



A WOMEN'S HEALTH STRATEGY FOR BRITISH COLUMBIA

Advancing the Health of Girls and Women



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Acknowledgements

The partners thank their colleagues across British Columbia for their contributions to the development of this Strategy to advance the health of girls and women in the province.

This Strategy is a joint initiative of BC Women's Hospital & Health Centre, an agency of the Provincial Health Services Authority, and the British Columbia Centre of Excellence for Women's Health (BCCEWH). Dr. Elizabeth Whynot, President of BC Women's, Dr. Lorraine Greaves, Executive Director of the BCCEWH, and Ann Pederson, Manager of Research and Policy at the BCCEWH lead the development of the Strategy. BC Women's and the BCCEWH funded the second phase of the Strategy development.

The Office of Healthy Children, Women and Seniors, Ministry of Health Services, provided the funding for the initial phase of work, and consulted on the early direction of the document. In particular, Tessa Graham, Executive Director, Healthy Children, Women and Seniors and Tracee Schmidt, formerly the Manager of Women's Health of the Office of the Special Advisor on Women's and Senior's Health, were key contributors to the Strategy.

Ann Pederson was the lead author on the document, with assistance and support from many individuals, particularly Lorraine Greaves and Elizabeth Whynot. A task group composed of the following people discussed the evolution of the document and reviewed an early draft in March 2003:

Jan Christilaw, BC Women's Hospital & Health Centre; Jill Cory, BC Women's Hospital & Health Centre; Lynda Anderson, Northern Health; Jan Blades, Fraser Health; Rita Bowry, Barrister and Solicitor (Dawson Creek); Anne Burrill, Women's Contact Society (Williams Lake); Allison Cutler, Vancouver Island Health Authority; Lydia Drasic, Fraser Health; Sandra Edelman, Vancouver Coastal Health; Maria Hudspith, Vancouver Coastal Health; Kelly Madigan, Interior Health; Shirley Morven, Nisga'a Valley Health Board; Alice Taft, Vancouver Island Health Authority; Angie Todd Dennis, BC Women's Hospital & Health Centre; Jennifer Vornbrock, Vancouver Coastal Health.

We would also like to thank Robin Barnett for assisting with a preliminary draft, Dawn Fowler for consultation regarding women's health surveillance, Kara Keam for facilitating the work of the Reference Group, and Anne Speer, Jill Cory and Patti Hunter for their support of the Provincial Women's Health Network, who also reviewed this document (see Appendix A for initial membership list).

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Partners in Advancing Girls' and Women's Health in BC

Advancing the Health of Girls and Women in British Columbia is presented by BC Women's Hospital & Health Centre, an Agency of the Provincial Health Services Authority, and the British Columbia Centre of Excellence for Women's Health (BCCEWH). These partners share a common aim to improve health and health care for girls and women in British Columbia but have distinct, complementary roles in developing policy, conducting research and providing care to achieve that aim.

BC Women's is the lead agency within the Provincial Health Services Authority (PHSA) with the mandate to address the broad range of health issues for women in BC. As the only facility in the province devoted primarily to the health of women of all ages and backgrounds, BC Women's provides a broad range of specialized health services and is the largest single provider of maternity services in Canada. It coordinates and evaluates specialized health services, disease prevention and health promotion activities, and works with the other health authorities in BC to support equitable and cost-effective health care for girls and women.

The British Columbia Centre of Excellence for Women's Health is one of four Centres of Excellence for Women's Health in a national program funded by Health Canada through its Women's Health Strategy. The BCCEWH conducts or facilitates research on a variety of women's health issues in collaboration with providers, policy makers and women in BC and across Canada. The particular mandate of the BCCEWH is to develop new knowledge to provide policy-relevant evidence for improving women's health, especially women on the margins of society. The BCCEWH has been hosted by BC Women's since 1996.

This Provincial Women's Health Strategy has been developed in consultation with many partners, including the Office of Healthy Children, Women and Seniors of the Ministry of Health Services, health authorities and community representatives. The document emphasizes the importance of working in partnership to achieve improved health for girls and women. It highlights opportunities for collaboration; provides guidance on future planning, programming, policy, and research; and provides a framework to develop indicators and measurement tools for gauging successes in the years to come. BC Women's and the BCCEWH will continue to support the strategy through various activities that directly or indirectly enhance capacity, services and knowledge of women's health in BC.

This document emphasizes the importance of working in partnership to achieve improved health for girls and women.



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We extend an invitation to health authorities to join us to improve the health of girls and women in BC. To support this involvement, BC Women's has invited representatives from each health authority, the Ministry of Health Services and selected community-based agencies to participate in a Provincial Women's Health Network to guide and support implementation of the Strategy. The Provincial Women's Health Network was formed in 2004; its mandate is to monitor women's health in BC and to support the goals of this Strategy.

Overview

The aim of the Provincial Women's Health Strategy is to improve the health of girls and women throughout BC. This document describes an approach to understanding girls' and women's health and provides background information to promote the development of initiatives to integrate girls' and women's health into research, policy and clinical care.

Overall, the health of girls and women in BC compares with the best in the world. However, while life expectancy among women has achieved an all-time high, there are nevertheless significant sources of disease and illness that continue to affect the quality of life of women and some groups of girls and women suffer from serious health problems. Researchers, policy makers and practitioners need to be strategic in addressing health conditions or diseases that are unique to, more prevalent among or more serious in women, or for which there are different risk factors or interventions for women and girls as compared to men and boys.

BC Women's and the BCCEWH are committed to improving the health of girls and women in BC and to ensuring that appropriate, gender-sensitive care is available for all girls and women. Through advances in knowledge about girls' and women's health, based upon research across all sectors of society and the evaluation of health care in all its dimensions, the partners are committed to the development of better policies and practices to enhance the lives of girls and women in BC.

At the time of writing, opportunities and challenges face us in British Columbia with respect to girls' and women's health. Based on consultations held during the past two years with government, health authorities, researchers and community members, we suggest that the initial priorities for action and research include developing enhanced capacity for women's health monitoring, surveillance and reporting within BC, improving access to maternity care and supporting women-centred approaches to mental health and addictions.

Truly advancing the health of girls and women in British Columbia depends on the contributions of many people. It will take a concerted effort from all sectors of society, not only those within the formal health sector, to fulfil the vision of this Provincial Women's Health Strategy.

The health of girls and women in BC compares with the best in the world, but some groups suffer from serious health problems.





Renewing Our Commitment to Women's Health in British Columbia

Nearly ten years have passed since a province-wide consultation on women's health was undertaken by BC Women's. Through discussion groups with women and telephone interviews with service providers, we learned about the challenges ahead for women's health in the province (see BC Women's Hospital & Health Centre 1995).

We learned that women in BC are resilient and resourceful but for many of them their lives are affected by violence, racism, aging, poverty, disability and change. We heard that women see their health as intimately connected to their lives and that women want a health care system that is responsive, respectful, accessible and accountable.

Those with whom we consulted called for innovations to improve their lives and their health. We responded — by establishing specialized women's health programs at BC Women's, by seeking support for a Centre of Excellence for Women's Health in BC and by joining in efforts across the province that supported women's health.

Since then, though average life expectancy has reached an all-time record of 82.6 years for women, some girls and women are not reaching their full potential for health and measures of life expectancy do not tell us the whole story of girls' and women's health status or concerns.

In his October 2003 review of infant mortality, for example, the Provincial Health Officer examined possible causes of recently-observed increases in infant mortality in BC. He found this trend to be related to increases in the numbers of very premature and low-birth-weight infants (see British Columbia 2003a). These indicators are a reflection of challenges faced by some women in BC in obtaining adequate resources to support them during pregnancy.

To give another example, many women in BC face significant challenges with respect to mental health and addictions. For instance, women in B.C. suffer from major depression at twice the rate of men (Statistics Canada 1998) and experience higher rates of anxiety (Howell et al. 2001). Women's poverty and experiences of violence are inextricably linked to their mental health and influence their recovery (Harris 1997, 1998; Sarceno and Barbui 1997). Trauma, violence and socioeconomic status similarly affect psychoactive substance use among girls and women, affecting both initiation of substance use and changing or overcoming problematic patterns of use (Currie 2001; National Center on Addiction and Substance Abuse 2003).

Women see their health as intimately connected to their lives.



Women's mental health issues and substance use complicate pregnancy and create challenges for mothering (Arnold et al., 2002; Nonacs, Viguera and Cohen 2002). Some groups of women, such as Aboriginal teen girls and low-income women, smoke cigarettes at higher rates than comparable groups in the general population, suggesting that prevention and cessation programs should be tailored to their particular circumstances rather than to a more general audience of smokers.

To continue to identify issues such as these, systematic changes in health status and health service utilization reporting are needed. Reporting data by "female" and "male" would help in identifying patterns and trends, and in allocating resources. More complex reporting derived from gender-based analyses would contribute to improving our understanding of the ways that social and biological factors interact in producing or limiting health for girls and women in BC. Health indicators and reporting systems built to answer such questions will be invaluable in answering these questions and helping planners and decision makers design interventions and support programs.

Promising developments are underway with respect to women's health research. Since the establishment of the British Columbia Centre of Excellence for Women's Health in 1996, there has also been a gradual but steady building of research capacity that promises to carry the improvements of the past decade well into the 21st century.

It is time for renewed commitment to improving the health of girls' and women's health in BC.

