The Participation Experience of Women's Groups in Regional Health and Social Services Planning in Quebec

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for the

Centre of Excellence for Women's Health

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ABSTRACT

This exploratory study examines the participation of women's groups in regional planning of health and social services in Quebec with the purpose of identifying problems and successes in their relations with regional health and social services boards (RHSSBs). Our report begins with a description of the commitments with respect to the status of women included in regional services organization plans for the 1998–2002 period, and the organizational structure introduced by the RHSSBs to ensure implementation of these commitments. We then present a descriptive-comparative analysis of the situation in four regions selected for their diversity; this allows us to contrast the intra-regional dynamics, and to identify indices with respect to the observed differences in the planning and programming of services and in the interactions of RHSSBs with women's groups. The report concludes with recommendations on strategies for promoting gender equality in regional health and social services planning for the Quebec Ministère de la Santé et des Services sociaux, the RHSSBs and regional coalitions of women's groups.

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ACRONYMS

AFÉAS	Association féminine d'éducation et d'action sociale
BoD	Board of Directors
CEWH	Centre of Excellence for Women's Health, Université de Montréal Consortium
CSF	Conseil du statut de la femme du Québec
GBA	Gender-based analysis
LCSC	Local Community Service Centre
MSSS	Ministère de la Santé et des Services sociaux du Québec
PHB	Public Health Branch
PHWB	Policy on Health and Well-Being
RAC	Regional Administrative Conference (regional interdepartmental structure)
RCCO	Regional committee/coalition of community organizations
RCM	Regional county municipality
RHSSB	Regional health and social services board
RHSSC	Regional health and social services council
RSOP	Regional services organization plan
SWC	Status of Women Canada

PREFACE

Good public policy depends on good policy research. In recognition of this, Status of Women Canada instituted the Policy Research Fund in 1996. It supports independent policy research on issues linked to the public policy agenda and in need of gender-based analysis. Our objective is to enhance public debate on gender equality issues in order to enable individuals, organizations, policy makers and policy analysts to participate more effectively in the development of policy.

The focus of the research may be on long-term, emerging policy issues or short-term, urgent policy issues that require an analysis of their gender implications. Funding is awarded through an open, competitive call for proposals. A non-governmental, external committee plays a key role in identifying policy research priorities, selecting research proposals for funding and evaluating the final reports.

This policy research paper was proposed and developed under a call for proposals in September 1999, on W*here have all the women gone? Changing shifts in policy discourses*. Researchers were asked to examine shifts in public policy discourse to anticipate affects on gender issues and develop strategies to ensure that the discourses recognize and serve women's interests.

The research projects funded by Status of Women Canada on this theme examine issues such as discourses around mothering under duress, child poverty, gender and academic success, as well as gender equality promotion strategies for regional planning.

A complete list of the research projects funded under this call for proposals is included at the end of this report.

We thank all the researchers for their contribution to the public policy debate.

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EXECUTIVE SUMMARY

Various levels of government in Canada have made commitments relating to the status of women and tools have been developed to foster the integration of gender-based analysis (GBA) in policy development and evaluation. In Quebec, the provincial government has developed a GBA implementation strategy that relies on pilot projects conducted mainly in the Ministère de la Santé et des Services sociaux (MSSS). However, departmental policies affecting the living conditions of women are not always reflected in regional health and social services planning, and the negative impact of health system changes on women in various situations has been a source of criticism by many women's groups. What is the reason for this disconnect between orientations and policies intended to take into account gender differences and the lack of consideration given to them in organizing health and social services?

This exploratory study examines the participation experience of women's groups in regional health and social services planning in Quebec, with the aim of understanding the problems and successes of their relations with regional health and social services boards (RHSSBs). The study is not limited to the consultations surrounding preparation of regional services organization plans (RSOPs). We begin with a description of the commitments related to the status of women included in RSOPs for the period 1998–2002 and the organizational structure put in place by the RHSSBs to ensure implementation of these commitments. Four more detailed case studies were conducted of the relations between regional coalitions of women's groups and the RHSSBs. Our assessment of these relations is based mainly on the perceptions of practitioners from the organizations that work with women in each of the regions, women representing the community movement on the boards of directors of the RHSSBs, managers responsible for planning or community relations, and status of women coordinators in the RHSSBs.

A descriptive-comparative analysis of the situation in each of the regions examined made it possible to:

1) contrast the intra-regional dynamics;
2) identify indices for understanding the differences noted in the planning and programming of services within the RHSSBs in the case studies, and in their interactions with women groups;
3) examine the similarities and differences in the procedures adopted in each of the RHSSBs to take into account the concerns of women's groups in RSOP planning and follow-up; and
4) make recommendations on strategies for fostering gender equality in regional health and social services planning, for the attention of MSSS, the RHSSBs and regional coalitions of women's groups.

With the women's movement being very active in the health field, factors such as organizational structures, available resources and RHSSB communications channels with various women's groups also significantly affect the extent to which the concerns of

women's groups and women's specific needs are included in the planning and organization of health and social services. Our analysis of the participation experience of women's groups in regional health planning yields two types of recommendations:

- Those that deal with the application of GBA to the review of the Policy on Health and Well-Being and the *Priorités nationales de santé publique,* which guide regional planning, and the inclusion of clear commitments to respond to the specific needs of women in the next RSOPs. Along with the results of GBA pilot projects currently under way within MSSS, a practical guide to GBA application should be distributed to regional health and social services planning officials. Training should also be provided to RHSSB boards of directors and staff.

- Those that highlight the need to provide RHSSBs with structures and resources to ensure coordination and implementation of the commitments in RSOPs, including status of women advisory committees and coordinators linked to the executive council of each RHSSB. The contribution and expertise of women's groups in these processes should also be recognized by remunerating representatives of women's groups who are members of regional status of women advisory committees.

INTRODUCTION

Over the past decade, issues raised by the women's movement have been incorporated into specific orientations, policies and programs adopted by the Government of Quebec, notably those dealing with perinatal care in 1993, spousal violence and sexual assault in 1995, and breast cancer screening in 1998. The purpose of these policies is to improve health and social services for women, taking into account their living conditions and their specific needs. However, women's groups and analysts interested in promoting gender equality are increasingly criticizing the impact on women of health care reforms introduced over the past 10 years in Quebec and other Canadian provinces (Armstrong et al., 2001).

In Quebec, the Coalition féministe pour une transformation du système de santé et des services sociaux, which brings together a number of women's groups, community agencies and unions, points out, "In the shift to ambulatory care,[1] it is the women who have been paying and continue to pay the price as users, as caregivers and volunteers, and as workers. . . . [This is] a resurgence of family-centred ideology, [a] step forward for privatization [and a] step back for democracy" [Translation] (Coalition féministe, 1998, pp. 74–75). For its part, the Réseau québécois d'action pour la santé des femmes notes, "Little or nothing is known about most women's health policies. They are poorly publicized, not made widely available or not applied. In addition, services that implement these policies are often lacking or invisible" [Translation] (RQASF, 1999, p. 15).

