAs and in Manitoba and HDs in Saskatchewan. In Manitoba, only South Eastman RHA expressed early interest in being a part of this initiative. Later South Westman RHA also agreed to participate. PWHCE consultants felt that the project may have remained intangible to the other Health Authorities and that they soon lost interest. The South Eastman RHA, with the strong involvement of the Medical Officer of Health there, received funding from the PWHCE for a separate but related project on women and health focusing on consultations with low-income and other marginalized groups of women,[26] as well as other women's health projects funded by PWHCE. There was some concern among the *Invisible Women* consultants over the possible reaction from the other RHAs about one district receiving more funding for women's health and possible confusion over how other PWHCE sponsored research fit within Phase II.

In the spring of 2001, PWHCE and Manitoba Health agreed upon a number of deliverables to be completed by one of the original *Invisible Women* consultants, using resources committed by PWHCE ($10,000) and Manitoba Health ($20,000). Deliverables included:

1. An examination of health planning documents;
2. Gathering information about gender indicators for inclusion in the various pieces of the community assessments;
3. A report documenting the successes of a women's health program in the South Westman Regional Health Authority; and
4. The production of a "Gender and Health Planning Workbook."

In her examination of health planning documents form Manitoba Health, the consultant recommended that it was not realistic to expect RHAs to include gender-specific wording in these documents. In March 2001, members of the PWHCE research team decided that it would not be useful to design a "gender template" to

[24] "Invisible Women - Phase 2: Gender and Health Planning — Draft Proposal for Project (January 25, 2001)."

[25] "The Manitoba Women's Health Strategy." Manitoba Health, Women's Health Unit 2001.

[26] "Women and Health: Experiences in a Rural Regional Health Authority." (PWHCE Research Grant 99R-T1-004) —Eastman Health/Santé Sud-Est Inc., in partnership with South Eastman Crisis Centre, Manitoba Centre for Health Policy and Evaluation, Rat River Health Council, Western District Health Advisory Council, Central District Health Council, Crow Wing Trail Farm Women's Institute, Anxiety Disorders Association of Manitoba Inc. This project was funded through a PWHCE funding competition, separate from the "Gender and Health Planning" project.

overlay RHA planning documents as gender-based analysis intervention must happen before plans are in the final stages of implementation. The Community Health Needs Assessment Guidelines were identified as a good place to intervene. It was reasoned by PWHCE and Women's Health that changing the guidelines themselves, rather than superimposing a template onto them may be more effective considering that Regional Health Authorities are likely to only follow the guidelines themselves. This intervention would come at an opportune time as the Regional Health Authorities and Manitoba Health were in the process of negotiating the next round of Community Health Needs Assessments (Spring 2001).[27]

A report was commissioned as a part of the project in Manitoba. The report, entitled *A Rural Women's Health Program: The Experience of the South Westman RHA* (Donner 2001), records the success of the South Westman Regional Health Authority Women's Health Project (WHP), describing the history and operation of the WHP, its strengths and the challenges it has faced, and draws conclusion and recommend areas for future consideration. It was hoped that an examination of the WHP would also serve as an example of a "practical tool" for other RHAs.

Even though Manitoba Health had included gender as a determinant of health, confusion remained over what gender meant, why data should be sex-disaggregated, and what indicators should be considered valuable in health needs assessments and health planning within the individual branches. A "Gender and Health Planning" workbook was to be developed with Manitoba Health by one of the consultants. The planning and development of this workbook met with its own set of challenges.

The Workbook

To provide the "practical tools for gender analysis" that Manitoba Health desired and expressed during the bi-provincial meeting in September 2000, the implementation of gender-based analysis into health planning was re-conceptualized as a "workbook." The *PWHCE Gender and Health Planning Workbook*, was initially intended to offer Regional Health Authorities:

- Tools that work in conjunction with the current templates used by RHAs to assist in gathering gender-sensitive data and tools to assist in incorporating the data into gender-sensitive health plans. These tools may include checklists and other learning resources.
- Detailed examples of plans that incorporate a gender-sensitive analysis, and, for the purposes of comparison, examples of plans that are gender blind.
- Workshops as requested by RHAs to assist staff to use the tools in a hands-on fashion to incorporate gender in their health plans.[28]

In developing the workbook, the emphasis of the project in Manitoba shifted to simply

[27] The next Community Health Needs Assessment are to be undertaken in the fall of 2002.

[28] "Invisible Women - Phase 2: Gender and Health Planning — Draft Proposal for Project, (January 25, 2001)".

producing a product (the workbook) from which RHAs might choose from a combination of tools, checklists, and case studies to assist in the application of health planning. The consultant was contracted to complete this work in close consultation with Women's Health Unit, Manitoba Health. It was hoped that this workbook could also be modified for use in Saskatchewan.

The workbook has since been repeatedly re-defined according to access to data. In the fall of 2001, the workbook was to be based on data that was to be provided to Manitoba RHAs to use in their health planning and needs assessment processes. Manitoba Health and PWHCE agreed to restrict the workbook to a general introduction and four case studies, using existing data to show the value of incorporating gender perspectives. The difficulty in developing the workbook lay not only in identifying *where* this data could be found (data is frequently held in many different parts of the department which appear to not communicate well among each other), but more importantly, *what* data the RHAs receive in the first place. This information was considered crucial in order to keep the workbook relevant to the RHAs.

Continuous delays in developing this workbook occurred as both the consultant and the Director of the Women's Health Unit struggled to obtain the appropriate information. Manitoba Health provided data on suicide, self-inflicted injuries, and diabetes. However, Manitoba Health's rich and much-envied data on health service utilization seemed to be beyond the project's reach. Ironically, while Manitoba Health did not seem able to provide sex disaggregated data at the RHA level, some of this data was publicly available on the Canadian Institute for Health Information (CIHI) web site (CIHI must have received this data from Manitoba Health) and was used whenever it was appropriate to the task.

Unfortunately, despite everyone's best efforts and best intentions, this workbook was still in the process of completion in September 2001. By the end of October 2001, the workbook had been completed and reconceived as a guide because there was actually no space for exercises. The guide has two case studies illustrating step-by-step procedures for doing gender-based analysis involving mental health issues and diabetes. In the end, the personal contacts made within the policy network enabled the consultant to obtain the information and data needed to complete the guide. Whether the guide will be utilized remains to be seen; however, it is another tool and educational resource that the policy communities (national, regional and local) can use to promote gender-based analysis. It is also an excellent example of the good-will of the non-governmental PWHCE in responding to the perceived needs of Manitoba RHAs, and this may be currency in moving beyond *Invisible Women PhaseII.*

SECTION II: ANALYSIS OF THE NARRATIVE OF THE INVISIBLE WOMEN PHASE II

Introduction

After preparing the above narrative, a major question for choosing an analytic framework was whether *Invisible Women Phase II* (Phase II) was a program development and implementation project with several potential sites (i.e., health regions in Manitoba and districts in Saskatchewan) or a policy development and implementation project. While at first glance this seems like a minor distinction, in fact the frameworks for analyzing Phase II would differ substantially under the two scenarios. A program is a set of activities designed to meet a need and we would traditionally do an assessment of the goals and objectives, activities, logic models, processes and outcomes to evaluate whether the program had delivered as promised, why or why not (Patton, 1997; Russell, Thurston, & Henderson, 2002; Thurston et al., 2002b). As analysis of the project proceeded as if it was a program, the first clue that a program model was inappropriate was that the recipients of the interventions were government officials and public servants (government members or bureaucrats or health region/district personnel) who did not stand to directly and personally benefit from their participation. The long-term goal of the project was certainly improvement in women's health, but the mechanism was health service re-orientation. Since adoption and implementation of a policy on gender-sensitive health plans was the intended outcome of Phase II, a policy change model was more appropriate for analysis. Definitions of public policy agree that it "result[s] from decisions made by governments and that decisions by governments to do nothing are just as much policy as are decisions to do something" (Howlett & Ramesh, 1995, p. 4).