The Provincial Women's Health Strategy seeks to improve the health of all girls and women in British Columbia by making positive changes in the health care system, ensuring that the system is responsive to issues of sex and gender, and supporting action to reduce health inequities and preventable conditions, manage chronic conditions and optimize quality of life in girls and women.



The strategy seeks positive changes in the health care system.



Building on a Legacy of Women's Health Action

British Columbia has a rich legacy of leadership in women's health. In the last decade, considerable groundwork has been laid and expertise developed in advancing women's health in this province. The Provincial Women's Health Strategy rests upon these achievements and the networks of supporters committed to improving the health of girls and women in the province. There are many milestones worth remembering.

Ministry of Health

In 1992, the BC Ministry of Health supported the establishment of a Women's Health Centre at Shaughnessy Hospital in Vancouver. In 1993, the Ministry of Health sponsored a Women's Health Conference to develop recommendations about the provincial health care system with respect to women's health. In response to the conference moderator's report, the Minister of Health established the Women's Health Bureau within the Ministry of Health and the Minister's Advisory Council on Women's Health to ensure a strong voice for women in health issues. These two entities led the way in fostering women's involvement in health in the province, creating a profile of women's health status for British Columbia, and advising on policy directions for women's health.

There are many milestones worth remembering.

BC Women's Hospital & Health Centre

In March 1994, the Women's Health Centre was amalgamated with Grace Hospital to create BC Women's Hospital & Health Centre (BC Women's), the largest facility in Canada specifically dedicated to women's health care. BC Women's provides maternity services for over 7000 women annually as well as a broad range of services for women of all ages and backgrounds. The hospital offers extensive clinical and educational outreach to communities across the province

Provincial Consultation

As noted previously, in 1995 BC Women's led a provincial consultation to develop a comprehensive understanding of women's health issues. Women told the project team that their lives were affected by poverty, violence and abuse, social isolation and the effects of the media. They called for greater recognition of the link between social issues and women's health in the organization and delivery of services.



Provincial Health Officer's Report

Also in 1995, the annual report of the Provincial Health Officer featured a discussion on women's health in the province (British Columbia 1995). Linked to the province's Health Goals, the report identified several factors contributing to women's health status, including the gap in wages between women and men, low education levels among Status Indian women, relatively few women in public office, violence, substance misuse, mental health, sexually transmitted infections, participation rates in screening for breast and cervical cancer, smoking, heart disease and osteoporosis. Many of these problems remain challenges for women in BC a decade later.

British Columbia Centre of Excellence for Women's Health

In 1996, the British Columbia Centre of Excellence for Women's Health (BCCEWH) was established at BC Women's. The BCCEWH is supported by the Women's Health Contribution Program of the Women's Health Bureau of Health Canada. Its mandate is to conduct and facilitate collaborative research on women's health and to work toward its translation into programs, services and policies.

Women's Health Research

Since the mid-1990s, women's health research in BC has been transformed and many new research networks developed. A Women's Health Research Initiative and Office at BC Women's was established in 2001, developing a full interdisciplinary agenda of women's health research for BC. Numerous researchers at BC colleges, universities and hospitals have generated new knowledge on girls' and women's health that is helping to foster health and improve health care services in BC and across Canada. New networks and organizations to support the further development of women's health research continue to emerge.

Health Authorities and Local Communities

Many communities and health authorities have conducted local analyses of women's health status and/or conducted needs assessments for their community (see Appendix B for a list of many of these documents). In what was then the Vancouver/Richmond Health Board, for example, the *Women's Health Planning Project Final Report* was released in January 2000. The project involved women from the community as equal partners with a broad range of acute and community sector service providers, policy makers and researchers. At the start of the project, a conceptual planning framework, *Framework for Women-Centred Health*, was prepared based on research into past work in women's health. The final plan combined traditional health status indicators with key social determinants, providing a snapshot of



Many problems named in the 1995 report of the Provincial Health Officer remain challenges for women a decade later.



the health and lives of women in specific geographic areas. The report provided a comprehensive profile with recommendations on three key areas of women's health: violence, mental health and heart health.

In fact, many community organizations across BC have worked tirelessly on women's health issues in collaboration with BC Women's, the Ministry of Health Services, and the BCCEWH. For example, educational initiatives in Women's Mid-Life Health and several demonstration projects in women's mental health have been conducted throughout BC. Under provincial initiatives on violence against women and HIV/AIDS, projects were funded in 17 communities while under the *Working Together for Women's Health* initiative, 12 projects were conducted from Bella Coola to the South Peace, from the North Shore to the Bulkley Valley.

Office of Healthy Children, Women and Seniors, Ministry of Health Services

In 2002, the Ministry of Health Planning created the Office of the Special Advisor on Women's and Seniors' Health to work within the government and among health authorities, women's health advocates, researchers and individual women on women's health issues. This Office initiated the Gender-Inclusive Health Planning Project in collaboration with the BCCEWH in 2000 and a follow-up Gender Inclusive Health Training Project with BC Women's and the Vancouver Coastal Health Authority. This Office was replaced in 2004 by the Office of Healthy Children, Women and Seniors, Ministry of Health Services, which has a comprehensive mandate to support children's, seniors and women's health in the province.

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Other Jurisdictions

There is also a rich women's health legacy from jurisdictions beyond our borders from which to draw inspiration and expertise. Canada committed itself to upholding the global commitment made in Beijing in 1995 at the Fourth World Conference on Women to ensure that the health care system accords women and men equal treatment and should strive to attain equitable outcomes for both. In 1999, the federal government released its Women's Health Strategy (Health Canada 1999), which outlined goals and objectives as a framework to meet both immediate and future health challenges for the girls and women of Canada. Among other things, the federal Strategy committed the federal government to the adoption of gender-based analysis within the context of the health care system and health planning (Health Canada 2003). Concurrently, several provinces have developed action plans for women's health designed to fit within their particular health care system and to meet the unique needs of their female population.



Building on the Legacy

Many women and men have demonstrated considerable commitment to fostering the health of girls and women in British Columbia, working with government, hospitals, health authorities, researchers and communities. This Strategy will continue in this tradition, and catalyze focused and measurable improvements in health and health care over the next decade.





“Every woman should be provided with the opportunity to achieve, sustain and maintain health, as defined by the woman herself, to her full potential.”

Key Concepts

The Provincial Women’s Health Strategy builds upon established concepts of women’s health, sex and gender. These distinctions are important for developing a fuller understanding of the factors affecting girls’ and women’s health as well as planning interventions and services and conducting or interpreting research.

Women’s Health

The United Nations Platform for Action arising from the Fourth World Conference on Women held in Beijing, China in September 1995 recognized that:

Health is a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity. Women’s health involves their emotional, social and physical well-being and is determined by the social, political and economic context of their lives, as well as by biology.

This broad definition of women’s health “recognizes the validity of women’s life experiences and women’s own beliefs about and experiences of health. Every woman should be provided with the opportunity to achieve, sustain and maintain health, as defined by the woman herself, to her full potential” (Phillips 1995, p. 507).

Women-centred Care

“Women seek health care within the context and circumstances of their lives” (Vancouver/Richmond Health Board 2001, p. 24). In turn, this determines when and how girls and women seek services or whether they are able to access services at all. Women-centred care addresses the barriers to access and respects women’s diversity, providing for their health needs in the social and cultural contexts of their experience. Women-centred care addresses issues beyond traditional medical interventions, placing health in its broad social context. Women-centred care aims to be holistic and comprehensive. It is based upon an inter-disciplinary approach to clinical care, teaching and research. It is evidence-based and accountable to the girls and women served, funders and communities. Women-centred care strives to ensure that care is efficient and effective.

Sex Differences

Sex differences are the biological characteristics such as anatomy (for example, body size and shape) and physiology (for example, hormonal activity) that distinguish females and males. Many of these differences arise from the reproductive system. To improve health status, we need to better understand how sex differences such as hormones and metabolic processes link to biological or genetic differences in suscepti-

bility to disease or responsiveness to treatment. Such differences are increasingly being studied.

Gender Influences

Gender influences are the socially constructed roles and responsibilities, personality traits, attitudes, behaviours, values and relative power that society differentially ascribes to the two sexes. Gender is a relational concept. Gender is often experienced as fluid and not restricted to the two distinct categories of male and female. Even so, all societies are organized along the “fault lines” of sex and gender (Moore 1988; Papanek 1990) such that women and men are defined as two different types of people, each with their own roles, responsibilities and opportunities. Gender is reflected in the common assumption that women are naturally suited to caring functions while men are more commonly suited to instrumental activities. This is in turn reflected in the division of labour in the household as well as in the labour force.¹

Sex- and Gender-sensitive Health Research and Policy

Sex- and gender-sensitive health research investigates how sex differences and gender influences interact to produce health conditions or diseases that are unique to, more prevalent among or far more serious in one sex, or for which there are different risk factors or interventions for women or for men (Pinn and La Rosa 1992; Greaves et al. 1999).

Health policies and programs have traditionally focused on biological aspects of diagnosis, treatment and prevention of disease. With respect to women's health, this led to a tendency to focus on sex-specific issues of reproductive health. Yet evidence continues to mount that gender influences girls' and women's health as much as, if not more, than biological sex differences.

Gender-based analysis permits the identification of potential inequalities that arise from belonging to one sex or the other, or from relations between the sexes. “These inequalities can create, maintain or exacerbate exposure to risk factors that endanger health” (WHO 1998: 6). They can also affect access to resources, such as education, income and decision-making power, which themselves promote health. Gender-based analysis illuminates both women's and men's roles. In the context of health, it considers the critical influence that social and cultural factors, and power relations between women and men, have on health.