What are the reasons for this disconnect between policies seeking to respond to the specific health needs of women and harmful health care reforms that tend to widen gender disparities? Various women's networks believe that, in the health and social services field, we are still waiting for action on commitments made by both the federal and provincial governments at the Fourth World Conference on Women in Beijing in 1995 regarding integration of gender-based analysis (GBA) into policy development and evaluation.

In Quebec, the Ministère de la Santé et des Services sociaux (MSSS) introduced its *Orientations en matière de condition féminine* (Quebec, MSSS, 1991) for the period 1992–2000 and a *Plan d'action 1997-2000 : santé, bien-être et conditions de vie des femmes* (Quebec, 1998) before developing regional services organization plans (RSOPs). The regional health and social services boards (RHSSBs) are responsible for implementing these plans, which cover the period 1998–2002.[2] In 1997, MSSS also launched a pilot project for the gradual incorporation of GBA into departmental orientations and policies relating to services for frail seniors, a project that ends in 2003.

Despite the orientations announced by MSSS and its ongoing initiatives, the RSOPs are quite disparate in terms of their consideration of the living conditions of women and in their responses to women's specific needs. Can an analysis of RSOP planning and monitoring procedures provide insight into the gap between certain departmental orientations and the way regional services are organized? What conclusions can be drawn from the experience of practitioners from women's groups who participated in these procedures?

The purpose of this exploratory study is to examine the problems and successes of regional coalitions of women's groups in their relations with the RHSSBs. We begin with an analysis of the RSOPs and the organizational structure of 16 of the 18 RHSSBs with respect to the status of women portfolio. These initial observations are followed by a study of the dynamics in four regions with differing RSOPs and board structures. The analysis of these experiences serves as the basis for identifying avenues for action to foster integration of the specific needs of women in regional health and social services planning. Recommendations for the various parties concerned are presented in the conclusion.

2. CONTEXT

Regionalization of the Organization of Health and Social Services

The public health and social services system was established in Quebec in the early 1970s.[3] Inspired by the report of the Castonguay-Neveu Commission (1966–71), services were reorganized by systematically linking health and social services, establishing a department of social affairs, and giving significant powers to its minister to ensure universal accessibility to services and to streamline the system's operation (Bergeron and Gagnon, 1994). Regionalization and community involvement were seen as important tools for improving service quality and efficiency (Turgeon and Anctil, 1994; Latérière and Voyer, 1995). The year 1971 saw creation of the first regional health and social services councils (RHSSCs) mandated to conduct consultations; this partly opened the door to public participation in the administration of regional institutions and organizations of the public health and social services system.

In the 1980s, the health and social services system had to adjust to numerous societal changes: technological advances, demographic shifts, increased immigration and ethnocultural diversity, increasingly available health information, and new values that favoured home support for frail individuals. As a result, services had to adapt to more and more varied needs. These changes, coupled with serious management problems, also contributed to a re-examination of the centralized planning of the health system. In addition, analyses revealed that living conditions had a greater impact on population health than the organization of health and social services, and that improving health was not necessarily related to increasing the cost of the health care system (Evans and Stoddart, 1990; Evans, Barrer and Marmor, 1994). The debt load of Western countries and the rise in health care spending became a political issue in the 1990s—especially in Canada, where the health system consumes a larger share of the national income than in other industrialized countries (Contandriopoulos, 1991; Deber and Swan, 1998).

It is in this context[4] that another reform of the health and social services system was launched in the early 1990s, in response to the report of the Commission d'enquête sur les services de santé et les services sociaux (Rochon Commission).[5] The Commission found that Quebec had failed in its efforts to democratize the health care system, and it suggested strengthening public participation in decision-making mechanisms. It recommended, among other things, greater decentralization of decision making to regional boards with taxation power and elected directors. The Government of Quebec accepted neither of these two recommendations.

Quebec's *Act respecting Health Services and Social Services,* enacted in 1991, created 18 regional health and social services boards to replace the RHSSCs.[6] Under the Act, each RHSSB has the following objects:

1) ensuring public participation in the management of the public network of health services and social services . . .

2) formulating priorities in matters of health and welfare according to the needs of the population of the region . . .
3) establishing service organization plans in its territory and evaluating the effectiveness of services . . .
4) allocating the budgets intended for the institutions and granting subsidies to community organizations . . .
5) ensuring the coordination of the special medical activities of physicians . . . institutions [and] community organizations . . .
6) implementing measures for the protection of public health and for the social protection of individuals, families and groups;
7) ensuring economical and efficient management of the human, material and financial resources at its disposal. (Quebec, RSQ, c. S-4.2, s. 340)

This act established the requirement for regional committees composed of members chosen by various bodies to enable public institutions, municipalities, community organizations, socio-economic organizations and other interested groups to express their expectations and to have a voice in the decisions of the RHSSB. Each regional committee was mandated to hold elections every three years for members of the board of directors (BoD) of the RHSSB, and to approve the regional priorities and annual reports of the RHSSB. The regional committees lasted only a few years and were abolished in June 1996.

The RHSSBs are responsible for developing and implementing the regional services organization plans in collaboration with institutions and community organizations, as well as with representatives from sectors that have an impact on health (Quebec, RSQ, c. S-4.2, s. 346). However, the Policy on Health and Well-Being, adopted in 1992, sets the framework for the activities of the regional boards in planning health and social services. Further, overall financial guidelines are decided by the Ministère de la Santé et des Services sociaux, and RSOPs must be submitted for approval by the Minister. The department retains all its powers with respect to policy development and regulation (Turgeon and Anctil, 1994).

This is the context in which the RHSSBs prepared their first RSOPs for the 1995–98 period, with the goal of achieving the budgetary targets set by MSSS. The initial regional plans for the restructuring of the public health and social services system were followed by a second planning phase aimed at consolidating changes over the period from 1998 to 2002.[7]

Consequences for Women of Reform of the Health Care System

Health care reform in all Canadian provinces and in a number of developed countries has several common features related to changing service organization modes in order to reduce public costs. While each Canadian province organizes its health system differently, decentralization and spending cutbacks are the two major components of the health care reforms begun in the 1990s. The financial framework is largely a response to reduced federal health funding. The first cutbacks were imposed in 1982 but the pace increased with major reductions in transfer payments to the provinces occurring in the mid-1990s.[8]

The Quebec government, which is demanding reinstatement of federal transfer payments, has slashed public funding of the health system. The Quebec government's budget for health and social services fell from $13.17 billion in 1994–95 to $12.61 billion in 1997–98, coinciding with the launch of the regional plans that are the subject of this study. The fall represents a drop in annual per-capita public spending from $1,692 to $1,608, while the Canada-wide average was estimated at $1,821 in 1997–98. Over a longer period, Quebec reduced the public proportion of health and social services funding from 81.5 per cent in 1980 to 69.1 per cent in 1998. Sadly, it has thus moved from being the province providing the highest proportion of public funding in 1980 to one of the provinces providing the lowest proportion in 1998 (Bernier and Dallaire, 2000). Should it be any surprise that women, who earn less than men and who make greater use of health services, have been especially affected by these cutbacks?