Phase II was analyzed using the conceptual frameworks of Howlett and Ramesh (1995) and Pal (2001). A draft analysis was circulated to PWHCE staff and the consultants for Phase II. Their feedback and comments provided a few points of clarification for the story, but was principally used as additional data. The policy analysis framework of Bacchi (1999) was then referred to in production of this report. Bacchi (1999) focuses on understanding how the way policies are spoken about reveals "policies as constituting interpretations or representations of political issues" (p. 2).

Howlett and Ramesh (1995) present five aspects of a policy cycle: 1) Agenda Setting; 2) Policy Formulation; 3) Decision-making; 4) Policy Implementation; and 5) Policy Evaluation. These are not considered linear processes as there may be several iterations,

therefore the implementation process can result in revised policies, evaluation can modify implementation, and so on. In addition, Howlett and Ramesh (1995) distinguish the actors in the policy cycle. Clarifying who the actors were in Phase II also helped clarify the broad context in which the project took place and the analysis will start there. The discussion will then focus on the aspects of the policy cycle. Finally, the planning of Phase II and the logic models implied will be discussed.

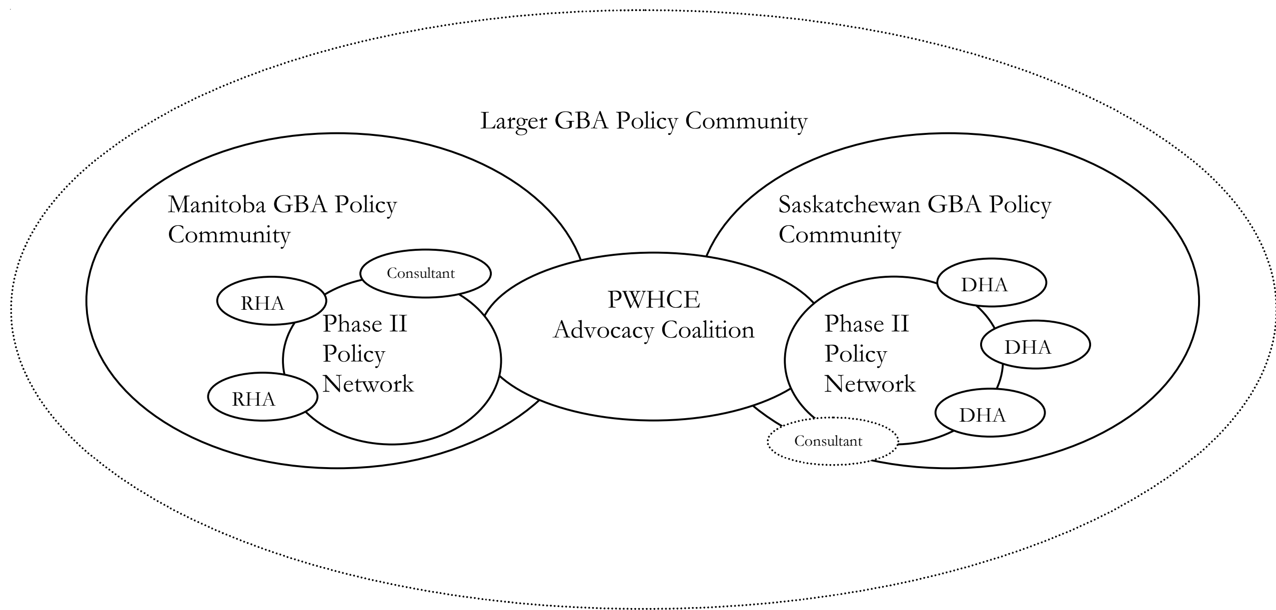
The Actors in Phase II

Howlett and Ramesh (1995) include all people who are concerned about an issue as members in a Policy Community. They are not clear about the role of geographical boundaries in defining Policy Communities, but for our purposes it makes sense to conceive of local, regional, provincial, national, and international Policy Communities on gender-based analysis in health planning. Some members of a Policy Community interact on a regular basis and these form what is called a Policy Network. Advocacy Coalitions form yet another subset of the Policy Community and are comprised of "actors from a variety of public and private institutions at all levels of government who share a basic set of beliefs (policy goals plus causal and other perceptions) and who seek to manipulate the rules, budgets and personnel of governmental institutions in order to achieve these goals over time" (Howlett & Ramesh, 1995, p. 126). Actors in the broad Policy Community may vary in knowledge and expertise and in ultimate goals, and they may be members of more than one Policy Network or Advocacy Coalition.

The Policy Community for Phase II

There were many actors at the center, in the middle and on the edges of Phase II. Figure 1 is a graphic representation of the Policy Community as identified in the narrative of this project. The larger Policy Community includes all those involved in policy formation who share a common policy focus and are linked by a shared knowledge base (Howlett & Ramesh, 1995), in this case advancing women's health through gender-based analysis of health policies and related programs. In Phase II national and international policy communities were very much behind the scenes, hence the dashed line. That is to say, the PWHCE staff and board members and consultants were linked to a larger policy community, active in other projects related to gender-based analysis, and used resources developed elsewhere, such as printed material and research findings. In fact the consultant who worked in Saskatchewan lived in Alberta and was part of the Phase II Policy Network, while the consultant for Manitoba is an active member of the Manitoba gender-analysis and women's health policy network.

Figure 1: Policy Community



Within both Manitoba and Saskatchewan, the members who were engaged in Phase II formed separate Policy Networks despite the efforts at the beginning to create a more unified bi-provincial network. Due to the nature of federal and provincial government relations, it is difficult for provincial government employees to partner across borders. Just from a practical perspective, the resources needed to travel are not easily accessed. Working in two provinces complicates policy processes.

Except for the early efforts to have a bi-provincial project, network development was never an explicit focus and stated outcome of Phase II activities. Participation in Phase II was voluntary and reasons for becoming part of the Phase II network seemed to vary. The nature of the Policy Networks within the Districts or Authorities were not discussed in the available data, in other words, the amount of support for gender-analysis policy available from people other than those assigned to Phase II in each case was not clear. Generally, collaborations between or among Districts or Authorities within provinces were also not discussed so we cannot characterize the nature of the Policy Networks in each province. It was not clear that there was any overlap among the District or Authority level networks in Phase II, except through the relatively few joint meetings that were held for the project.

PWHCE: The Advocacy Coalition

PWHCE has partnered with Universities in each province and clearly worked through board membership, committee membership, structures, staffing, and projects to develop extensive networks within both provinces. Within policy communities there are Advocacy Coalitions, a subset of members

from government and non-government organizations who "seek to manipulate the rules, budgets and personnel of governmental institutions in order to achieve these [policy] goals over time" (Howlett & Ramesh, 1995, p. 126). PWHCE can be viewed as an Advocacy Coalition in Phase II. It should be noted that Advocacy Coalition is the term used by Howlett and Ramesh (1995) and that some people were uncomfortable having the label applied to PWHCE because the term advocacy is often devalued in our current political context. In fact, the public participation literature often dismisses the input of "special interest groups" while at the same time extolling the virtues of a well-informed participant (Eyles, 1993).