¹ The categories of sex and gender as described here do not address the complex issues of trans-sexual, transgendered or intersexed persons. These issues remind us that the categories of sex and gender are not necessarily discrete and are not experienced similarly by all people. Issues of transgendered and intersexed health reinforce the need to examine and understand the complex links between sex, gender, sexuality, identity and health.

Gender-based analysis permits the identification of potential inequalities that arise from belonging to one sex or the other, or from relations between the sexes.





Advancing the Health of Girls and Women in British Columbia: A Provincial Women's Health Strategy

10 Year Vision

Advancing the health of girls and women in British Columbia involves understanding the contributions of sex and gender to health conditions or diseases that are unique to, more prevalent among or far more serious in women, or for which there are different risk factors or interventions for women or for men and developing appropriate policies, programs and services.

BC Women's and the BCCEWH are keen to partner with health authorities, communities, researchers, and policy makers throughout BC to work on improving the health of all girls and women in BC through equitable access to services and gender-sensitive policy, research and planning. We are optimistic that working together over the next decade will make a difference for all concerned.

Values

Women are the centre. All elements of the strategy are conceptualized as women-centred, meaning that they consider women's experiences and everyday lives in the conduct of research, planning, policy development and care.

Recognize diversity. Women are diverse. Important differences among girls and women that affect health include variations in age, sexual orientation, language, ability, geographic location, education and income. These differences affect women's capacity to participate fully in society and experience optimal health.

Promote equity. Developing, enhancing or sustaining equity among girls and women in British Columbia will improve health for all.

Goals

Three general goals animate this strategy:

- To improve the evidence base on girls' and women's health
- To improve health of all girls and women
- To provide appropriate gender-sensitive care for all girls and women



Strategic Priorities

Priorities will continue to be identified and evolve as evidence, funding and opportunities arise. The initial priority areas were selected because they are relevant to health services planning across all health sectors in BC and they provide a platform on which to develop and evaluate future priorities. However, these priorities are not intended to exclude critical work underway in many areas such as addressing rising incidence rates of HIV infection, improving rates of breast cancer screening, enhancing access to care for women with disabilities, addressing violence and health, and supporting women's efforts as caregivers. Rather, these initial priorities respond to short- and long-term issues and opportunities for partnering in the current provincial environment.

The suggested initial priorities of the Strategy are:

- Improving women's health monitoring, surveillance and reporting
- Sustaining access to maternity care for women across the province
- Supporting women-centred approaches to mental health, problematic substance use and addictions for girls and women





1. Improving Women's Health Monitoring, Surveillance and Reporting

Having good data is key to ensuring that advances are being made toward improving the health of girls and women in British Columbia. Obtaining a fuller understanding of girls' and women's health depends upon monitoring and surveillance mechanisms being developed from the perspective of sex and gender as well as comprehensive reporting. Enhancing the capacity of data collection mechanisms and increasing skills in gender-based analysis in health will assist in assessing progress. This will entail the refinement of existing health indicators, the development of more sensitive and appropriate health indicators and systematic reporting at all levels.

Monitoring women's health is not the sole responsibility of any one body. In addition to the partners, it is incumbent upon health authorities, women's health network members, and others throughout the health care system to identify health issues related to sex differences and gender influences and to develop plans for addressing them. Developing internal monitoring systems for ensuring that planning processes and strategies are inclusive of women's health issues and that sex-disaggregated data are utilized is just as important as provincial-level monitoring.

Concurrently, our efforts in BC benefit from national and international initiatives in improving surveys, indicators and surveillance systems. Improving health service accountability is an important activity across all sectors. As we improve our capacity to identify and monitor the impact of the system on population health outcomes, it is important to adopt and recommend a sex- and gender-sensitive approach.

Enhancing the capacity of data collection mechanisms and increasing skills in gender-based analysis in health will assist in assessing progress.

Supporting Initiatives

National Initiatives in Improving and Collecting Data

BC can utilize many national data collection systems, surveys and broader initiatives to improve the health of women in BC. Researchers from BC contributed to the Women's Health Surveillance Report (available from the Canadian Institute for Health Information), a national project involving researchers at numerous institutes and universities. Women's health indicators are widely acknowledged to be underdeveloped and both national and international bodies are addressing this problem with research and development projects. Further there is an ongoing critical examination of the nature and sources of evidence used to support women's health treatment, research and policy. The BCCEWH is engaged with projects in all of these issues, some in concert with the Centres of Excellence for Women's Health Program.

Women-centred Research Strategy at BC Women's

In 2004, BC Women's released its approach to research and its strategic themes (see www.cw.bc.ca/whri/strategic.asp). In 2005, the priority themes for intensive development are maternity care, addictions and mental health. In addition, the areas of violence and health, and Aboriginal women's health will be coordinated to create a research approach and agenda in each. Several strategic actions will enhance the improvement of data and the capacity to do women's health research in BC. The development of a Women's Health Research Institute will begin to provide a framework for focussed growth of research, evaluation, training and leadership to support the provision of women-centred care at BC Women's and across BC in the many communities served by BC Women's. In addition, efforts will be made to develop an electronic research platform to enable participation in all phases of the research process for women and researchers from all sectors and regions.

Women's Health Research Network

The Michael Smith Foundation for Health Research is supporting the development of eight health research networks in BC, including a women's health research network, designed to enhance researchers' productivity and capacity for acquiring national and international funding. (See <http://www.msfhr.org/sub-funding-network.htm>). In the fall of 2004, women's health researchers and collaborators from across BC made plans for the network through videoconferencing in a virtual colloquium, to support a design for infrastructure of such a network. The bonus of a network is the opportunity to link studies and data collection across sites in BC, as well as to create better information sharing about current and future projects.

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2. Sustaining Access to Maternity Care

Ensuring appropriate access to maternity services for all women across BC is becoming increasingly challenging for a variety of reasons. Though births have been decreasing for many years in BC, they are expected to rise significantly over the next decade. The numbers of physicians and nurses available to provide maternity care across the province are decreasing and our training programs for these professions as well as midwifery are not keeping up with this decline. These demographic phenomena are occurring at the same time as health authorities are consolidating limited resources to ensure optimal resource utilization. Recent reports by the Provincial Health Officer have focused on important indicators of maternal health, specifically noting a trend to increased infant mortality and an alarming rise in the proportion of infants born by Caesarean section. There is a need for a provincial strategy to ensure that both rural and urban women in BC have access to the maternity care they need.

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Supporting Initiatives

Maternity Planning

The Ministry of Health Services, health authorities across BC, and a variety of other stakeholders are involved in a number of maternity care planning projects aimed at ensuring women's access to safe and appropriate maternity and newborn services. Each of the five regional health authorities is engaged in planning of maternity services, as well as supporting the Provincial Specialized Perinatal Program. In addition, the Ministry of Health Services continues to work with stakeholders on sustaining and developing the human resources key to ensuring this service. For example, in 2004 the Ministry of Health Services and the British Columbia Medical Association have agreed to support a Maternity Care Enhancement initiative to suggest a plan to sustain maternity services across the province.

Maternity Care Research

BC Women's, the BCCEWH and other partners are engaged in considerable research to improve maternal and fetal health outcomes. These range from research in primary care through to high risk and complex pregnancy and birth. The latter require research on conditions and diseases in the mother, the fetus and newborn. Research on the issues and health threats posed by substance use, smoking and HIV/AIDS to healthy pregnancy and birth is ongoing. Giving more women across BC access to high quality care and treatment around maternity issues will help improve primary maternity care services.



Rural maternity care is under additional pressures. Research investigating better service delivery models, ensuring adequate service provision and the impact of giving birth outside of home communities is ongoing. A project investigating Aboriginal maternity care models is dedicated to developing capacity in community-based researchers and to better understand the unique experiences and challenges Aboriginal women face when giving birth. This project evolved out of consultation with rural communities across the province that involved listening to women, their families, and other members of the communities about leaving their home communities to give birth. This project worked with communities from Skidegate, Old Massett, Alert Bay, and Bella Coola.

Primary Health Care Transition Projects

The Northern Health Authority, working in partnership with BC Women's, has implemented a strategy to improve access for women in very small communities to women's health information and screening. This project builds on previous work to train community health nurses and community health representatives in providing these services to women, and is linked in several communities with the development of primary health care centres.

BC Women's Primary Health Care Transition funding is supporting (in partnership with the relevant health authorities) the implementation of innovative approaches to sustaining primary maternity care for women, including a Family Practice Maternity model in the Interior Health Authority and the multidisciplinary South Health Community Birth Project in Vancouver in conjunction with Vancouver Coastal Health.

Women's primary health care needs were also the focus of a national workshop in the late winter of 2004 as well as at the National Primary Health Care conference held in Winnipeg (see www.cewh-cesf.ca/healthreform/primary_care/index.html). At the core of these discussions was whether and in what ways women's particular needs with respect to primary health care are being considered in discussions of primary health care reform.

South Health Community Birth Project

The Departments of Family Practice and Midwifery at Children's and Women's Health Centre have received funding in conjunction with Vancouver Coastal Health for a collaborative, inter-disciplinary primary health care initiative. In this model, family physicians, midwives, community health nurses and doulas work as a collaborative team to offer care in an underserved, multi-ethnic community in Vancouver. The program will also establish a multidisciplinary education and research centre for current and future health care professionals focusing on healthy birth.