The health system reform introduced in Quebec in the 1990s is referred to as the "shift to ambulatory care"; it focuses on alternatives to institutional treatment, with an increase in day surgery, increased ambulatory care services, shorter hospital stays, transfer of care to the community, and home support for individuals with more severe disabilities (Quebec, MSSS, 1994). The purpose of this delivery model is to foster integration and complementarity of services and to promote co-operation between institutions, with the overarching objective of improving the efficiency of the entire system. While Quebec has lagged behind other provinces in this area, the "shift" occurred very quickly, in a climate of fiscal restraint, and without adequate resources being re-invested in home care services (Bernier and Dallaire, 2000).

This reform is often portrayed as neutral in terms of gender relations. However, a number of studies, both in Canada and abroad, have shown that failure to acknowledge gender differences has negatively affected the circumstances of many women who use and provide care in the public system, in private services, in the community or in the family. Such reform leads to a deterioration in the living conditions of numerous women; it is a step backward in terms of gender equality (Armstrong, 1996, 1999; Coalition féministe, 1998; AFÉAS et al., 1998; CSF, 1999; Bernier and Dallaire, 2000; Armstrong et al., 2001).

Transferring responsibilities to the home setting, which is the outcome of the changes in service organization, considerably alters relations between the government, the public system, community services, private service providers and informal caregivers (primarily female family members) (Standing, 1999; Broom, 1999). Given the gender-based division of social roles, women provide most of the care for persons who are sick or have disabilities. Following the changes in the health care system, many women are assuming an increasingly heavy and complex burden of care for those close to them, and they take on an additional burden when support measures or concrete alternatives to family care are not in place (AFÉAS et al., 1998).

The cutbacks, along with mergers and restructuring, also resulted in significant layoffs in the health and social services system, which is staffed mainly by women. These measures disrupted caregiving and intensified instability, insecurity and burnout in the workplace (Bourbonnais et al., 1998; CSF, 1999). Employees and volunteers active in community

organizations in the health and social services sector, where women are also in the majority, must now respond to greater and more complex demands for services from people abandoned by overburdened public services (ROCQ-03, 1997; AFÉAS et al., 1998; RIOCM, 1998).

Some of the consequences of this change in service delivery vary depending on the personal characteristics of the women, their living conditions, their age, their place of residence, their cultural background, and so forth. Problems with access to health and social services, for example, are more severe for women who live in rural areas far from major urban centres (shortage of physicians, transportation problems, etc.). The deterioration in the quality of care is a particular problem for elderly women and women with disabilities living at home or in residential and extended care centres. Lastly, ensuring proper services to meet the special needs and values of women from diverse ethnocultural communities or marginalized groups is more difficult at a time when resources are being cut back.

The impact on women of the shift to ambulatory care raises questions about how service organization is planned. How are the specific needs of women taken into consideration in the RSOPs? What are the constraints of the RHSSBs in their planning efforts? What were the interactions between the regional boards and the advocacy groups for the status of women in the regions?

Gender-Based Analysis and Regional Health Planning

For several decades, feminists have been carrying out critical analyses of government programs and policies to determine whether they respond to the specific needs of women and whether they perpetuate or exacerbate gender inequalities. “Gendered analysis” and “gender-based analysis” (GBA) are the most recently coined expressions for this type of analysis. They are used mainly in connection with government efforts to integrate a perspective that considers gender disparities in policy analysis.[9] The federal government and some provinces, including Quebec, have conducted various initiatives of this type, especially since committing to promote women’s rights at the 1995 Fourth World Conference on Women in Beijing.[10]

In the federal government, it is the responsibility of Status of Women Canada (SWC) to foster GBA; the department has produced a guide for incorporating this type of analysis in policy development, along with a somewhat complex eight-step tool (Canada, SWC, 1996). This guide has been used or adapted by various departments including Health Canada, which prepared a Women’s Health Strategy (Canada, 1999). In the guide, GBA is defined as “a process that assesses the differential impact of proposed and/or existing policies, programs and legislation on women and men . . . [and] makes it possible for policy to be undertaken with an appreciation of gender differences, of the nature of relationships between women and men and of their different social realities, life expectations and economic circumstances” (Canada, SWC, 1996, p. 4).

The Quebec government’s approach differs in its orientation and its implementation strategy, even though both levels of government are pursuing similar objectives. In 1993, the Quebec government adopted a *Politique en matière de condition féminine* (Quebec, 1993) with a

10-year implementation timeline and implementation plans established on a three-year planning cycle. Under its *Programme d'action 1997-2000 pour toutes les Québécoises* (Quebec, 1997a), the Quebec government established a GBA project.[11] The implementation strategy, initiated by the Secrétariat à la condition féminine, is the responsibility of an interdepartmental committee[12] and calls for the gradual involvement of all government bodies through pilot projects. This initiative to incorporate GBA into government practices is a long-term effort.

In the *Programme d'action 1997-2000 pour toutes les Québécoises*, GBA is defined as "during the design and development of a policy, program or any other initiative, a preventive process to identify the differing impact that its adoption by the government might have on affected women and men given their particular socio-economic conditions" [Translation] (Quebec, 1997a, p. 15). GBA is described as a mechanism for finding solutions to gender inequality, recognizing that policies and programs are not neutral and can contribute to systemic inequalities. Its use is intended to foster not only equality in law between men and women but also in fact, which can lead to the development of specific programs to deal with the particular circumstances of either sex.

GBA sees the social relationships between the sexes as a key determinant of living conditions, vulnerability, exposure to certain risks, use of services, the social response of family and professionals in the health and social services system to the needs expressed, and the contribution of women to the provision of formal and informal care. While the use of demographic or statistical data broken down by gender is necessary, it does not in itself ensure the application of GBA. GBA requires that the analysis move from simply comparing raw data to examining the conditions specific to women and men, and to identifying the problems that affect their health, so that the necessary attention can be given to organizing services and setting priorities to reduce gender inequalities (Broom, 1999; Standing, 1999).

To take into account the diversity of women's circumstances, GBA must consider sources of inequality other than gender, particularly socio-economic position, age, disability or place of residence, all of which affect health and access to services (Zambrana, 1988; Standing, 1997; Teghtsoonian, 1999; Rankin and Vickers, 2001). The diversity of women's circumstances—whether associated with social class, sexual orientation or regional, cultural, ethnic or religious characteristics—makes the application of GBA quite complex.