As defined by Howlett and Ramesh (1995) the PWHCE is an Advocacy Coalition, made up of board members and staff from both provinces who are committed to a number of policy goals, one of which, by virtue of creation and funding of *Invisible Women, Phases I and II*, can be assumed to be gender-based analysis in health policy. In terms of projects like Phase II that seek health system changes, it is notable that the federal government funds the PWHCE. In essence, the federal government has enabled the Centres of Excellence initiative to create Advocacy Coalitions. Arguably, the federal government, that has a policy promoting gender-based analysis, has no other legitimate policy instruments (Howlett & Ramesh, 1995; Pal, 2001) with which to implement women's health centred gender analysis at the provincial and local levels. Both Health Canada and Status of Women Canada do fund local projects though regional offices. The relationship of PWHCE to the federal government would not be lost on provincial politicians, but we do not know if or how it affected Phase II. The fact that both provinces committed funds to Phase II was an indication of provincial commitment and suggests that the support of the federal government was not a problem around this issue. The good relations established by PWHCE are clearly important to achievement of the Centre's long-term goals.

It is important to keep in mind that other Advocacy Coalitions can create competition for policy makers' time and attention. We do not know which Coalitions other than PWHCE were active with the RHAs and Districts during Phase II.

Gender-based analysis was not the only policy concern for PWHCE or for districts and authorities while Phase II was underway and this raises the issue of competing and complementary internal policy agendas. This was evident in the fact that PWHCE staff had many other projects to which they were attending. This may have benefited the work of Phase II at some times and detracted from it at others. There is little data that relates to this. Through a research grants process, one of the regional health authorities received money to do "a separate but related project on women and health involving sex disaggregation of health data"; however, no clear relation to Phase II had ever been made and this created confusion and a perception of disparity among some members of the Phase II Policy Network. Another pressure on Phase II participants was that PWHCE was under pressure to produce evidence of action (policy uptake or a pilot) because its financial support was uncertain past March 2002.

The Phase II Policy Networks

Howlett and Ramesh (1995) describe Policy Networks as groups of people who interact on a regular basis and who participate directly in the policy process. People in policy networks are distinguished from the larger community by a shared focus on material or observable interests, such as budgets. As illustrated in Figure 1, there were two Policy Networks, one in each province, and within these, for the purposes of Phase II, there were three smaller Policy Networks in Saskatchewan (Regina, Touchwood-Qu'Appelle, and Midwest health districts) and two smaller Policy Networks in Manitoba (South Eastman Health/Sante Sud-Est Inc. and South Westman health authorities).

The relationships among actors in Phase II may not be captured precisely in Figure 1, nevertheless, some important considerations can be raised. The PWHCE Advocacy Coalition staff members were the common actors and linked the two provincial Policy Networks. One of the consultants who worked on both *Invisible Women Phase I and Phase II* was part of the Manitoba Policy Network while the other two were part of the Policy Community but not from either province. This meant that PWHCE staff presented gender-based analysis to the District Management Support Branch, Saskatchewan Health and the Saskatchewan Evaluation Network rather than the consultants. The consultants did not have the opportunity to build relationships or to become part of the policy network in Saskatchewan. This meant that an outsider gave the workshop in Saskatchewan. We have no direct evidence that this made any difference in the project. An argument could be made that one should not use outsiders when building a network. An alternative argument concerns the role that experts can play; for instance, one of the most concerning contextual barriers for personnel in gender-based analysis is marginalization of their work within the bureaucracy, labeling them as 'one of those'[29] and consequential limitations for career advancement. This experience has been expressed by others in the literature, for instance, "Activists and femocrats created support and network meetings because 'being the gender equity officer and the sexual harassment officer makes you isolated' " (Marshall, 2000, p. 142). In a political context such as this, it may be protective of the policy network to shield insiders from this marginalization by having spokespeople from outside the province. Also, sometimes people from outside of bureaucracies can speak about failure to implement policies in ways that insiders cannot.

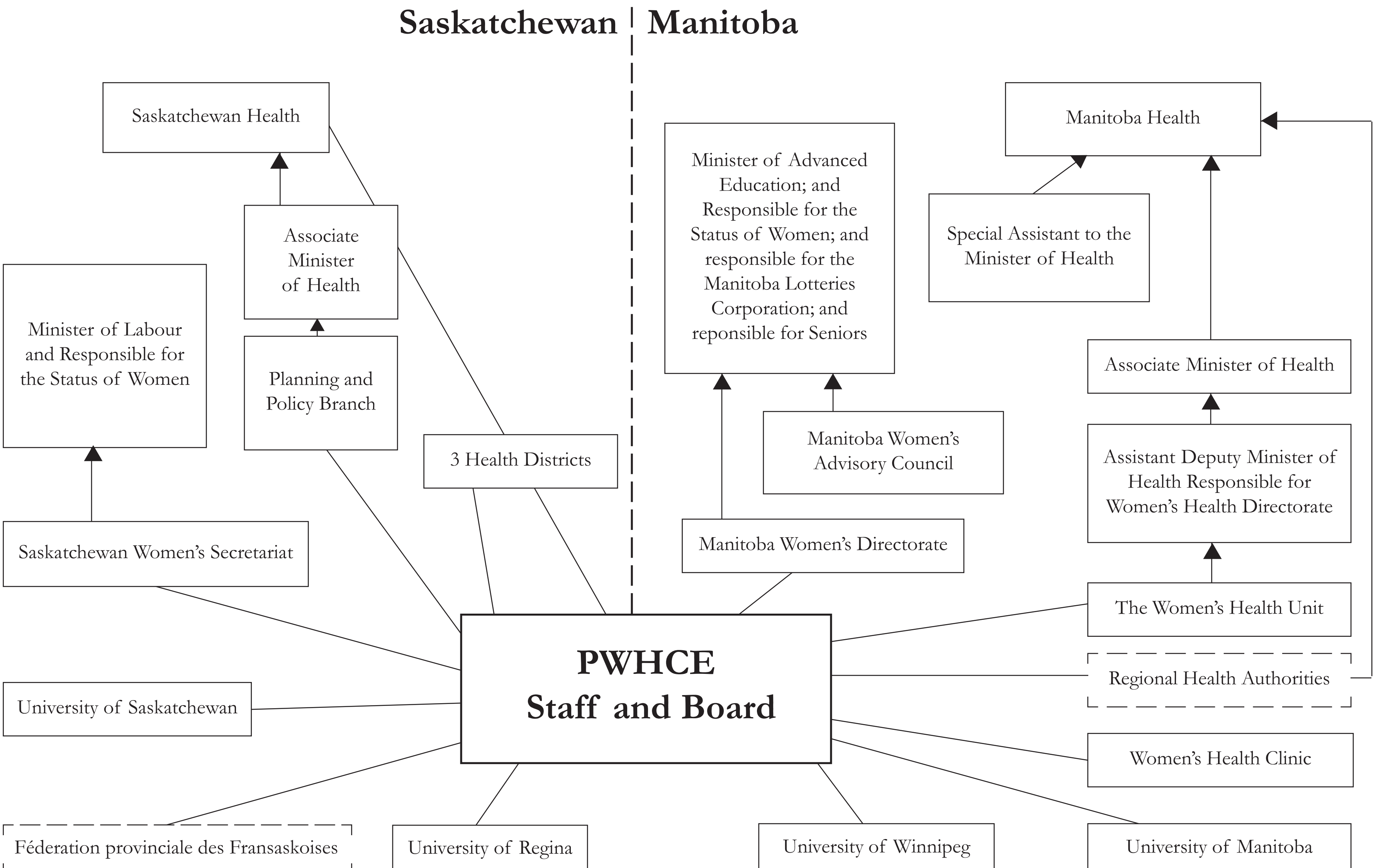
One of the outcomes of regionalization and decentralization of health system management is that each local policy network must be enlisted to create change where some policies were previously enacted by one Department of Health. The staff of separate regional health authorities and districts do not necessarily meet regularly as a norm; however, individuals may meet because of common interests that draw them to workshops, conferences and projects like Phase II. The role of provincial ministries of health in building and maintaining policy networks has therefore been diminished. Atkinson (2002) draws our attention to the importance of "the informal aspects of local

[29] One of those feminists.

health system management and the political culture of the district in which the local health system is embedded" (p. 121). The informal aspects refer to, among other things, personal relationships and political positions and beliefs. In short, Atkinson (2002) calls upon health policy researchers to include organizational culture as a serious factor to be understood, rather than as a "residual explanatory factor for why things are not working" (p. 122). It is beyond the scope of this study to explore the cultures of all of the health authorities and health districts in Phase II. We anticipate that the key informants could identify cultural differences if asked, however, and this might be a consideration in future projects. Conceptually then, decentralization restricts policy networks at the level of health authorities or districts. This has practical implications for health policy advocates.