In what ways are women's particular needs with respect to primary health care being considered in discussions of primary health care reform?



UBC School of Midwifery

In September 2003, the University of British Columbia Faculty of Medicine initiated the UBC midwifery program, a four-year, full-time program leading to the Bachelor of Midwifery degree. Currently funded for 10 students annually, the first class (a “double” class of 20) will graduate in 2007. This program is an important step towards ensuring enough maternity providers in BC in the future. Graduates of this program will provide effective and appropriate midwifery care as a full member of the primary care system. The development of midwifery in BC is also supported by research into midwifery in the province and policy discussions on the contribution midwifery could make to addressing access to maternity care in Canada (see Kornelsen 2003).

3. Supporting Women-centred Approaches to Mental Health, Problematic Substance Use and Addictions

Mental health and addictions are often interrelated problems and both may be associated with a history of trauma and abuse. The health care system's efforts to assist people with these problems must also take care not to further traumatize the women it serves. Women-centred approaches to supporting harm reduction strategies – such as those adopted under the terms of the Four Pillars Strategy of the City of Vancouver or articulated in the BC Ministry of Health Services' planning framework, *Every Door is the Right Door* (British Columbia 2004a) – are needed, as are services that are appropriate and accessible for young women.

The redevelopment of Riverview Hospital has implications for regional and provincial access to services, both for people already in care and for those needing mental health services in the future. The province's Aboriginal communities must be involved in developing and providing approaches that are appropriate and relevant to their own communities. Innovations such as Fir Square Combined Care Unit at BC Women's Hospital, a unit that supports substance-using mothers and their infants, need to be evaluated. The province's Foetal Alcohol Spectrum Disorder strategy must be implemented and supported by the many agencies and communities involved. Multi-disciplinary research must be conducted on the sources of women's mental health problems and the effectiveness of intervention strategies.

Addictions and mental health services need to be coordinated.

Supporting Initiatives

Mental Health and Addictions Planning

A provincial strategic planning framework on substance use and addictions, *Every Door is the Right Door* (British Columbia 2004) was released in May 2004. It identifies the need for addictions and mental health services to be more coordinated, and mentions how gender and diversity matter in terms of how we create services and what kinds of co-occurring issues emerge. It defines what a comprehensive continuum of integrated services might look like and provides examples from current work on prevention, early detection, harm reduction, treatment and supported self-management. Strategies for leadership, partnership development and system integration that link individuals, communities, health authorities, the Ministry of Health Services, the Ministry of Children and Family Development and other provincial ministries are proposed that are highly consistent with the vision in this Provincial Women's Health Strategy.





It is the first plan
in the country
to recommend
balancing efforts
to prevent FASD
through supporting
women's health
with treatment for
those affected by
FASD and their
families.

Research and Program Evaluation

BC Women's is a national leader on women's addiction treatment and research. The Fir Square Combined Care Unit, which provides pre- and antenatal withdrawal management for pregnant women, mothers and their babies, and the Aurora Centre, a day and residential treatment program for women with serious addictions, mental health and trauma issues, are important provincial resources for women with substance use problems. The Provincial Research Consultant on Women and Substance Issue, based at BC Women's, conducts clinical and evaluative research with these two programs and links policy makers and program providers to research on substance use issues and women.

Researchers at the BCCEWH and BC Women's are actively involved in program evaluation and research studies related to women's use of tobacco, alcohol and other drugs, disordered eating and the problematic use of prescription drugs. The links between substance use, violence and trauma among pregnant women and mothers is a key area of research within the BCCEWH. Research has been translated into suggestions for designing interventions related to pregnancy and tobacco smoking as well as tobacco policies for Aboriginal groups. The BCCEWH is developing a longitudinal study on housing for mothers with substance use issues in conjunction with the YWCA.

Provincial FASD Strategy

The Strategic Plan for British Columbia on Fetal Alcohol Spectrum Disorder (Poole, 2003) advocates supporting women to reduce or stop alcohol and other substance use during pregnancy. It is the first plan in the country to recommend balancing efforts to prevent FASD through supporting women's health with treatment for those affected by FASD and their families.

Impart

The BCCEWH, along with partners from UBC and BC Women's, launched the first training program for addictions researchers interested in gender and women's health in Canada in September 2004. Funded by the Canadian Institutes of Health Research (CIHR), The Integrated Mentor Program in Addictions Research Training (Impart) is an innovative, multidisciplinary research training program designed to equip health researchers from across disciplines, sectors and settings to conduct gender and sex-based analyses in addictions research (see www.addictionsresearchtraining.ca).

Building Capacity to Support the Strategy

In order to advance the health of girls and women in British Columbia, we need to build even more capacity among communities, researchers, policy makers, health authorities and health services providers with respect to girls' and women's health issues, gender-based analysis within the health field and the role of sex- and gender-sensitive evidence in health policy making. The elements and skills needed to provide women-centred care need to be developed. While every organization will have its own approach to developing these capacities, two initiatives were underway in 2004 to support the capacity of clinicians, researchers and policy makers to meet the challenges of improving girls' and women's health in BC: a provincial women's health network and training in gender-inclusive health planning and women-centred care.

Supporting Initiatives

Provincial Women's Health Network

The Provincial Health Services Authority, in partnership with the Ministry of Health Services, has established a Provincial Women's Health Network to build on the existing capacity regarding women's health throughout the province. This network, which includes representatives from every health authority, had its infancy with the establishment of a Reference Group for the development of this Women's Health Strategy. The Network will support the future implementation of this strategy as well as other pivotal work regarding women's health.

Gender Inclusive Health Training

BC Women's is managing a project co-funded by The Ministry of Health Services and the Vancouver Coastal Health Authority to promote an awareness of sex differences and gender influences in health care practice and policy. Training will be directed to two distinct groups – front-line workers in health care settings and health planners. While there is overlap in the curriculum development, two separate but complementary curricula will be developed for these audiences. Training is intended to be delivered to each audience (i.e., one for front-line workers and one for health planners) in each regional health authority across the province.

In conjunction with research, evaluation and policy initiatives, the Provincial Women's Health Network and Gender Inclusive Health Training will contribute a solid base for advancing and measuring progress in women's health. New mechanisms and training programs will need to be developed over the next 10 years to meet the goal of advancing the health of women and girls in British Columbia.

The Network will support the future implementation of this strategy as well as other pivotal work regarding women's health.





Background: Sex, Gender and Women's Health

Whether one is a woman or man affects one's health status, use of health services, experience of illness and health-related activities such as caring for others. Women's health is grounded in the context of women's lives, the roles women play, the expectations that girls encounter and the opportunities available to girls and women.

The material that follows explores each of these aspects of girls' and women's health in more detail. This is not intended as an exhaustive review of girls' and women's health issues, but rather as an illustration of the value of looking at health issues in relation to sex and gender.

Women's Health, Women's Lives

The United Nations' definition of women's health inextricably links women's health to the context of women's lives. Women are situated differently than men, socially, politically and economically which, in turn, affects health. Researchers have argued that gendered differences in access to resources and opportunities tend to disadvantage girls and women disproportionately such that they experience various forms of social exclusion arising from poverty, social and geographic isolation, discrimination and disability (WHO 1998).

The resulting marginalization of girls and women with respect to opportunities for full participation in social life and the associated limits on education, employment and lifetime income and security have implications for health. "To be included is to be accepted and to be able to participate fully within our families, our communities and our society. Those who are excluded, whether because of poverty, illiteracy, unemployment or under-employment, geographic remoteness, ill-health, gender, race, or lack of education, do not have the opportunity for full participation in the economic and social benefits of society" (Guildford 2002, p. 3).

Therefore, Health Canada (1999) includes gender in its list of the determinants of health, arguing that it has a powerful effect on health, alone or in concert with the other determinants of health:

- Biology and genetic endowment;
- Healthy child development;
- Personal health practices and coping skills;
- Culture;
- Social support networks;
- Physical and social environments;
- Income and social status;

The United Nations' definition of women's health inextricably links women's health to the context of women's lives.



- Health services; and
- Education, employment and working conditions.

Both the determinants of health and the concepts of inclusion and exclusion assist in understanding how the context of women's lives is different than that of men's and how this difference affects health. The determinants of health approach reminds us that factors beyond the health care system are key to not only health status but how, when and with what result women use the health care system. The social exclusion lens offers us a mechanism to explain how social processes marginalize some individuals and groups in society more than others.

While looking at the context of women's lives is useful from a planning perspective, the broad trends do not necessarily apply at the individual level. Tailoring health care for individual women also means understanding their personal circumstances, genetics, lifestyle and health history, not simply the typical pattern for all women. For example, while elderly women are far more likely than elderly men to live alone, not all elderly women do. Thus, while it is more likely that elderly women who are discharged from hospital in general have less support upon returning home, this will not be the case for every elderly woman. Moreover, aging means different things for different cohorts of women, depending upon their lifetime histories of nutrition, physical activity, migration, employment, fertility, discrimination and level of income, among other factors.

A particular way in which women's lives shape women's health is through the content of women's social roles. While the specific social expectations of women's roles has varied historically and varies today in different societies, what has not varied is that women are generally expected to be particular sorts of people and to perform certain social roles within the family, the economy and society as a whole. Gendered norms, expectations and assumptions shape the nature of the lives girls and women lead, from their choice of occupation, to their sense of themselves, to the kinds of physical activities they engage in, to whether they are likely to undertake post-secondary education, to whether they are likely to be the lone parent of their children, to their lifetime income potential.