As part of the Quebec government's status of women initiative, MSSS developed the *Orientations en matière de condition féminine 1992-2000* (Quebec, MSSS, 1991). It also prepared a *Plan d'action 1997-2000 : santé, bien-être et conditions de vie des femmes* (Quebec, 1998); this covers a significant part of the 1998–2002 planning period of the RHSSBs.

As part of the Quebec government's strategy to implement GBA, MSSS is conducting a pilot project that includes the development of guidelines for services offered to frail seniors. This project ends in 2003. The *Orientations ministérielles sur les services offerts aux personnes âgées en perte d'autonomie* (2000a) effectively recognizes the more delicate situation of elderly women and mentions support for family in the range of services to be

offered (Quebec, MSSS, 2000). Nevertheless, in practice, Quebec is still the Canadian province that allocates the least resources to home support services, thereby leaving the burden largely to family, and to women for the most part.

Since 1995, the Conseil du statut de la femme du Québec has expressed its interest in the integration of women and status of women issues in regional board structures (Quebec, CSF, 1995a, 1995b). In 1997, a fifth strand was added to the Quebec government's policy on the status of women, entitled *La place des femmes dans le développement des régions* (Quebec, 1997b); it sought to strengthen the regional application of the status of women policy, and it encouraged regional authorities to adopt measures for ensuring representation of women in needs analysis and decision making. Three methods were proposed to put this strand into practice: the introduction of structures and resources for the status of women in regional institutions (boards, advisory committees, status of women coordinators); implementation of GBA in the policy development and evaluation process; and active recourse to "regional status of women expertise" held by local and regional women's groups (Quebec, 1997b, pp. 22–23).

Women's groups working on an ongoing basis in the field with women from diverse communities play a crucial role in identifying women's needs and understanding the specific impact of certain policies on women. However, some groups have particular reservations about getting involved with GBA implementation: "Since GBA is a management tool, groups have concerns about its impact on their autonomy in relation to the government apparatus" [Translation] (Kurtzman and de Sève, 2001, p. 17). They are afraid of being drawn into the role of "sub-managers," which requires a level of knowledge and statistical tools that they do not have and that will drain the limited resources they have available to respond to demands for their expertise. Further, at a time of budget cutbacks, some activists fear that GBA will simply be used to reduce the funds available for projects intended specifically for women, redirecting them instead to programs for a mixed or solely male clientele (Kurtzman and de Sève, 2001). For example, some RHSSBs have proposed using funds allocated to services for women who are victims of spousal violence to develop resources for treating violent men.[13]

Our analysis of the 1998–2002 RSOPs raises questions about the repercussions of the approaches developed by central bodies of MSSS during the same period. Similarly, there are questions about whether the inclusion of a section on the living conditions of women in certain RSOPs might merely increase lobbying by regional coalitions of women's groups, just as the sectoral policies responding to the specific needs of women have given rise to lobbying by the women's movement—notably the 1995 World March of Women Against Poverty, under the slogan "Bread and Roses."

Participation of Women's Groups in Regional Structures

During the 1990s, Quebec's Conseil du statut de la femme (CSF) made numerous recommendations to MSSS on the participation of women and women's groups in regional boards (CSF, 1989, 1995a, 1995b). The department's *Plan d'action 1997-2000 : santé, bien-être et conditions de vie des femmes* (Quebec, MSSS, 1998) also emphasizes the importance for Quebec women of becoming involved in regional decision making to ensure that collective choices reflect the different circumstances of men and women.

Beginning in the mid-1980s, coalitions of women's groups were formed in all regions of Quebec to draw participants into regional discussions and action. They "bring together in a single forum a variety of local and regional groups that aspire, as a matter of principle and despite practical difficulties, to an ideal of participatory democracy. Established around various issues related to the living and working conditions of women, these organizations together have a wide variety of knowledge and practices" [Translation] (Masson, 2001, p. 101). These coalitions are well placed to act as points of contact for the RHSSBs in regional planning related to health, social services and the status of women.

The RHSSBs have established a variety of mechanisms for working with women's groups with expertise in the specific needs of women. In several Quebec regions, there are advisory committees on the status of women, committees on violence, and breast cancer working groups. In general, women's groups are actively involved in partnerships with the health and social services network (Latérière and Voyer, 1995; Couillard and Côté, 1997; Fournier et al., 2001). Within the community movement, women's groups devote more days per month to collaborative activities than do other groups, whether in dealings with the health and social services system, in coalitions, or in exchanges between women's groups at the local, regional and Quebec-wide levels: 26.6 per cent of women's groups devote five or more days per month to these activities (Fournier et al., 2001). These authors add: "As shown by the analysis of regional dynamics . . . the fact that several of the priorities of regional boards deal with the concerns of women's groups encourages use of their expertise" [Translation] (Fournier et al., 2001, p. 119). This participation puts pressure on women's groups with limited resources, especially if the participation does not involve remuneration or recognition of their contribution. Latérière and Voyer (1995) note that participation in regional bodies affects women's groups, notably by setting up a certain hierarchy among groups and a tendency to specialization because of the problems associated with demanding, unpaid involvement in regional structures.

Since the RHSSBs were established, several studies have analyzed the conditions of participation with respect to democratization of the health system or relations between the community and the public system, or both (Lamoureux, 1994; Forest, Bryson and Lorion, 1994; Couillard and Côté, 1997; Tremblay, 1999; Forest et al., 2000). According to Lamoureux, who examined the mental health planning experience at the regional level, "Shared planning in this field has significant potential to expand democracy" [Translation], but there is a danger of the government taking control of community initiatives (Lamoureux, 1994, p. 197). Researchers have also found that involvement in decision-making bodies of the health and social services network shifts debate toward administrative matters and away from policy, thereby strengthening the technocratic apparatus (Godbout, 1991; Tremblay, 1999).

A number of women who are former members of RHSSB boards of directors reported the difficulty of getting people to listen to their concerns, especially in the context of spending cutbacks. A survey of this experience conducted by L'R des centres de femmes du Québec shows that the women consulted felt trapped by a "program-client" approach, set within "service continuums"; this reflects a technocratic approach to organization of services. The "culture shock" between a feminist and community-based approach (advocated by many

women's groups) and an epidemiological approach targeting vulnerable clienteles (the preferred approach in health and social services planning) was evident in this survey (L'R des centres de femmes du Québec, 1997). The overall approach of women's groups bucks general trends in the management of health and social services.

In their discussions of the negative impact of health and social services reform on the health and living conditions of women, women's groups question whether the needs of women have been taken into consideration in regional planning: "The service changes in recent years, budget cutbacks, institutional mergers and the shift to ambulatory care have placed considerable pressure on the nature of discussions and deliberations within the various participatory bodies. At no time could these economic imperatives be challenged by the institutions and regional boards mandated to carry out MSSS orders" [Translation] (Tremblay, 1999, p. 123). The opportunity for public participation in the administration of the health system continues to shrink. Lastly, the pluralistic nature of society is seldom reflected by participants in consultations or in decision-making bodies in the health and social services network, but this fact has received little attention in these analyses of modes of participation in the health and social services field.