In reviewing the narrative in Section I, it appeared that the Phase II Policy Networks differed in Saskatchewan and Manitoba. Figure 2 includes the organizations represented in the Phase II Policy Networks and the PWHCE Advocacy Coalition included in Figure 1. The universities and Féderation provinciale des Fransaskoises are included because these are represented on the PWHCE board. The Women's Health Clinic was the site of the bi-provincial meeting. As we read in the narrative, a number of people, including Ministers, were consulted with and/ or their approval for Phase II was sought. The consultants are not included here. The arrows in this figure are intended to capture normal reporting patterns, while the lines indicate that there is a relationship and communication, without specifying the nature of these relationships.

Figure 2: Phase II Policy Networks



As we can see, the Manitoba Policy Network was denser and better resourced than that in Saskatchewan. There were three government units with which to ally Phase II. As will be discussed in Agenda Setting below, the density of relationships may play an important role. Doern and Phidd (1992) suggest that "Bureaucracy is also a system of delegation that immediately creates an impetus for 'bottom-up' policy initiatives emanating from departments that possess their own agendas reinforced and challenged by their policy communities" (p. 154). This seems to be what transpired in Manitoba. In Saskatchewan, however, PWHCE staff had maintained long-standing working relationships with the Saskatchewan Women's Secretariat and this strengthened Phase II. Therefore, quality must be considered along with quantity of relationships.

Howlett and Ramesh (1995) suggest that dense policy networks, where both the government and society are strong and close partnerships between the two are possible, result in more "cohesive and long-term policies" (p. 65). Networks where the government and society are both weak will produce "ineffective and short-sighted policies" (p. 65). Doern and Phidd (1992) go further in saying that the absence of a network[30] "may make coherent policy impossible" (p. 77). This would suggest that strengthening policy networks should be a project goal in some instances. We must emphasize that the Policy Networks seen in this diagram are those reflected in the data for this project and are not intended to imply that the provinces vary this way on all policy issues. However, given the differences between the provinces in government sponsored organizations with a mandate for women's health or equity issues, the approaches to Phase II in the two provinces might have differed. One suggestion, for instance, is that greater effort could have been made to expand the Policy Network among non-governmental arenas in Saskatchewan by inviting community groups to participate. Another suggestion is that PWHCE board members from Saskatchewan might have played a larger role in strengthening the gender-based analysis Policy Network, but both these suggestions assume that gender-based analysis is an area of interest and expertise for those involved. Like any suggestions, implementations of these would also have required resources.

Summary

The policy communities and networks portrayed in Figures 1 and 2 may explain some of the outcomes of Phase II. First, in Manitoba there were more government bodies (either internal or arms length) to provide guidance and advice on status of women issues. PWHCE developed a working relationship with the Women's Health Unit in particular, having a staff member from that unit serve as *ex-officio* on the board. One substantial and not insignificant benefit of this style and the relationships was that Manitoba Health (not the Minister Responsible for Women) contributed financially to the project. In policy lingo, Manitoba Health chose grants as a policy instrument to impact on the health sector (Howlett & Ramesh, 1995; Pal, 2001). Similarly, in Saskatchewan the Women's

[30] They actually speak of the policy community and do not make the distinction between communities and networks.

Secretariat had a long-term relationship with PWHCE and committed money to the project. Yet neither province had a successful example of implementation of a gender-based needs assessment or health plan. In Manitoba, activity around development of a workbook did continue and this sustained activity may have been because of the larger network. In the long run, however, PWHCE will be able to use the workbook in Saskatchewan in continued advocacy for gender-based health policy.

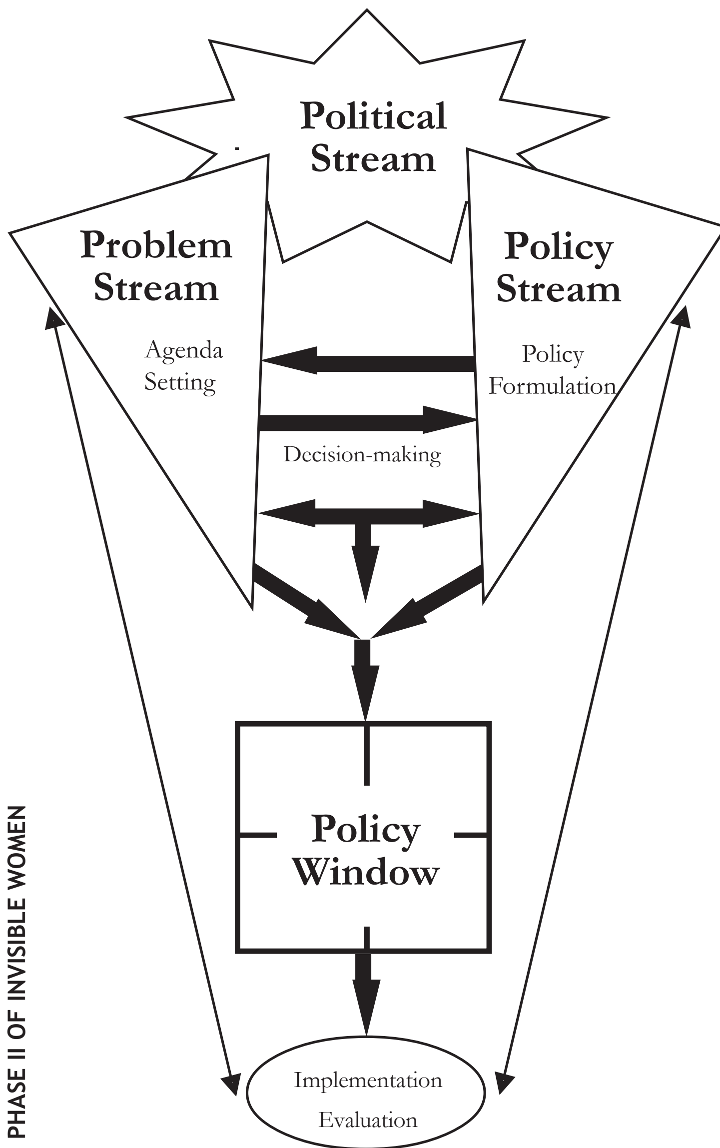
It is now clear why the idea of a bi-provincial project was rejected by members of the policy networks of both provinces, yet aspired to by PWHCE. For the latter, this was a matter of efficiency given that the numbers and hours of staff were limited. In addition, PWHCE staff meet and communicate regularly. For the separate provincial Policy Networks, a bi-provincial strategy made no sense since it would attempt to create a network where only a policy community existed. To assume that the policy making process would be the same in both provinces would be in error. Even though people in policy communities often look across borders for resources and ideas, it does not mean that they can operate bi-provincial policy networks. In retrospect and in light of the focus on policy making, trying to develop a bi-provincial network was an error that created confusion and discomfort and may have inhibited the development of partnerships within the same province. People within a province were justified in not wanting to spend their resources on travel to another province for meetings with people who could not commit to actions back in their local policy subsystem.