For example, as the principal caregivers in most families, women have responsibility for recognizing health problems in children, spouses, elderly relatives and family members with disabilities and seeking appropriate care for these problems. As the family health guardian, many women also literally feed their families, clean households, transport people to schools, workplaces and recreational activities, handle household finances, and educate children and others on human development, sexuality, nutrition, first aid and appropriate social behaviour.



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Many features of women's lives are not changeable through individual action but can be influenced by social and economic policies.

Thus women are the target of many health promotion and disease prevention efforts because they are either directly or indirectly involved in many preventative health actions. However, critics of traditional health promotion suggest that these assumptions about women's responsibility for the health of others often put women into a situation of "responsibility without power" (Daykin & Naidoo 1995) wherein women are expected to change the behaviour of others when this is not necessarily possible. More appropriate health promotion strategies would recognize this conflicted situation for girls and women and adopt a gender-sensitive approach.

Many features of women's lives are not changeable through individual action but can be influenced by social and economic policies. Recognition of the inequities that may arise between women and men, and among women, as a result of the link between women's lives and women's health calls for alliances between health and social services professionals, researchers, policy makers. It also means that we need research and training about diverse aspects of women's lives and health, and a broadening of the tools used to monitor progress in health and health policy such as health indicators and surveillance systems.

Some Women's Health Issues

Some of the diverse aspects of women's lives that are important for health include poverty, violence, homelessness, levels of physical activity, tobacco use and caregiving. Each of these factors has dimensions that are known to be different for girls and women than boys and men.

Mothering and Poverty

Women's poverty continues to be an important health determinant and "child poverty," which reflects the proportion of women who are lone mothers, remains a key challenge for healthy child development. In 1996, 83percent of all one-parent families were headed by women (Statistics Canada 2000). Nearly nine-out-of-ten lone parents in BC are women (BC Council for Families 1997). Average after-tax income in 2001 constant dollars in Canada for female lone-parent families was \$31,208 compared to \$39,880 for male lone-parent families (Statistics Canada 2004). Given that most lone-parent families are headed by women, most children in lone-parent families live in low-income households. Child poverty is really women's poverty. Low-income mothers are more likely to have small birth weight infants, a factor that can influence health over a lifetime. Knowing this, the Provincial Health Officer has recommended that we ensure that women have adequate incomes.

Violence is Gendered

Gender also shapes whether and how one is affected by violence. Sexual assault, for example, is primarily a female problem. In 1998, 85 percent of all sexual assault victims were female (Statistics Canada 2000). Woman abuse is another serious example of violence against women. The *Police and Crime Summary Statistics for BC* (British Columbia 2003b) indicate that 10,121 incidents of spousal assault were reported in 2000. In these reported incidents, 78.2 percent of the accused were males, 12.9 percent of the accused were females and the remaining 8.9 percent of reports involved both spouses assaulting each other.

Women are the Invisible Homelessness

Estimates of the number of homeless people are typically based on emergency shelter use, but such figures likely underestimate the number of homeless girls and women, as there is evidence to suggest that they are more likely than homeless men to use alternative forms of shelter such as staying with friends or relatives or in small centres, to use facilities such as transition houses for emergency shelter (Eberle 2001; Lenon 2000).

Women and children are often referred to as the “invisible homeless.” Women with mental illnesses are overrepresented among the homeless, particularly among single women, likely as a result of deinstitutionalization. Women who are homeless are also likely to suffer from domestic, sexual assault or physical abuse (Ontario Women's Health Council 2002). Sexual and physical abuse accounted for approximately 70 percent of youth homelessness in Toronto (City of Toronto 1999).

In BC, an analysis of the Vancouver Injection Drug Use Study found that encountering sexual violence in childhood was predictive of females entering the sex trade at age 17 or earlier (Braitstein et al., 2003), which in turn is associated with street-involvement. A McCreary Centre Society (2001) of street youth in BC identified that among the 12-19 year olds that they surveyed, young women were more likely than young men to cite conflict with parents, violence and abuse at home, and having friends hanging out on the street as reasons for their involvement with street life. Youth on the street are at increased risk for discrimination, violence, sexually transmitted infections, pregnancy, problematic substance use including injection drug use and suicide (McCreary Centre Society 2001).

Girls and Women are Physically Inactive

Participation in physical activity is widely promoted as part of a healthy lifestyle and as a means of preventing or managing a number of chronic health problems, including cancer, diabetes, heart disease and osteoporosis. British Columbians are active

Women and children are often referred to as the “invisible homeless.”





Based on self-reports, girls aged 12 to 18 smoke tobacco as much or more than boys in all age groups and in every geographic community in BC.

compared to other provinces (Canadian Fitness and Lifestyle Research Institute 2002a), however, a significant proportion of British Columbians are still sedentary. Approximately 47 percent of British Columbians are insufficiently active for optimal health benefits (Canadian Fitness and Lifestyle Research Institute 2002b). Among women with high incomes, 51 percent were physically inactive, according to the 1996/97 National Population Health Survey, compared with 60 percent of women with the lowest income level. For lower income Canadians, including women, income may pose a barrier to exercise participation in terms of the costs associated with user fees for facilities and equipment (Federal, Provincial and Territorial Advisory Committee on Population Health 1999).

Teen Girls' Smoking Rates are Increasing

Fewer young people in BC smoke tobacco on average as compared to the average across Canada and BC continues to report the lowest prevalence of tobacco smoking among Canadians age 15 and older (Health Canada 2004). However, the highest rates of current tobacco smokers are adolescent females living in the Northwest region of the province (27 percent) whereas only 13 percent of adolescent girls in Greater Vancouver report being current smokers (McCreary 2002b). Based on self-reports, girls aged 12 to 18 smoke tobacco as much or more than boys in all age groups and in every geographic community in BC. Among girls, 12 percent are daily smokers, five percent are occasional and 28 percent are experimenters, while nine percent of boys are daily smokers, four percent are occasional smokers, and 27 percent are experimenters (McCreary 2000a). Among school-aged girls, 32 percent of Aboriginal girls are current smokers (McCreary 2000b), well above rates for non-Aboriginal girls and women. Cannabis use among girls has increased in the past decade, with twice as many girls who have ever smoked cannabis reporting frequent cannabis smoking (20 or more times in the past month) going from four percent in 1992 to eight percent in 2003 (McCreary 2004).

Caregiving is Often a Woman's Job

Women are often responsible for caring for their children, family or friends. This role as primary caregiver affects women's lives and their experiences with the health care system. In 1996, 15 percent of women between the ages of 25 and 54 provided both unpaid child care and care or assistance to a senior (Statistics Canada 1996). According to the *National Profile of Family Caregivers* (Health Canada 2002), family caregivers are predominantly female (77 percent) and typically older than the population-at-large; women aged 45 and older comprise 51 percent of the country's family caregiver population.

Strategies are being developed to both enhance alternatives to hospital-based care and to find new ways of providing care in non-hospital settings. Two such examples include boosting home care and providing home-based palliative care (or end-of-life care), both of which often mean increased caregiving on the part of women. Caregivers may face different health risks from those who do not perform this role. Recent research links caregiving, for example, with a greater risk of developing coronary heart disease (Lee 2003).

Women's Health Status

Patterns of health and illness vary by sex and gender. The most obvious difference between women and men in recent decades has been in life expectancy but a comprehensive understanding of health status also must include an assessment of morbidity and quality of life. From the latter perspective, women often fare more poorly than men.

In 2000, British Columbia ranked first in Canada in terms of life expectancy at birth for both females and males. A female born in 2000 in BC had a life expectancy of 82.9 years while a male had a life expectancy of 78.2 years. Explanations for this difference likely involve factors associated with both sex and gender. Some of women's advantage in relation to life expectancy is biological as male fetuses are more often spontaneously aborted or stillborn and "in most societies this pattern of excess male mortality continues to be marked during the first six months of life" (WHO 1998: 12). Scientists believe that chromosomal structures and sex-linked genetic conditions make male fetuses more vulnerable than female ones.

Over the life course, male excess mortality continues to be affected by sex but gender influences play an increasingly larger role. Risk-taking behaviour and occupational exposures to health hazards differ between men and women, with men traditionally more likely to engage in high risk behaviours and to work in hazardous conditions than women. Despite their average greater longevity, women in most communities report more illness and distress than men. This excess in female morbidity has significant implications for women's quality of life.

Women have not always lived longer than men. Fifty years ago, there were more senior men than women in Canada. Improvements in women's life expectancy are usually attributed to overall economic development, improvements in reproductive health that gave women greater control over family size, and improvements in maternity care that led to reduced maternal mortality (WHO 1998).

The tide may be changing again with respect to women's health advantage. Increases in tobacco smoking among women over the latter half of the twentieth century are reflected in lung cancer and cardiovascular disease rates. Diabetes is a significant

Patterns of health and illness vary by sex and gender.





problem among Canadian women, particularly Aboriginal women. The contributors to cardiovascular disease remain firmly entrenched in our society and evidence accumulates that women are not being recognized as having heart disease as early as they should be to maximize the effectiveness of interventions. These, and many other health problems confronting girls and women deserve closer examination and demand better responses.

Sex differences in terms of physiology and genetics mean that women and men have unique reproductive health needs but the differences do not stop there: body size differences, hormonal differences – even the functioning of organs – make a difference in how male and female bodies function, respond to treatment and experience a disease trajectory.