Our review of women's experiences of participation in the planning processes of RHSSBs is not restricted to the consultations that provided input for the development of the various RSOPs. Indeed, the establishment of health and social services policies in regional programming is an almost continuous process of implementation and adjustment that goes beyond the specific task of developing and approving the RSOPs, and is pursued in the meetings of RHSSB boards of directors and in various advisory committees. A variety of factors, including available resources, organizational structures in the RHSSBs and their methods of communicating with the different women's groups, can have a significant impact on how the demands of women and of women's groups are integrated into regional health and social services planning.

3. METHODOLOGY

This study was developed and carried out with community partners, especially the L'R des centres de femmes du Québec and the Alliance des communautés culturelles pour l'égalité dans la santé et les services sociaux (ACCÉSSS), and with the collaboration of a regional coordinator of the Conseil du statut de la femme du Québec; these partners and the research team together formed a steering committee for the project. The committee was consulted on plans for the research, data collection tools and methodology at each stage of the study, the choice of Quebec regions to be included in the case studies, selection criteria for participants in the discussion groups, the analysis plan, and the drafting of recommendations. The ongoing presence and diversity of the steering committee members were essential to ensure the relevance of the development and performance of this study on the experience and concerns of women and women's groups active in various communities. Lastly, with regard to the ethical aspects of the research, the University de Montréal's Comité d'éthique de la recherche des sciences de la santé approved the data collection procedure and tools.

The purpose of this exploratory study is to examine the participation of women's groups in the consultation for and the follow-up on the 1998–2002 RSOPs to better understand the difficulties and barriers, as well as the successes, that have characterized their relations with the RHSSBs. This research reveals the factors that promote and impede the development of programs that respond to the specific needs of women and that help to reduce gender inequalities. One of the expected outcomes of this study is to provide support for efforts to include precise commitments for the promotion of gender equality in future RSOPs.

Data Collection

There were three stages to data collection between May 2000 and June 2001. RHSSB respondents, both male and female, completed a short questionnaire on the planning and consultation practices used in preparing the 1998–2002 RSOPs and on responsibilities in the organizational structure for follow-up on status of women issues. The RSOPs were then analyzed to determine how they reflected MSSS policies on the status of women. In some cases, additional documents on RSOP follow-up and the mandate of the status of women coordinator and committee were also reviewed. These steps provided information on 16 of the 18 regional health and social services boards in Quebec[14] in terms of commitments to women's health included in the RSOPs and responsibilities in the organizational structure for implementing these commitments.

The third part of the data collection process included discussion groups or individual interviews in four regions of Quebec on how women representing the community on RHSSB boards of directors and representatives of women's groups perceived the planning and co-operation processes related to women's health and living conditions. Lastly, interviews were also held with officials responsible for planning and consultation in the regional boards, and with status of women coordinators when such positions existed.

The regions selected by the steering committee differed in two respects: the diversity of methods used to consult the public and communicate with women's groups, and the internal structure ensuring monitoring of status of women issues.

Questionnaire for Regional Health and Social Services Boards

The first data collection step involved 16 of the 18 RHSSBs in Quebec. A questionnaire (reproduced in Appendix B) was sent to the executive council. One part of the questionnaire covered the planning and consultation activities used in developing the 1998–2002 RSOPs; the other part covered responsibilities in the organizational structure relating to the status of women mandate, and in particular, whether or not there was a status of women coordinator or advisory committee. The questionnaire was returned to us by the RHSSBs with their 1998–2002 RSOP, an organizational chart and where applicable, the list of participating individuals or organizations in regional consultations. In addition, nine boards provided documents relating to the status of women coordinator function or the mandate of a status of women advisory committee.

Selection of the Four Regions for the Case Studies

The documents thus gathered were analyzed in order to classify the regional boards by the following criteria: (1) methods of planning and public consultation in developing the RSOPs (Forest et al., 2000); and (2) the presence or absence of a status of women coordinator or advisory committee. The time spent by the coordinator on status of women issues and this individual's position within the regional board's decision-making structures, as well as that of the status of women advisory committee, were also considered in refining the application of the second criterion.

Table 1: Board Classification Criteria for the Case Studies

Planning and Public Consultation Methods
• Variety of tools for disseminating information to the public • Variety of tools for evaluating the region's priority needs • Variety of mechanisms for consulting partners • Variety of approaches for consulting the public • Variety of mechanisms for facilitating participation • Role of the board of directors in the planning and consultation process
Organizational Structure Regarding the Status of Women Portfolio
• Presence or absence of a status of women coordinator • Percentage of time devoted to status of women issues • Presence or absence of a status of women advisory committee • Decision-making level to which the coordinator or advisory committee reports in the regional board's structure, if applicable • Frequency of contact with women's groups and coalitions

The classification of the RHSSBs by these criteria served as the basis for selecting the four regions used in the case studies. However, applying the criteria proved more complex than expected. The planning and consultation methods involve a wide range of procedures and means that may be related to the regional board's policies, available resources, or the characteristics of each region. This factor was considered when classifying the regions because the procedures and means used by the RHSSBs are linked to regional circumstances.

The consultation activities of the RHSSBs vary depending on whether they are in a high-density urban region with a culturally diverse population, or in outlying regions that cover a wider territory with a more homogeneous population, where the focus is often on local bodies (regional county municipalities, Local Community Service Centre areas).

Among the four regions selected, Region A has a relatively homogeneous population in terms of cultural background; it includes a major urban centre surrounded by an extensive rural area. Region B is a resource-producing area, far from major centres, where communities are far apart from each other. Region C includes a major urban centre with a culturally diverse population and a concentration of specialized services. Lastly, Region D is located in the urban belt of a major centre where the population is relatively diverse and growing quickly (see Table 2). To comply with the recommendations of the ethics committee, the regions are not named.

As for the organization and internal resources allocated to status of women issues, it should be mentioned that the RHSSBs for Regions A and B indicated that they have a status of women coordinator and advisory committee; in the RHSSBs for Regions C and D, the responses to the questionnaire indicated that there was no coordinator or advisory committee. However, the situation in Region C changed while the study was under way.

The first step when contacting the four selected RHSSBs was to verify that the information used to make the selections had not changed. One region selected initially had to be reclassified because some of the information in the questionnaire completed by the RHSSB could not be confirmed when it was contacted. The information from women's groups and the RHSSB's respondent revealed a very unstable situation in terms of the position of status of women coordinator. For the purposes of the case studies, we wanted two regions with a status of women coordinator and two other regions without such a coordinator in the RHSSB.[15]

Individual Interviews

Officials Responsible for Planning and Consultation

In each of the four RHSSBs, individual interviews were conducted with the officials designated by the executive council as responsible for planning or consultation, or both, with respect to the 1998–2002 RSOP. In Region A, this was the assistant executive director. In two other regions (B and C), it was the communications and community relations directors, and in Region D, it was the coordinator of planning and development in the public health branch. In Region B, the communications director was joined for the interview by two officials from the regional board: one from the public health branch and one from the programs and services branch.