The Policy Process

Introduction

The process of policy development described by Howlett and Ramesh (1995) assumes that public policies result from a complex and iterative process where actors in the policy community and policy networks exchange information and make decisions. Power determines who can make decisions that affect implementation and evaluation. Howlett and Ramesh (1995) discuss five aspects of a policy cycle: 1) Agenda Setting; 2) Policy Formulation; 3) Decision-making; 4) Policy Implementation; and 5) Policy Evaluation. Howlett and Ramesh (1995) also discuss Kingdom's Agenda Setting Model. Figure 3 integrates these two models.

Figure 3: The Policy Process



Howlett and Ramesh (1995) state that when solutions are joined to problems within a favourable Political Stream, Policy Windows open. When a window is opened, Implementation and Evaluation are dependent on further decisions. Once Implementation and Evaluation are undertaken the Policy Window may stay open and Problem and Policy Stream modifications may happen. However, the Policy Network cannot assume that the Policy Window will remain open, as evidenced by recent cuts to women's programs. Figure 3 tends to obscure the fact that deciding not to act is also a policy option. We will now discuss the narrative using the elements of Figure 3.

The Political Stream

The Political Stream might also be seen as the social or political context in which policy making takes place. Looking for a moment at the larger context, tools and frameworks for gender-based analysis abound in Canada and abroad but their utilization is less common (MCEWH, 1998; Teghtsoonian, 1999; Marshall, 2000). Thurston, Scott, and Crow (2002a) assessed the treatment of gender and women's health in key federal documents: the 1990 report of the Federal Provincial Territorial Working Group on Women's Health; the 1994 report of the Federal Provincial Territorial Advisory Committee on Population Health; and the 1997 reports of the National Forum on Health. While produced federally, these reports were the result of collaboration with the provinces and provide an indication of the discourse across the country. The first report had a clear understanding of the need for strategies to address gender and diversity among women. The second pointed out some problems common to women but there was no specification of strategies to deal with social stratification by gender nor reference to the previous report of the Federal Provincial Territorial Working Group on Women's Health. The final report in the

National Forum on Health is An Overview of Women's Health. This report clearly articulates the implications of a gendered analysis of health and of health policy; however, this gender analysis is lacking in much of the material available to policy makers, including the 30 background papers commissioned by the Forum (Thurston et al., 2002a).

Two more recent policy federal documents, *Toward a Healthy Future: Second Report on the Health of Canadians* (Federal Provincial and Territorial Advisory Committee on Population Health, 1999) and *Taking Action on Population Health* (Health Canada, 1998) were reviewed by Donner, Horne and Thurston (Donner, Horne, Thurston, & Prairie Women's Health Centre of Excellence, 2001). *Taking Action on Population Health* was intended to provide direction to the staff of the Population and Public Health Branch of Health Canada in implementation of a population health approach. Gender is included as a determinant of health and the interrelated nature of the determinants is stressed (Donner et al., 2001). Despite the inclusion by Health Canada of both gender and culture as determinants of population health in internal policy documents**,** Toward a Healthy Future does not include either. The report does, however, refer to health problems of particular importance to women and considers women's health more broadly than reproduction and conditions specific to women. This was viewed as an improvement over the first *Report on the Health of Canadians* (Donner et al., 2001).

The book *Exposing Privatization* (Armstrong et al., 2002) shows that gender analysis continues to be lacking in most provinces. It concludes: "Outside the Centres of Excellence for Women's Health, there is little research being done to examine the impact of health reforms on women" (p. 307). Thus, in terms of the broader social context in which Centres of Excellence are trying to have health authorities and decision makers integrate gender analysis, there are few examples where gender analysis has been implemented. Solutions are therefore not forthcoming from other parts of the country. Solutions are also not coming from academic medicine or other health faculties, such as nursing. The Political Stream does shift, however, and Manitoba now has a women's health strategy and each health authority has one staff person named as a women's health representative who will meet regularly with Manitoba Health. The Saskatchewan policy community, on the other hand, has lost the Women's Secretariat.

We might ask what role Canadian universities are playing in creating a favorable Political Stream and joining the Problem and Policy Streams to open Policy Windows. The fact that the 30 background papers commissioned by the National Forum on Health (Thurston, Scott, Crow, forthcoming) contained little gender analysis indicates that the health research sector does not integrate gender analysis. This, of course, suggests a gap in the university system. As many have already identified, teaching and research about gender has been marginalized within the university as well as the community (Caplan, 1993; McCallum & Radtke, 2002). Similar problems exist in England (Anonymous. 1998) and the United States (Institute of Medicine (U.S.) Committee on Understanding the Biology of Sex and Gender Difference, 2001). The latter report extends beyond the

U.S. since health research and researchers cross borders more than ever. "The use of sex and gender as synonyms in science is apparent throughout the literature. According to the current scientific literature, rats, mice, guinea pigs, other research animals, even plants have gender" (p. 175).

Manitoba and Saskatchewan each have medical schools. In June 2002, Manitoba had a representative on the Association of Canadian Medical Colleges Special Resource Committee on Gender Issues, Saskatchewan did not, although faculty did attend meetings of that organization. Neither school has a highly visible gender and equity program compared to others in the country. The Faculty of Medicine web site at the University of Manitoba does not mention gender and equity nor does it appear in the listing of departments and other resources (University of Manitoba, 2002). There is a similar absence at the University of Saskatchewan (2002).

The Political Stream changed drastically within Saskatchewan; one might say it went from bad to worse. Specifically, health care workers in Saskatchewan threatened strike action and this necessarily became the primary focus of managers and decision-makers within that system. The Regina Health Authority was not able to complete the Policy Stream and no Policy Window opened after the workshop was held. Failure to open a Policy Window should not be treated as a failure of Phase II given the iterative nature of the policy process and the significance of the Political Stream. In addition, the Political Stream changed during the project when the Saskatchewan Health representative to the planning group went on leave. She was not replaced, therefore one may assume that she was not surrounded by other members of the Policy Network. Similarly, there was a change in Directors at PWHCE and new relationships had to be developed with the new Director.

Problem Stream, Agenda Setting

Agenda Setting is the process through which problems come to the attention of government or policy makers. This is the problem recognition stage. *Invisible Women Phase I* was a significant effort on the part of PWHCE to do problem analysis. The PWHCE staff met with government officials in both provinces to discuss the findings of *Invisible Women Phase I*. In both provinces, government ministers and representatives accepted the report as evidence of a problem that should be addressed. In both provinces, provincial spokespeople agreed to work with PWHCE to find solutions to the gaps in gender-based analysis in health. This was a success in terms of problem identification. Unfortunately, provincial governments, as mentioned above, have limited leverage over regional health authorities or districts and one of the tenets of decentralization was that regional authorities would set policy agendas specific to local needs. One bit of leverage that provincial health departments maintained was the requirement that community health needs assessments be completed.

From the narrative, it seems to be clear that where actors in the policy community can have most influence may be important. The Problem Stream is the process whereby a problem or lack of an ideal state becomes perceived as a problem that public bodies

should address, in this case, that needs assessments and health plans should incorporate gender-based analysis. Decision-makers receive feedback from both external and internal sources. The strength of the policy network clearly impacts on this feedback process. In this project, no concerted effort was made to develop the Problem Stream in terms of health authority leadership. Instead the focus was in soliciting government support. In another project, "participants frequently mentioned that demonstrated (emphasis added) high-level political and bureaucratic support for gender analysis considerably mitigates attitudinal problems within the policy ranks" (MCEWH, 1998, p. 4-5).