While it is true that women currently fare better than men on certain measures of health status (such as life expectancy), such indicators do not tell the whole story and obscure issues around quality of life, experience of illness, appropriateness of care, and effectiveness of treatment. For example, some health problems are unique to women such as cervical cancer, pelvic inflammatory disease, menstrual disorders, menopause, ovarian cancer, post-partum depression and endometriosis. Other health problems are more prevalent in women including osteoporosis, Alzheimer's disease, breast cancer, multiple sclerosis, lupus, osteoarthritis, migraine, depression, anxiety, anorexia and hyperthyroidism. Some health problems are more serious in women, for example, cardiovascular disease and alcoholism. Finally, some health problems have different risk factors for women including hypertension, HIV/AIDS, schizophrenia, problematic substance abuse and cardiovascular disease.

Despite similarities, women are diverse and not a homogeneous group. The differences among groups of women and girls can be as or more significant than those between women and men. Many of the differences among women are associated with important social characteristics such as socioeconomic status, geography, age, sexual orientation, education and country of birth. For example, some groups of women may face language, physical access and cultural barriers to health care which in turn affect their rates of diagnosis and treatment of some health conditions, such as cervical and breast cancer.

Some Significant Conditions or Diseases for Women

Evidence is emerging daily on conditions or diseases that have different, less well understood or more serious implications for girls and women. For example, a recent study appeared that indicated that contrary to prior understandings, migraine appears to cause some forms of brain damage and should be regarded in some cases as a form of chronic brain disease (Spears 2004). Given that women are far more

The differences among groups of women and girls can be as or more significant than those between women and men.



prone to migraine than men, probably as a result of hormonal influences, the meaning of this new finding is different for women than men. Some of the conditions of significance for women in BC are: mental health, problematic substance use and addictions; cardiovascular disease; diabetes; HIV/AIDS; lung cancer; breast cancer and falls.

Mental Health, Problematic Substance Use and Addictions

Evidence shows that certain mental health problems are more prevalent in women and that women utilize mental health services more frequently than men do (Frackiewicz et al., 2000; Federal, Provincial/Territorial Advisory Committee on Population Health 1996; Rhodes et al., 2002; Health Canada 1999). Women are more likely than men to be diagnosed with depression, anxiety, eating disorders, panic disorders, and phobias, and they make more suicide attempts (Kessler et al., 1994). Collectively, this evidence suggests that the mental health needs of women are significantly different from those of men and warrant particular attention (Prior 1999; Federal, Provincial/Territorial Working Group on Women's Health 1993).

Women's mental health needs differ across the life course. During their child-bearing years women may require mental health supports related to pregnancy and post-partum depression, especially if they have mental illness (Nonacs 2002; Arnold et al. 2002). Sex differences, such as variations in lean body mass, hormonal concentrations, and gastric absorption, have been shown to affect the absorption, distribution, metabolism, and elimination of drugs and the biochemical and physiologic effects of drugs (Frackiewicz 2000; Halbreich and Kahn 2001). These factors make a difference in how male and female bodies function, respond to treatment and experience illness.

Mental disorders and substance use problems are serious among girls and women in British Columbia. Indeed, research has shown that mental health problems and problematic substance use in women are often interconnected and that these problems in turn are exacerbated by women's experiences of violence and trauma (e.g., Harris 1998; Anderson and Chiochio 1997).

Women develop a wide range of adverse health consequences from the problematic use of alcohol, tobacco and other drugs over shorter periods of time and with lower consumption levels than men. Physical health problems associated with women's use of substances can include: a wide range of cancers, cardiovascular disease, liver diseases, hypertension, obstructive pulmonary disease, sexual dysfunction, infertility, menstrual irregularities, malnutrition, osteoporosis, cognitive deficits, as well as HIV, hepatitis C and other health consequences associated with injection drug use (British Columbia 2003d; Institute on Alcohol Abuse and Alcoholism 2002;



Women's mental health needs differ across the life course.



Compared with men, women are not only more likely to be prescribed benzodiazepines but they are also more likely to be prescribed them for longer periods of time.

National Institute on Drug Abuse 1999; Stevens and Wexler 1998; US Department of Health and Human Services 2001).

Mental health problems are also associated with and exacerbated by some types of psychoactive substance use and research has shown that as many as two-thirds of women with substance use disorders may have a concurrent mental health problem, such as depression, post-traumatic stress disorder, panic disorder and/or an eating disorder (Zilberman et al. 2003). A large proportion of women with substance use problems are victims of domestic violence, incest, rape, sexual assault and child physical abuse (Ouimette et al. 2000).

The physiological effects of alcohol and psychoactive substances on adolescent girls are not yet well defined, despite the fact that this is the time during which many young women begin drinking, smoking and using other drugs. There is, however, evidence that significant gender differences exist in the pathways to and consequences of substance use by girls and young women (National Center on Addiction and Substance Abuse 2003).

Women are twice as likely as men to be prescribed tranquilizers (benzodiazepines), sometimes for extended periods of time, despite forty years of research that indicate that these medications should only be prescribed for two weeks of continuous use. Compared with men, women are not only more likely to be prescribed benzodiazepines (Taylor et al., 1998) but they are also more likely to be prescribed them for longer periods of time. While over-prescribing is a particular problem for elderly women, many women are frequently prescribed benzodiazepines for “non-clinical” symptoms arising from stress at work, grief, acute, or chronic illness, physical pain or adjustment to major life changes such as the birth of a child or menopause (see Gabe 1991; Reed 1987). Evidence suggests that contrary to initial indications, benzodiazepine use can lead to severe dependency for some people, even when following recommended usage guidelines (Currie 2003). Benzodiazepine use has been implicated in falls, motor vehicle crashes, memory impairment and depression, particularly among elderly women. The costs and consequences of benzodiazepine use are extensive.

Cardiovascular Disease

Cardiovascular disease (CVD), and its multiple manifestations as myocardial infarction, ischemic heart disease, valvular disease, peripheral vascular disease and arrhythmia, has recently been recognized as the number one cause of mortality in both women and men (Heart and Stroke Foundation of Canada 1999). However, CVD is not as well understood in women as it is in men. Preventing and treating car-



Cardiovascular disease in women requires an investment in research and programs tailored to women's unique anatomy, physiology and daily lives. Besides deaths due to cardiovascular diseases, these conditions may also reduce women's quality of life through physical disability, by limiting women's ability to fulfill family and economic roles, and contributing to depression and anxiety. The risk factors, diagnosis, effects, treatment and rehabilitation of cardiovascular diseases differ for women (Legato 1998; Schulman et al. 1999).

Diabetes

Aboriginal women are particularly prone to diabetes, contracting the disease at a rate roughly twice that of Aboriginal men (Health Canada 2000b). According to the 1991 Aboriginal Peoples Survey, the provincial prevalence rates for First Nations were lowest in BC (Health Canada 2000), but more recent data indicate that the prevalence of diagnosed diabetes mellitus in on-reserve Status Indians more than doubled from 1987 to 1997 in British Columbia, with women experiencing a higher prevalence rate than men (Johnson, Martin and Sarin 2002). Prevalence is expected to increase over time as a function of incidence, survival of people with the condition and aging of the population (Health Canada web site).

In Canada as a whole, approximately 2/3 of the First Nations people diagnosed with diabetes are women, in contrast to the entire Canadian population in which diabetes prevalence is significantly higher among males than females (Health Canada 1999). Local community studies show significant variation in the rate of diabetes among communities. In British Columbia, 17 percent of adults over age 35 in Haida Gwaii had Type 2 diabetes.

HIV/AIDS

During unprotected intercourse with an infected partner, women are two times more likely than men to contract a sexually transmitted infection and ten times more likely to contract HIV (Society for Women's Health Research 2001). Of the 15,754 adult AIDS cases reported in Canada up to August 1998, 1,093 (6.9 percent) were among women. The proportion of Aboriginal women living with AIDS is even higher (15.9 percent of adult Aboriginal AIDS cases). AIDS case statistics do not include the number of women with HIV who have the potential to develop AIDS. By the end of 1996, there were an estimated 4,600 women living with HIV and women were estimated to comprise 22.6 percent of new infections in Canada in 1996.

The estimated proportion of women living with HIV has increased steadily over time. When diagnosed with AIDS, women have a lower survival rate than men. This may be due to factors such as late diagnosis and delay of treatment because of misdiagnosis of early symptoms; exclusion from drug trials and lack of access to anti-



The risk factors, diagnosis, effects, treatment and rehabilitation of cardiovascular diseases differ for women.



As the population ages over the next several years, the numbers of women in BC diagnosed with breast cancer will increase.

viral treatment; lack of research into the natural history of HIV in women; higher rates of poverty among women and lack of access to adequate health care; and the tendency of many women to make self-care a lower priority than the care of children/family (Health Canada 2003).

The impact of HIV on women in British Columbia is reflected in the ministry's blueprint to complement, guide and support community and health authority efforts to address HIV/AIDS in the province (British Columbia 2003c).

Lung Disease

Women who smoke tobacco are 20 to 70 percent more likely to develop lung cancer than men who smoke the same number of cigarettes (Manton 2000; Shriver et al. 2000). Twenty-five percent of the cancer deaths in women are due to lung cancer and it is the leading cause of cancer death in Canadian women in 2003, accounting for an estimated 7,900 deaths, as compared with the 5,300 deaths expected for breast cancer. This reflects the rapid increase in lung cancer mortality rates among women over the past three decades, reflecting in turn the uptake of tobacco smoking among women three to four decades ago. Chronic Obstructive Lung Disease (COPD) is also on the increase among women, with different and more serious manifestations in women's bodies.