The interviews focused on: regional planning processes and the responsibilities of the various decision-making bodies involved; the main sources of information to support planning and the tools to monitor RSOP implementation; the public consultation mechanisms; the means used to take into account gender differences and the diversity of the population; the powers and constraints of the RHSSB in relation to MSSS and the service delivery institutions; and lastly, perceptions of the most pressing health needs of women in the region.

Status of Women Coordinators
The individuals who performed the role of status of women coordinator in RHSSBs A, B and C were also interviewed.[16] In Region D, because there was no status of women coordinator, we interviewed the director of human resources, who answered our questions relating to status of women issues.

The purpose of the interview questions was to clarify how this mandate was carried out, the position's location in the organizational structure, the perspective on gender differences in programming, the perception of the powers and constraints of the RHSSBs in the area of the status of women, communications with women's groups in the region, and the most pressing health needs of women, in the view of the person interviewed.

Community Representatives on the RHSSB Board of Directors
The opinions of women representing the community on the boards of directors of the RHSSBs for the selected regions were also collected.[17] In total, seven women members of boards of directors were interviewed.

The interviews focused on the role of the board of directors in preparing and following up on the 1998–2002 RSOP, the internal operation of the board of directors, and its relations with service partners and with the public. They also examined the mechanisms for public consultation and participation, the powers and constraints of the RHSSB, the consideration of gender differences in regional planning, and the perceptions of the main needs of women, in the opinion of the respondents.

Discussion Groups with Women's Group Workers
Discussion groups with workers from community organizations (mainly women's groups) were also organized in each of the four selected regions.

Special efforts were made to ensure that the participants in the discussion groups reflected diverse needs for health and social services, while taking into account the circumstances of the women's movement in each region. The participants, all of whom were women, were recruited from organizations selected with the help of the committee of women's groups in each region, using several lists of community organizations.[18]

The discussion focused on participants' perceptions of the primary needs of the women with whom they work, their opinions of the RHSSB's consultation mechanisms and of the consideration of gender differences by the RHSSB, and their assessment of: (1) the appropriateness of services to meet the diverse needs and living conditions of women; (2) the powers and constraints of the RHSSB in terms of services planning and programming; and (3) the outcomes of their interactions with the RHSSB.

The response rate to the invitation to participate in the discussion groups varied by region.[19] In Region A, two discussion groups were held, one with women's group workers from various communities who did not interact directly with the RHSSB, and one with members

of the status of women advisory committee. The members of this committee who participated in the discussion group were drawn from women's groups and other community organizations that did not deal exclusively with women.

In Region B, a discussion group was organized with a health committee belonging to the regional committee of women's groups, which also acts informally as the RHSSB's status of women advisory committee.

The other two RHSSBs did not have status of women advisory committees. In Region C, where the population is highly diverse in terms of cultural background, three discussion groups were held, including one with women from community organizations working with ethnocultural communities. The other two discussion groups brought together workers from women's groups, including several that deal with specific issues (the homeless, women with disabilities).

In Region D, which covers quite an extensive geographic territory, a discussion group was held with women's group workers and three individual interviews were conducted: one with the coordinator for the regional committee of women's groups, who interacts directly with the RHSSB; and two others with workers from women's groups located in a sector far from the region's administrative centre. These interviews were conducted in Region D to take into account the regional circumstances and the sub-regional characteristics that affect health needs.

A total of 30 women from community organizations were consulted. They included workers from regional committees of women's groups, women's centres, women's health centres, shelters for women who are victims of spousal violence, centres for assistance and advocacy against sexual assault, a women's mental health residential facility, women's education and social action associations, a women with disabilities group, a resource for homeless women, organizations working with ethnocultural communities, a volunteer service, a food bank, and a family support organization. All of the women consulted worked in these organizations as either employees or volunteers.

Data Analysis

Case studies, which allow an in-depth examination of a larger organization or social unit, were used to understand certain features of integrating status of women issues in the RSOPs (Yin, 1989; Patton, 1990; Marshall and Rossman, 1995; Fortin, 1996). The region selected is the analysis unit (context and environment in which an RHSSB is situated) and the RHSSB in question is a sub-unit analyzed to identify what promotes or impedes the development of health and social services programs that respond to the specific needs of women and contribute to reducing gender inequalities. More specifically, we analyzed the planning and consultation procedures established to develop each of the RSOPs, and the attention given to the needs of women. Lastly, we also took time to examine the modes of interaction of the RHSSB of each of the selected regions with community and feminist organizations, and with regional coalitions of women's groups in particular.

A descriptive-comparative analysis of each of the selected units made it possible to:

1) contrast intra-regional dynamics;
2) identify indices for understanding the differences observed in the planning and programming of services within the RHSSBs examined, and in their interactions with women's groups;
3) examine the similarities and differences in the procedures adopted in each of the RHSSBs to take the concerns of women's groups into account in RSOP planning and follow-up; and
4) make recommendations on the strategies for fostering gender equality in regional health and social services planning.

The procedure followed was to transcribe all of the interviews and discussion groups by copying the interview tapes word for word. Coding grids were then used to compare data collected from different respondents on the same theme. The *Atlas-Ti* (2000) software was used to identify units of meaning relating to similarities or differences of opinion on specific themes between respondents from the same region, taking into account the status and affiliation of the respondents.

In addition to this analysis, we undertook a systematic examination of the RSOPs developed by the boards, and of various documents obtained during the interviews and discussion groups in the four selected regions. These documents contained information on the indicators for monitoring regional planning, the specific measures for responding to women's circumstances in the implementation of health and social services, or the activities of the status of women advisory committee.

Lastly, since we knew that the case study method does not provide for generalization of the findings to other populations or situations (Fortin, 1996), a number of themes and recommendations that emerged from the analysis of the four units and sub-units were compared with data obtained from an additional interview with a key respondent in a fifth region.[20] The RHSSB in this region was conducting regional consultations on women's health at the time of our study in order to develop a specific action plan. Case study methods offer significant advantages; in particular, they make it possible to gather a wealth of detailed information on specific situations, which can be used to formulate potential recommendations.