In Phase II there was verbal as well as material support provided by governments, however, arguably this was the wrong "high-level". The high-level decision-makers at the local level might include Chief Executive Officers, Senior Managers or Regional/ District Health Board members. It is these people who can combine the Problem and Policy Streams and decide to open a Policy Window. Government officials might be seen as helping to create a positive Political Stream. This was the hope when staff of the Regina Health District requested that someone from the Ministry of Health address their workshop to emphasize the importance of gender-based analysis. It was hoped that this would influence other health district managers to set a gender-based analysis Policy Agenda. The Saskatchewan Women's Secretariat was not seen as a viable alternative. Ministers of Health or senior government bureaucrats who support gender-based analysis in decentralized structures arguably can easily[31] express (even demonstrate) support, when they no longer control where policy is made. As one Phase II participant said, supporting gender-based analysis is a "motherhood statement".

From the narrative, however, we can see that the decision to engage the Saskatchewan Ministry of Health in exhorting the Regina Health District to make gender-based analysis a public problem may have backfired. Instead, those who attended the October 2001 workshop in Regina learned that the government did not think this a serious issue. While the senior official asked to speak to the workshop held the appropriate position in the health department and was a member of the Advocacy Coalition, he did not appear to have a gender-based analysis policy as a high priority. In future projects, the distinction between Policy Stream spokespeople and decision makers should be considered and weighed. In practice, Regina Health District, by volunteering for Phase II, expressed that it was ahead of Saskatchewan Health. The staff of Regina Health District who were members of the Policy Network needed the support of their managers. While managers were invited to the workshop, it was the staff "who were already supportive of gender-based analysis" who were sent. Why this occurred is not clear, but the result was that the managers in a position to open a Policy Window were not directly affected by the training. Further, since the "level of public support for the resolution of a problem is critical" (Howlett & Ramesh, 1995, p. 116), there could have been more

[31] Notwithstanding the larger political climate and position of the cabinet and party leader; for instance, bureaucrats in Alberta who support gender-based analysis would be wise not to say so. Therefore, easily should be read as a relative term.

engagement of other groups to lobby[32] health districts to put gender-based analysis on the policy agenda.

Policy Stream and Policy Formulation

The Policy Stream is the process whereby experts and analysts pose solutions to the problem and is consistent with the stage of Policy Formulation. When solutions become joined to problems within a favourable Political Stream, argued Kingdom (1984, cited in Howlett & Ramesh, 1995), a Policy Window opens. A Policy Window provides an opportunity for decision-makers to decide to implement a new policy. In Phase II, much of the time and energy was spent in the Policy Stream. It was hoped that implementation of a gender-based analysis workbook or pilot gender-based analysis needs assessment would "demonstrate its benefits and practicality in order to get it back on the agenda and get more buy-in from decision-makers" (Phase II participant). As it became more evident that policies were not going to be adopted by health authorities and districts, the focus on implementation, especially training, grew.

The Policy Stream for government action, however, was never a focus; that is, the project from the start was intended to have individual regional health authorities and districts implement gender-based analysis. No pressure was put on departments of health to enter the Policy Stream and to examine options or policy instruments that could change the practices of health authorities, apart from informing or encouraging (Howlett & Ramesh, 1995). Governments could, for instance, require that all public agencies show evidence of gender-based analysis. This lack of attention to other options continued despite the argument of PWHCE staff and consultants that training of health professionals at the authority and district level was a government responsibility.

The arrows in Figure 3 point to the importance of a varied membership in a Policy Network and the role of Advocacy Coalitions and the broader Policy Community. The Policy Stream relies on experts and analysts examining problems and proposing solutions. PWHCE supplied different experts and analysts to each province. In Manitoba, having a consultant within the province meant that she had relationships with other members of the Manitoba Policy Network. This could have made the process of joining problems and solutions easier to implement. In addition, the placing of the main office of PWHCE in Winnipeg likely reflects the historical existence of a strong women's health Policy Community in Winnipeg as evidenced by presence there of the Women's Health Clinic and the Canadian Women's Health Network. Despite these possible advantages over the environment in Saskatchewan, the outcomes for Phase II seemed very similar in both provinces; that is, implementation did not occur at the authority or district level.

Decision-Making

The decision-making stage is where policy makers select from among policy options developed in the formulation stage. In

[32] It remains to be seen if speaking about gender-based analysis, rather than women-centred policies, loses some of the groups that normally would be lobbying.

Manitoba, government (not health authority) decision-makers were able to settle on a gender-based analysis workbook. The fact that the workbook idea did not come from health authority leaders suggests that another policy cycle will be needed to see the workbook implemented at that level. Decision-making does not ensure implementation and at the implementation stage, challenges and resistance may occur at many levels. Further, the difficulties described in the narrative experienced in accessing health data for the workbook project suggest another example where government support did not materialize into action.[33] As mentioned earlier, governments have a limited range of policy instruments. In this case, even if the Manitoba government had opted to use something like regulation instead of exhortation (through a workbook) to require health authorities to integrate gender-based analysis in needs assessments, regulation would have been problematic. The skills, according to *Invisible Women Phase I*, may not have existed to implement the regulation.

The project did not reach the decision stage in Saskatchewan. In that province, Phase II was not able to assist in moving the Policy Community past Agenda Setting.

[33] Understanding what the government and health authority relationships are and what the government has off-loaded to CIHI is a challenge for the policy network. Some people also perceive fragmentation and compartmentalization of government activities as an additional challenge that may have been in effect here.