Breast Cancer

Although breast cancer can affect both women and men, it is a much more significant cause of disease and mortality among women. The Provincial Health Officer's report for 2002, *The Health and Wellbeing of People in British Columbia* (British Columbia 2003d), identifies breast cancer as the second leading cause of cancer deaths in women. That year in BC 2,454 women were diagnosed with breast cancer for the first time. As the population ages over the next several years, the numbers of women in BC diagnosed with breast cancer will increase.

Clearly, continued research is required to identify factors that put women at risk. Meanwhile, early detection through screening provides the best opportunity to reduce mortality from breast cancer. Unfortunately participation in BC's Screening Mammography Program varies across the province and falls well short of recommended rates in most areas. Our immediate challenges therefore are ensuring optimal participation in the screening mammography program and equitable access to appropriate diagnostic and treatment facilities, while developing more knowledge about risk factors and prevention.

Falls

Falls are a common problem, particularly among older adults. The likelihood of falling increases with age and while most falls in the community do not result in fracture, the five percent that do can be very serious. One-third of people aged 65 and over will fall at least once each year. Falls are the most common cause of injury and the sixth leading cause of death for seniors. Women are 3 times more likely than men to be hospitalized for a fall-related injury. In 2001, approximately 3100 seniors were hospitalized for a broken hip; two-thirds of these seniors were women (British Columbia 2004b). A preliminary analysis of epidemiological findings from BC PharmaCare data, hospital separations, and mortality and morbidity data shows a strong association between falls in elderly women and prescriptions for anxiolytics, sedatives and hypnotics, of which 90 percent are benzodiazepines (tranquilizers).

Women and Health Services

The significance of sex differences in the burden of illness becomes more evident when health care utilization is examined. Women use the health care system more than men in Canada, both for themselves and on behalf of others for whom they are responsible. Statistics Canada (1997) reports that 68 percent of women compared to 51 percent of men over the age of 12 see their doctors twice a year or more. Women are more likely to consult physicians, obtain preventative health care, consume medications and have surgery than men, although men and women tend to use the services of physicians at the same rate if we exclude reproductive and sex-specific conditions from the analysis (only women seek care for pregnancy-related matters; only men seek care for prostate problems). These patterns of health care utilization are linked to women's reproductive health, violence against women, mental health and aging (WHO 1988), as well as the other health problems noted earlier.

Women are also often the key targets of public health and prevention messages and programs (e.g., healthy nutrition, healthy childhood development, pregnancy planning and prevention). As noted previously, this role makes women responsible for many household health-related decisions. Some women are also involved in the health care system as decision makers at other levels including community health centre board members, health authority board members and staff, volunteers, and so on.

The third major relationship that women have to the health services system is as health care providers. Women comprise the vast majority of paid and formal health care providers as well as unpaid/informal caregivers. In other words, as women are

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the primary users of health care services and comprise the majority of health care workers (both paid and unpaid), changes to the health care system will have the greatest impact on women (Armstrong et al. 2001; Grant et al. 2004).

In 1998, Health Canada published a study on the economic costs of illness and injury in Canada (Health Canada 1998). The economic burden of illness consists of two measures – direct and indirect costs. Direct costs are those borne by the health care system and indirect costs are borne by the individual. Total costs include both direct and indirect costs.

One significant limitation of applying this measure to women is that indirect costs include loss of wages, however, women have lower rates of labour force participation and earn less than men. In addition, the value of unpaid labour such as caregiving, while taken into consideration, is lower than that of paid labour. This explains, for example, how it is possible for it to appear that despite women's higher rates of both short and long-term disability, the costs to women and men are roughly equal (Health Canada 1998). One area where this issue is significant is for musculo-skeletal diseases. These conditions are more prevalent in women (they rank 7th for women and 10th for men) in terms of the burden of illness, however, 91.7 percent of the indirect costs of musculoskeletal diseases are the result of morbidity due to long-term disability. These analyses render the full costs of many diseases and disorders with respect to women invisible.

Health care services need to be both accessible and appropriate. The 1995 report on the provincial consultation, *The Challenges Ahead for Women's Health* (Ballem et al. 1995), identified a number of factors as limiting women's access to care in British Columbia, including geography, income, community dynamics, physical ability, hours of operation, language and lack of child care. The authors made a number of specific recommendations regarding ways that BC Women's Hospital could be more accessible including: self-referral to programs; child care for patients and staff; flexible hours of operation; the use of interpreters for women whose first language is not English; better discharge planning and communication; and better access for women with disabilities. Many of these recommendations have since been implemented at BC Women's.

Despite Canada having a universal health care system, there are still many barriers to care. Poverty may still affect access to care if transportation is needed to reach services or if medications are needed. Homelessness, a growing problem in Canada, poses significant barriers to care. Homeless women, particularly those with children, confront numerous barriers to accessing health services because they were initially designed to serve the needs of homeless men (Ontario Women's Health Council 2002). Homeless girls and women are particularly in need of family planning serv-

ices, detoxification and addictions treatment, perinatal care, treatment and screening for sexually transmitted infections, breast and cervical cancer screening.

Other barriers to care have been identified in research. For example, it has been demonstrated that fear of child apprehension prevents some women with substance use problems from accessing needed care while pregnant or mothering. Reducing the stigma and shame of seeking care, as well as having programs that serve mothers and children together, are important strategies for overcoming the barriers to care for such women (Poole and Isaac 2001).

Geography also plays a role in access to care. Women living in rural and remote areas of British Columbia face barriers to care, particularly with respect to access to specialists and increasingly in terms of some forms of primary care such as maternity care, but women in urban areas of the province also experience location-related barriers to care. For example, urban women may also have to travel to care that is difficult to reach by public transportation, may face language barriers, or may suffer from physical disabilities that inhibit their ability to enter certain buildings, participate in screening or receive health information.

Evidence suggests that women with physical and mental disabilities are less likely to receive cervical and breast cancer screening than women without disabilities. Innovations such as The Access Clinic at BC Women's, which provides breast and cervical cancer screening for women with disabilities who are not able to have a Pap test or clinical breast exam in their doctor's office, demonstrate that with appropriate equipment, training and time, women with all types of disabilities can have these examinations done in a safe and respectful way.

Some Health Services Issues

Maternity Care

Recent survey data indicate that 30 percent of family physicians and general practitioners deliver babies in BC (Reid et al. 2001). The attrition rate for physicians who provide maternity care is high and there is a mal-distribution of practitioners between rural and urban areas, resulting in rural and remote women facing particular challenges accessing perinatal care (Kornelsen 2003). According to the Midwives Association of British Columbia, midwives presently attend four to five percent of births in the province. There is a need to increase these numbers to ensure adequate numbers of maternity care providers all over BC.

The amalgamation of health service administration under six health authorities in 2001 was the first step in a major reorganization of health care delivery in BC. One of the most challenging aspects of this reorganisation has been the need to create

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systems to both capture economies of scale and balance access against cost. Ensuring access to safe maternity services for women across the province within this context of change is an extremely important challenge

Primary Health Care

Primary health care is usually first point of contact with the health care system and may include a visit to the family doctor, a visit from a home care worker, a trip to the pharmacist, mental health counsellor or school nurse. While taking many forms, primary health care is usually the point in the health system where short-term health issues are resolved, where people with more serious illnesses or injuries are linked to specialized services, where the majority of chronic illnesses are managed, and the point where health education is often conducted (British Columbia 2003e).

Some analysts suggest that elements of primary care reform such as proposals for rostering patients to physician-based group practices, electronic records and multi-disciplinary practices have particular implications for women who are the majority of health care workers as well as recipients of services (Armstrong & Armstrong 2001). Important questions as to who provides this first level of care, who has access and under what conditions, and how care is governed, monitored and funded will need to be addressed. A gender-based analysis of any reform proposals is needed in order to assess their potentially different effects on women and men and to ensure that integrated, high quality, efficient primary care is available in BC.

Unfortunately, for many marginalized individuals, both women and men, the Emergency Room, the police or the morgue is sometimes the first point of contact with any support system. This situation underscores the need for low-threshold interventions for injection drug users such as the supervised injection site in Vancouver's Downtown Eastside.

Access to Emergency Contraception

Since December 2000, pharmacists in BC have been able to provide emergency contraception without a prescription from a physician. This innovation in access to contraceptive care increases women's options for care but issues remain. Data collected on the use of emergency contraceptives from BC pharmacies indicate that access varies across different regions of the province and for different groups of women as a result of age and language.

A gender-based analysis of any reform proposals is needed to ensure that integrated, high quality, efficient primary care is available in BC.



Home Care

The report of The Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada* (Commission 2002) observed that home care is one of the fastest growing components of the health care system as services formerly provided in physicians' offices, hospitals, clinics or long-term care facilities are increasingly provided in people's homes. Home care is provided for children and adults with physical and mental disabilities, to manage acute and chronic conditions, as well as for seniors. Home care is provided by paid health and social services workers and unpaid family members and friends. The majority of home care is provided by women (Cranswick n.d.). Given the aging of the population and women's levels of labour force participation, the question of who is home to care is a burning policy issue.

Tailored Services

Sometimes women and men require services tailored to their specific needs. With respect to addiction services for example, other than the highly specialized Fir Square program at BC Women's for very high risk women and their newborns, there are no women's withdrawal management services in BC. Although women are able to undergo detoxification at existing facilities, this approach does not typically afford women much privacy and may even be a re-traumatizing experience, given the fact that most women in need of such services have experienced violence and abuse. Women-centred withdrawal management, outreach and harm reduction services would provide safe and tailored services, that may in turn encourage more women to take this important step toward health.