Table 2: Interviews and Discussion Groups

Regions	Data Collection Mode	Persons Questioned
Region A Homogeneous region Major urban centre Vast rural area	Individual interview	RHSSB's assistant executive director
	Discussion group	4 women's group workers
	Discussion group	4 members of the status of women advisory committee
	Individual interview	RHSSB's status of women coordinator
	Discussion group*	2 members of the BoD of the RHSSB representing community organizations
Region B Resource region 5 mid-sized urban centres Vast territory located far from major centres	Discussion group*	Community relations officer, a manager from the public health branch and a manager from the programs and services branch of the RHSSB
	Discussion group	6 members of the health committee of the coalition of women's groups
	Individual interview	RHSSB's status of women coordinator
	Individual interviews	2 members of the BoD of the RHSSB representing community organizations
Region C Major urban centre Diverse population Concentration of specialized health services	Individual interview	Manager from the community relations department of the RHSSB
	Discussion groups	2 discussion groups with women's group workers (5 women) 1 discussion group with workers from groups working with cultural communities (4 women)
	Individual interview	RHSSB's status of women coordinator
	Individual interviews	2 members of the BoD of the RHSSB representing community organizations
Region D Located in an urban belt of a major centre Fast-growing and relatively diverse population Vast rural area	Individual interview	Planning coordinator in the public health branch of the RHSSB
	Discussion group	4 women's group workers
	Individual interviews	Coordinator of the region's committee of women's groups 2 women's group workers located in an area far from the region's administrative centre
	Individual interview	1 member of the BoD of the RHSSB representing community organizations
	Individual interview	Director of human resources for the RHSSB

Note:
* The participants wanted to be interviewed together but the guide for individual interviews was used.

4. FINDINGS

Commitments Included in the 1998–2002 RSOPs Relating to Status of Women Issues

To some degree, the RSOPs represent the strategic planning of the RHSSBs and reflect their priorities for action and for the allocation of resources over the period in question. A review of the 1998–2002 RSOPs provides an initial indication of whether women's needs and circumstances have been taken into account and what measures are planned to address them. Our study is based on an analysis of the RSOPs of 16 of the 18 RHSSBs in Quebec, and on the analyses of a representative of the Conseil du statut de la femme du Québec that was presented to the research steering committee.

From the outset, it is clear that the 1998–2002 RSOPs are structured to reflect the action priorities announced in the Policy on Health and Well-Being (PHWB) (Quebec, 1992). This policy suggests that health and social services be organized into five major areas of activity: social adaptation, physical health, public health, mental health and social integration. It sets objectives to be achieved with respect to 19 issues related to each of these areas. For activities of the health system, the PHWB provides an organizational and management framework that guides resource allocation and all regional planning in Quebec.

The Policy recommends that vulnerable groups be targeted and that intervention focus on the determinants of health and well-being: biological factors; lifestyle and behaviour; communities and the social environment; the physical environment; living conditions; and the system of services. The Policy calls for five major strategies: helping to strengthen individual potential; supporting communities and creating healthy environments; improving living conditions; acting for and with vulnerable groups; aligning public policies and actions to promote health and well-being; and pointing the health and social services system toward the most effective and least costly solutions.

The Policy declares, "Women generally experience worse health than men . . . if we look at overall health. This statement applies to all age groups with the exception of those under 15 years, and to all socio-economic groups" [Translation] (Quebec, MSSS, 1992, p. 20). Also, in the strategy for creating healthy and safe environments, the PHWB notes the importance of fostering greater equity in social relations between men and women. In this regard, it can be seen as avant garde since at the time of its publication in 1992, no health policy in Canada or in most industrialized countries recognized the effects on health of the social division of gender roles.

However, the RSOPs are organized first and foremost by service continuums based on the management framework, [21] thereby reducing the scope of strategies focused primarily on factors that generally are not addressed by the health system. This approach has been criticized by various feminist networks and gave rise to the following comment from the Conseil du statut de la femme du Québec: "The Policy [on Health and Well-Being] is simply a continuation of previous policies of the Ministère [de la Santé et des Services sociaux] in terms of its failure to translate the specific needs of women into major orientations and

action plans. This failure has significant consequences given that the Policy is the government's instrument panel for the next 10 years" [Translation] (Quebec, CSF, 1995b, p. 9).

With regard to women's health, the strategy to respond to the specific needs of women has taken the form of specific policies and action plans on spousal and sexual abuse, planned parenthood and perinatal care. However, integration of these policies into the RSOPs remains limited; in some aspects of the range of services, gender differences are often obscured. Let us use the example of elderly women living alone, who may not be able to maintain their independence and have little social integration: they are identified as a vulnerable group in the PHWB but not one of the regional plans examined explicitly recognizes the growing preponderance of women among the elderly, even though the feminization of ageing is a phenomenon mentioned in the PHWB (Quebec, 1992, p. 120). The few references to the specific needs of senior women are found outside the continuum of services for seniors, in sections dealing with alcoholism and drug abuse or mental health, with reference to the problems of over-medication. Only one RHSSB, in Lanaudière, explicitly mentions in its 1998–2002 RSOP the problems of violence and abuse suffered by senior women. This lack of acknowledgement undermines the development of an integrated approach to services that takes into account the specific needs of senior women.

Again in the continuum of services for seniors, the majority of 1998–2002 RSOPs overlook the contribution of women to the care of family members, mentioned in the PHWB (Quebec, 1992, p. 150), and consequently the effects on female caregivers of the transfer of responsibilities from health institutions to home care. Only four of 16 RHSSBs (in Québec, Mauricie-Centre-du-Québec, Abitibi-Témiscamingue and Bas-Saint-Laurent) explicitly acknowledge the risk of burnout among female caregivers and plan to adopt measures to lighten their burden.

In the continuum of physical health services, the 1998–2002 RSOPs do not take into consideration the differing reproductive roles of men and women (planned parenthood, obstetrics and perinatal care) or the particular problems associated with physical characteristics, notably breast and uterine cancer. In other areas of physical health, such as cardiovascular disease or analysis of carcinogenic factors, no consideration is given to gender differences even though documents have been produced showing that failure to consider gender differences affects clinical research and consequently the relevance of diagnostics and treatment (Stewart, 1996a, b; Messing, 1998).

In the continuum of mental health services, four of 16 RSOPs—those of the RHSSBs of Québec, Laval, Lanaudière and Gaspésie-Îles-de-la-Madeleine—use the PHWB analysis of the prevalence of psychological distress in the female population. The Québec RHSSB recommends promoting access to mental health services in Local Community Service Centres (LCSCs) for women living in at-risk situations and those who are victims of violence. The Gaspésie-Îles-de-la-Madeleine RHSSB plans training activities for network staff to encourage them to adapt services to the specific needs of women. The Abitibi-Témiscamingue RHSSB focuses on identifying situations at risk for mental health problems by targeting persons living in extreme poverty, single or isolated mothers, and women caring for a sick person. The regional board calls for support for mutual aid groups working with these individuals. In all

of the other RHSSBs, the 1998–2002 RSOPs focus mainly on services to populations that have serious and persistent problems, without any indication that temporary mental health problems are prevalent in the female population (Quebec, MSSS, 1996, 1997b).