Planning Phase II

Project Logic Models

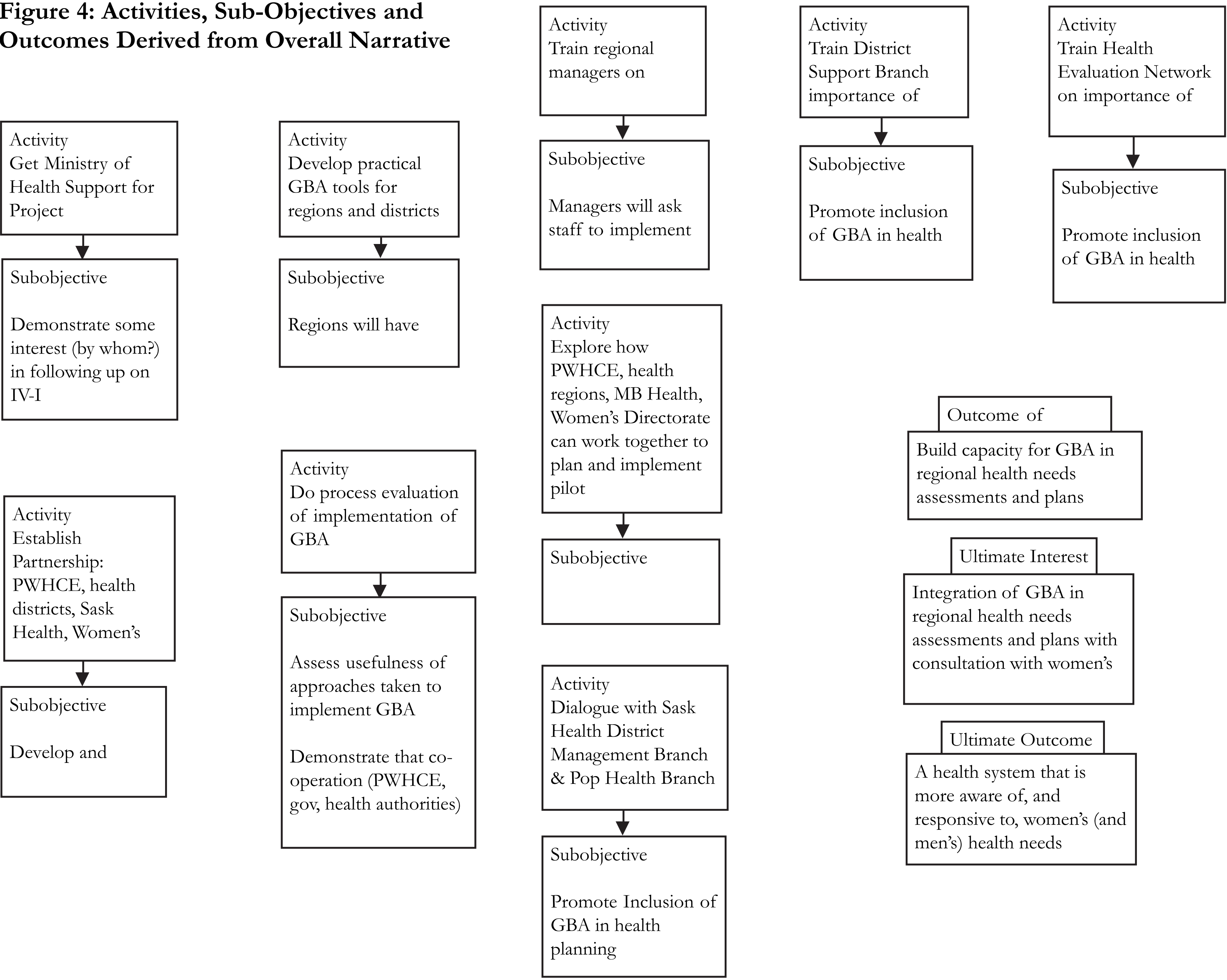
In the narrative we stated: "The lack of attention to identifying and planning for women's health needs seems to contradict international, federal, and provincial commitments to gender-based analysis of public policies and programs. While both Saskatchewan Health and Manitoba Health now recognize gender as an important determinant of health, this recognition had not yet been reflected in regional and district health planning processes." The narrative suggests, therefore, that we expect governments that make commitments to gender-based analysis to be able to influence health authority policy making processes. This seems to be a mistake in logic. According to the Policy Process in Figure 3, governments can create a positive political stream. Politicians could choose to legislate gender-based analysis, but that would be an unlikely first choice. Government bureaucrats could exhort but not require decision-makers at the local level to implement gender-based analysis. Focusing on implementation at the operational level of authorities and districts was not necessarily an error, but it may not have been the most appropriate strategy to affect policy at the governance level.

In trying to understand the logic of Phase II, we tried to create a program logic model from the narrative. A program logic model defines a program theory as that which "tells what is to be done in the program and why – what is to result from the program and how. It is, in short, a testable assertion that certain program activities and sub-objectives will bring about specified results" (Mohr, 1995,

p. 18). Mohr distinguishes between the Ultimate Outcome, usually the more distant goal, and the Outcome of Interest, or the more immediate outcome that we will be expected to assess. Activities in a project are linked to some sub-objective. Sub-objectives should be expected to produce the conditions necessary for the Outcome of Interest.

As Figure 4 shows, we identified a number of activities, several of which were intended to affect the Problem Stream and generate interest in and support for gender-based analysis. It is difficult to link the various activities or to decide which of the Ultimate Outcomes should remain. From the narrative, logical links between the sub-objectives were not clear, suggesting that there was no agreement on the overall nature of the project. As one reviewer of this report stated, "This is so true! Try as we might". Part of the difficulty may have been that different people were unknowingly focusing on different parts of the Policy Process.

Figure 4: Activities, Sub-Objectives and Outcomes Derived from Overall Narrative



The early focus of Phase II "to develop practical tools to assist regions and districts in including gender issues in their health planning and community needs assessments" was, in hindsight, very simplistic. In fact, it is difficult to tell from the narrative whether this was an activity of the project intended to reach some sub-objective, or a sub-objective of other activities. The continued focus on training of senior management and staff in "understanding the need for gender analysis in health planning" identifies that the Policy Community and the Policy Network knew that the Political Stream needed to be improved. Policy Windows were not open as people needed to be convinced that gender-based analysis was "practical" or "feasible". While training might be helpful in recruiting members to the Policy Network, this was not articulated as the hope; in fact, people seem to continue to believe that recruits among managers will be able to implement gender-based analysis within a hostile environment. The consultants continued to stress that a one-shot workshop should be viewed as "a springboard to further work, as *merely one step in a longer process*". Since some players had difficulty committing to a short-term process, the idea of a longer process may have sounded impossible to implement.

The key issues identified by the Saskatchewan Health Evaluation Network in the narrative (Section I) point to the lack of authority of government over health authorities. They were pointing to the failure of the project consultants and PWHCE to clarify the logic model; however, what happened is typical of many planning discussions. According to minutes, the discussion centred on what activities would be undertaken by the consultants and the processes, rather than on clarifying the intended outcomes of the activities and the logic of the model. Consultants expressed some frustration about this, but also felt it may have represented a belief that "not much more than a one shot activity could be done". Partnership was a recurring theme in the narrative but there was little clarity on what it meant and no activities were described as specifically to accomplish partnership development (Scott & Thurston, 1997; Scott & Thurston, 2002). In short, this part of the model for a process of gender-based analysis was assumed. The assumptions articulated for the pilot project all refer to the "partner organizations" but participation was uneven and all were not equal partners. There were common goals and commitments of funds from government departments, but there is some evidence that some health authorities wanted control of some of the funds.

The failure to do partnership development is highlighted in the Saskatchewan case by the decision in January 2000 to consult separately with districts about their expectations with the plan that these would be used to "brief" other partners (i.e., the government). After the bi-provincial meeting and revision of the project objectives, Saskatchewan people rejected the logic model (Figure 5) presented and opted for a model that excluded consultation with community women's groups. They also identified a specific training need: use of disaggregated data (Figure 6). In both models, the connection between the outcome of interest selected and that originally envisioned for the project is not explicit.