Sometimes women and men require services tailored to their specific needs.



Information Gaps in Girls' and Women's Health

Information gaps remain in understanding girls' and women's health in British Columbia. Though the province has one of the most sophisticated systems of linked health information in the country, the usefulness of that information is limited by its sources, which remain administrative information for managing the health care system. Additional information, particularly in sex- and gender-dissagregated forms, is needed to enable researchers, clinicians, program developers and administrators to understand the sources of poor health among girls and women in BC and the effects of policy, clinical and educational interventions.

For example, a study on the health care utilization experiences of women with breast implants in British Columbia (Tweed 2003) demonstrated one of the challenges that decision makers face when information is unavailable. The study suggested that women who have undergone breast implant surgery use more health care services than women without implants. We cannot fully understand the reasons for this pattern however because breast implant surgery, when performed for cosmetic reasons, is paid for privately. As a result, data are not recorded about these procedures in the provincial administrative databases.

Researchers trying to investigate the health consequences of breast implant surgery must contend with self-reports from women who volunteer to participate in research, potentially biasing the research findings. A combined prospective and retrospective registry of women who have undergone breast implant surgery could provide important information about the effects of this procedure and answer questions for researchers, policy makers and women (Pederson and Tweed forthcoming). Other procedures performed in the private sector of the health care system generate similar information gaps. Registries are also being proposed in BC to help manage chronic diseases such as asthma, diabetes, hypertension, depression and congestive heart failure. Such registries – and others such as those developed to monitor arthritis, cancer, cardiac care and perinatal outcomes – are valuable resources for clinicians, researchers, decision makers and patients.

Women's health indicators have typically been restricted to sex-specific conditions such as maternal mortality and screening participation rates or to diseases broken down by sex. A more comprehensive understanding of women's health, and the capacity to monitor changes over time, requires the refinement of existing indicators and/or the development of new ones to capture the effects of gendered differences over the life course in access to resources, power and participation in society. Work on women's health indicators throughout the country and internationally should make valuable contributions to data collection procedures and analytic capacities in the next few years.

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Research on girls' and women's health has been facilitated by the development of infrastructure among national health research funding agencies, such as the federally-supported Centres of Excellence for Women's Health, the Institute for Gender and Health of the Canadian Institutes for Health Research, and university-based women's health research centres. Community groups, health authorities and researchers outside of the traditional health sector are all making important contributions of new knowledge regarding girls' and women's health. Yet challenges remain with respect to capacity in British Columbia to conduct sex- and gender-sensitive health research. These will be partially met by the development of a women's health research network, currently underway with support from the Michael Smith Foundation for Health Research, but significant additional training, funding and opportunities for research and knowledge brokering are needed.

For example, a comprehensive approach to the development of women's health research in British Columbia needs to include: identifying and conducting women-centred research relevant to women's lives throughout the life cycle; providing opportunities for multi-sectoral involvement in research; linking and brokering research evidence directly to improve clinical practice, programming and policy making; increasing accessibility by using technology to link researchers, women, policy makers and providers across the province; developing authentic partnerships and collaborative research projects with universities, hospitals, Aboriginal communities, health authorities and all levels of government and providing leadership in training, education and evaluation in gender-based approaches to women's health research. These priorities remind us that it is both the process and content of research that needs to be women-centred (see www.cw.bc.ca/whri/strategy.asp).

Such an approach would go a great distance to improving the capacity of researchers, health program planners, policy makers and communities to understand and monitor trends in girls' and women's health in British Columbia. With the infrastructure of such resources as the linked health data base, the many university- and hospital-based health research centres and a commitment to a comprehensive reporting and surveillance system, we will be well-placed to develop and support interventions in women's health that run the gamut from prevention to rehabilitation.



Challenges remain with respect to capacity in British Columbia to conduct sex- and gender-sensitive health research.



Women-centred Care and Research

The examples provided throughout this Strategy illustrate the value of providing women-centred care. Women-centred care has been an operating principle of BC Women's since its inception but needs to be embraced more widely throughout the health care system. A *Framework for Women-centred Care* was developed during the women's health planning process undertaken by the Vancouver/Richmond Health Board (2001). It has been widely distributed and front-line staff in some health authorities have participated in pilot training initiatives.

Underlying the appropriate development of care, programs and policy for girls and women is critical women-centred research. The Strategy outlining BC Women's research plans, *Women-Centred Research: A Strategy for BC Women's* was released in 2004, delineating a commitment to expanding research, evaluation and training in many of the women's health issues outlined in this document. Developing women-centred care begins with the question that underpins this Strategy. Are the differences between women and men reflected in services, programs and policies? From that foundation, health care planners and providers can begin to work toward making programs and services safe, accessible, coordinated and empowering.

Underlying the appropriate development of care, programs and policy for girls and women is critical women-centred research.

Beyond Health Care

This Provincial Women's Health Strategy has illustrated that the health care system is but one of the determinants of girls' and women's health. Many issues that are of critical importance to the health of girls and women in British Columbia remain to be tackled.

For example, violence – its many forms and its sequelae – has particular gendered dimensions that are just beginning to be addressed by the health sector from the perspective of prevention, identification and support. Healthy child development in the broadest sense demands support across all sectors of society. The status of women's labour continues to challenge women's equality, security and health. Girls and women on the margins as a result of physical or mental disability, sexual orientation, geographic isolation, immigration status, political values, substance use or poverty continue to bear the consequences of social exclusion. The safety and quality of homes, workplaces, streets, public spaces, parks, automobiles, air, water and social contribute to girls' and women's health, both directly and indirectly.

Health care providers and administrators within the health care system need to recognize their role and responsibilities with respect to the determinants of health (Health Canada 1999). This may mean paying particular attention, for example, to assuring that access to care is not constrained by income, transportation, ability or language, facets of a person that shape their health and their access to care but which are not always within their control. Health authorities can promote health by working on the factors that help girls and women increase control over their health – through the provision of health information, participation in health coalitions, fulfilling their public health functions, advocating for healthy public policies and measuring progress toward health goals.

Advancing the health of girls and women in British Columbia depends upon a comprehensive approach to the determinants of health, an evidence base to inform decisions and monitor progress, women-centred services and a shared commitment to improving the health – and the lives – of girls and women across the province.

Many issues that are of critical importance to the health of girls and women in British Columbia remain to be tackled.





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APPENDIX A Initial Representatives of the Provincial Women's Health Network

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Assistant Manager, Prevention Services (Public Health Nursing), North Okanagan area, Interior Health

Lynda Anderson *Prince George*

Public Health Nurse, Coordinator of women's health programs, Northern Health

Margaret Antolovich *Powell River*

Manager for Community and Family Health Programs and Services, Prevention and Promotion, Coast Garibaldi Region, Vancouver Coastal Health

Lesley Cerny *Smithers*

Lesley is a Program Manager for Public Health Nursing, Child/Family portfolio, Northern Health

Jan Christilaw *Vancouver*

Head of Specialized Women's Health at BC Women's Hospital & Health Centre, Clinical Professor, Department of Obstetrics-Gynecology, University of British Columbia

Ann Crawford *Kamloops*

Manager of Women's Health, Neonatal and Pediatric services, Royal Inland Hospital

Allison Cutler *Nanaimo*

Area Director, Child Youth Family program, Central and North Island areas, Vancouver Island Health Authority

Ann Dauphinee *Richmond*

Health Promotion Coordinator, Community & Family Health, Richmond Health Services, Vancouver Coastal Health

Lydia Drasic *New Westminster*

Director for Planning and Systems Development, Population Health, Fraser Health

Sandra Edelman *North Shore*

Manager of Community and Family Health, North Shore, Vancouver Coastal Health

Diane Gagnon *Nelson*

Site Director, Director of Patient Care for the Kootenay Lake Hospital in Nelson, Interior Health

Maria Hudspith *Vancouver*

Coordinator, Community Consultation and Partnerships for Vancouver, Vancouver Coastal Health



Darlene McGougan *Victoria*

Regional Manager for Aboriginal Health, Vancouver Island Health Authority

Shirley Morven *Nisga'a*

President, Nisga'a Valley Health Board

Katharina Patterson *Prince George*

Regional Director, Aboriginal Health, Northern Health

Sonia Singh *White Rock*

Family/Emergency Physician, CIHR Research Fellow in Trans-disciplinary Primary Health Care

Lynn Stevenson *Surrey*

Leader, Professional Practice/Chief Nursing Officer, Fraser Health

Alice Taft *Victoria*

Director for Primary and Community Hospital Care and Acting Director for Mental Health and Addiction Services, Vancouver Island Health Authority

APPENDIX B

Selected Resources on Women's Health in British Columbia

Listed below are some reports that have been prepared by health authorities, the provincial government and women's health advocates through out British Columbia. They address a wide range of women's health concerns throughout the life span, as well as the diversity that is unique to each of the province's geographical regions. These documents reflect a long tradition of interest in women's health in the province and are a resource for those interested in particular aspects of girls' and women's health.

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Women's

BC WOMEN'S HOSPITAL
& HEALTH CENTRE

*An agency of the Provincial
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The British Columbia Centre of Excellence for Women's Health and its activities and products have been made possible through a financial contribution from Health Canada. The views expressed herein do not necessarily represent those of Health Canada.