Figure 5: Logic Model As Derived from Project Framework Goals and Objectives

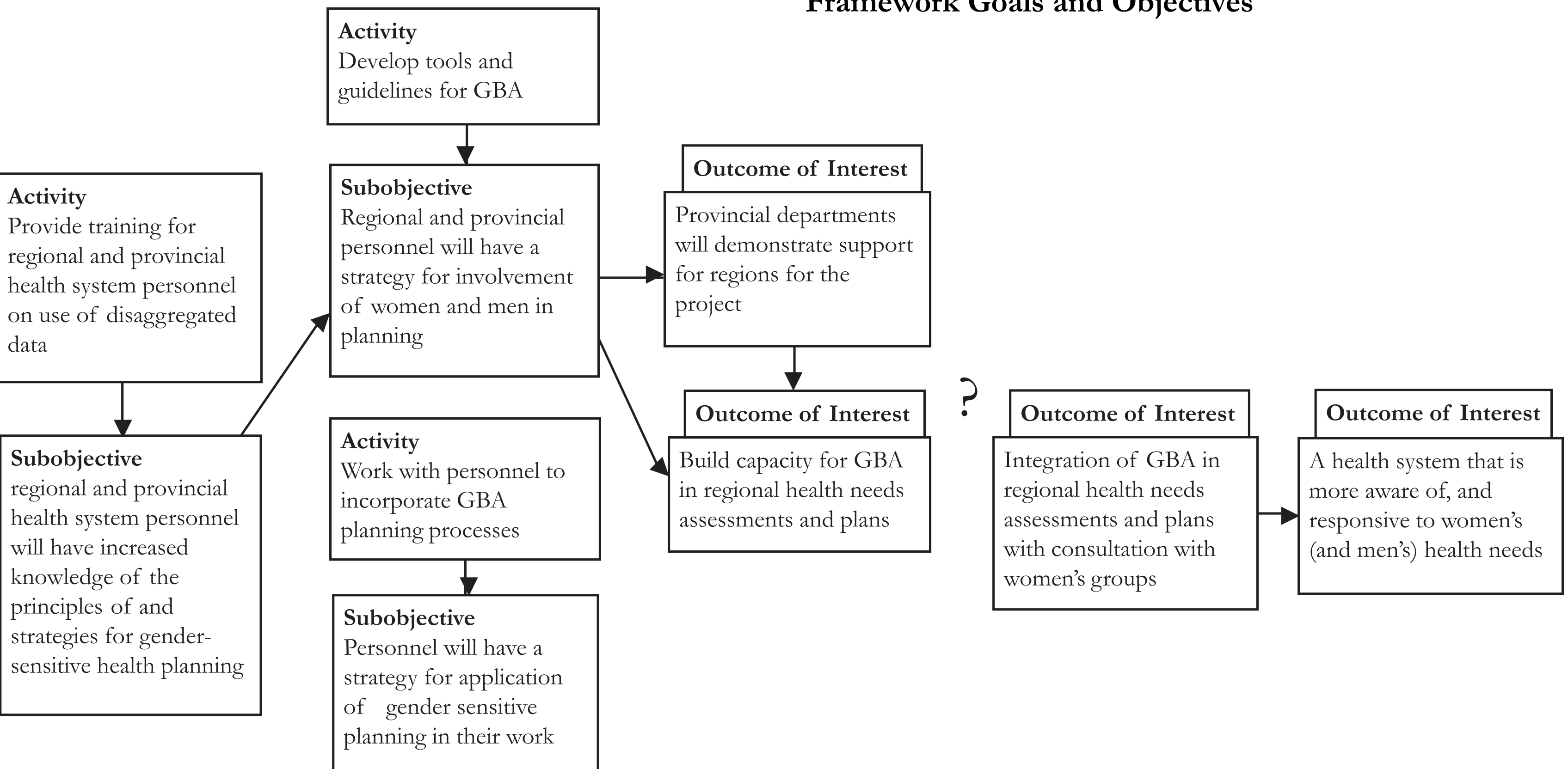
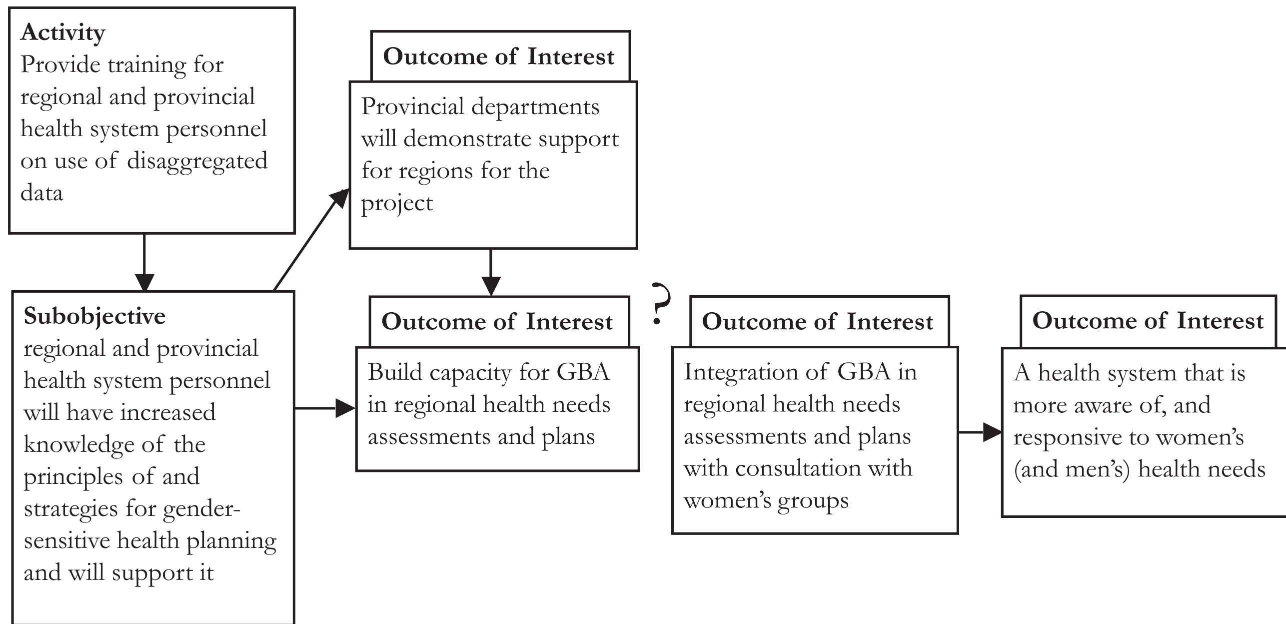


Figure 6: Logic Model Proposed for Saskatchewan after Bi-Provincial meeting



Although inclusion of women's organizations was mentioned early in the project (Figure 1) as an ultimate outcome for gender-based analysis, this was virtually invisible in the narrative as government departments, regional authorities/districts, PWHCE, and consultants negotiated the project activities and goals. An example of how context may have had unexpected influences on the project is the application for the CAHR. In so doing, the consultants and PWHCE may have inadvertently communicated to members of the policy networks and the policy community at large that this undertaking could be envisioned as requiring a lot more time and resources than were available. Inadvertently, PWHCE was framing the project as an add-on to staff work, just as regional health authority staff were framing gender-based analysis as an add-on to their work.

CONCLUSION

This study was not intended to assess whether Phase II was "successful" or not. Generally, the informants were disappointed with the outcomes of Phase II; however, looking at the project through a policy development framework suggests some key findings:

- The work of the PWHCE in building good relationships with members of the policy community is important to achievement of the Centre's long-term goals and should be valued as such. In the long-run, this project, combined with other activities, may build policy networks that will benefit women's health. Quality as well as quantity proves to be important.
- Goals, objectives and logic models should be developed around phases of a policy development and implementation, specifically:
  - Defining the aspect of the policy process (agenda setting to evaluation) to be addressed;
  - Characterizing the policy networks that might be helpful;
  - Clarifying the assumptions about partnerships; and
  - Identifying the resources required to accomplish the project.
- Using existing policy networks may be more effective than attempting to merge networks (e.g., bi-provincially or among health authorities or districts). Working in two very different policy environments, Manitoba and Saskatchewan, complicates policy processes.
- Given the success of PWHCE in encouraging women's health projects, caution should be exercised by PWHCE in assessing the potential for conflict or convergence between objectives of projects that are apparently independent.
- Decentralization restricts policy networks at the level of health authorities or districts and requires health policy advocates to work with more networks dispersed over a larger geographic area.
- Changes in the political stream are quite common and often have a significant impact on a policy initiative; therefore, process evaluations should look at the broader context in order to explain successes and failures.
- Policy initiatives should be clear on the leverage available to provincial authorities to make changes in decentralized health authorities or districts and in the difference between governance and operations at the health authority or district level.
- Governments and health authorities need to make disaggregation of data a priority so that information systems are developed with this capacity and can be utilized.
- It is important to successful policy processes that Policy Formulation activities (e.g., discussing various solutions) not be confused with Implementation activities (e.g., workbook, guidelines, training).

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