In the children-family-youth continuum, five of 16 RSOPs—those of the Bas-Saint-Laurent, Estrie, Abitibi-Témiscamingue, Gaspésie-Îles-de-la-Madeleine and Laval RHSSBs—refer to the integrated perinatal care program. In all of the RSOPs, the approach focuses on vulnerable clients with the goal of reducing fetal or child health risks (teen pregnancies, young mothers at risk). Only the Lanaudière RHSSB explicitly mentions the objective of establishing egalitarian relations between boys and girls, as recommended by the PHWB (Quebec, 1992, p. 151).

Only the Québec, Mauricie-Centre-du-Québec and Laval RHSSBs make explicit reference in their RSOPs to the *Politique d'intervention en matière de violence conjugale* (Quebec, MSSS, 1995a) adopted in 1995. However, action on spousal violence under this policy is addressed in all of the RSOPs, and the regions have spousal and sexual abuse committees to coordinate regional action by the various partners in matters related to violence against women. On the other hand, some RSOPs look more to the *Priorités nationales de santé publique : 1997-2002* (Quebec, MSSS, 1997a) and refer to the issue of violence against women in sections dealing with "intentional and non-intentional trauma" or with "violence against persons." This approach tends to obscure the impact of inequitable social relations between the sexes and the fact that the victims of spousal violence causing trauma and injury are mostly women.

Six of 16 RHSSBs—those of Québec, Mauricie-Centre-du-Québec, Abitibi-Témiscamingue, Gaspésie-Îles-de-la-Madeleine, Laurentides and Lanaudière—included a specific section on the status of women in their RSOPs. Three of them acknowledge the difficulty and challenge involved in integrating GBA and creating services that reflect the specific needs of women in all of the service continuums. Among these RHSSBs, Québec's has set the goal of developing a women's health action plan. The Abitibi-Témiscamingue RHSSB makes the same type of commitment, but sets as an initial step the preparation of a profile of the health and living conditions of women in its territory. The Mauricie-Centre-du-Québec RHSSB focuses on support for the status of women advisory committee and on the gradual incorporation of GBA into planning development. Similar measures are included in the RSOPs of the Lanaudière, Laurentides and Gaspésie-Îles-de-la-Madeleine RHSSBs.

In all of the RSOPs examined, services are directed almost exclusively to the most vulnerable segments of the population, which is in keeping with the orientations of the PHWB. In terms of women's health, this strategy has an impact on such specific policies as the *Politique en périnatalité* (Quebec, MSSS, 1993) or the *Orientations ministérielles en matière de planification des naissances* (Quebec, MSSS, 1995b), which address the needs of all Quebec women.[22] Our review also revealed that there are virtually no specific references to elements of the *Plan d'action 1997-2000 : santé, bien-être et condition de vie des femmes* of MSSS (Quebec, 1998), which appeared prior to the 1998–2002 regional planning period.

As for ethnocultural diversity, six RHSSBs in urban environments (Montréal, Québec, Montérégie, Laval, Laurentides and Outaouais) set out a general orientation referring to a

regional services access plan for cultural communities, without any special strategy for the women in these communities.

In the RHSSBs that participated in the data collection, the specific needs of the Aboriginal population were often not addressed in the RSOP.[23] The Montérégie RHSSB targets the problems of diabetes, cancer and drug abuse in its orientations addressing the specific needs of the Aboriginal population in its territory. The Abitibi-Témiscamingue RHSSB mentions suicides among Aboriginals in the region but without any gender-based analysis and without identifying a specific strategy for combatting this severe problem in the Aboriginal population. The various RSOPs examined do not really address the problems of poverty, violence and sexual abuse that afflict the Aboriginal population.

Overall, the analysis of the RSOPs reveals that there is poor integration of a perspective that considers gender differences. Not one of the RSOPs presents ongoing, consistent gender-based health and social services data. The RSOPs give little attention to the social determinants that give rise to gender inequalities. The dominant epidemiological approach gives priority to actions that target vulnerable individuals, designated as "at-risk" clientele, rather than putting in place measures to address issues affecting the population as a whole, including the health of women. When the specific needs of women are taken into account, it is often from a simplistic perspective, focusing on their reproductive function, and the planned activities are limited. The RHSSBs do not have true indicators for evaluating the impact of the shift to ambulatory care on women's living conditions. Moreover, the RSOPs analyzed have little in common with the sectoral policies on women's health developed in the 1990s.

However, the commitments of six RHSSBs that developed specific orientations on the status of women provide a foundation for fostering services to meet the specific needs of the female population. The question is whether such commitments reflect different practices in terms of the integration of gender equality concerns in regional planning and programming activities. Part of the answer can be found in the organizational structures put in place by the RHSSBs to monitor status of women issues.

Organizational Structure of the RHSSBs with Respect to Status of Women Issues

The data gathered in the questionnaire completed by the 16 RHSSBs throw light on the position of status of women coordinators and status of women advisory committees in their organizational structure. The results are presented in table form in Appendix C. However, as was mentioned in the study's methodology section, the data should be interpreted with caution.

With regard to the place of status of women issues in the organizational structure of the RHSSBs, analysis of data from the questionnaire indicates some instability in the resources allocated to this portfolio. Eleven of 16 RHSSBs indicated that they have a staff coordinator for status of women issues but in some cases they noted that the incumbent changed often. Four of the RHSSBs had established this position in the early 1980s and seven others

indicated that the position was established in the 1990s; this is especially true of the RHSSBs that came into existence as a result of the subdivision of areas covered by the defunct RHSSCs. Five RHSSBs reported that they did not have a status of women coordinator at the time they completed the questionnaire; these were the regional boards for Côte-Nord, Baie-James (Nord-du-Québec), Saguenay-Lac-Saint-Jean, Laval and Montréal-Centre. The Montréal-Centre, Saguenay-Lac-Saint-Jean and Baie-James RHSSBs reported that they had previously had a status of women coordinator but that the position had been discontinued. The Montréal-Centre RHSSB indicated that there was corporate-wide responsibility for status of women issues and that the coordinator of the violence against women file routes requests to the appropriate individuals in the sectors concerned.

Of the status of women coordinators in the 11 RHSSBs, most (seven) report to a branch responsible for services programming and organization, the actual designation of the unit varying depending on the RHSSB. The position is within the public health branch in the Montérégie and Abitibi-Temiscamingue boards. In the Mauricie-Centre-du-Québec and Outaouais RHSSBs, the status of women coordinator reports to the executive council.

Based on the data from the questionnaire, the time spent by the coordinator specifically on status of women issues varies widely. Most often, this portfolio is combined with implementation of the spousal violence policy and sometimes includes follow-up on sexual assault orientations. In some cases, it is combined with less closely related files and the status of women coordinators are responsible for a wide variety of programs, such as alcoholism and drug abuse, mental health or suicide, child abuse and neglect, senior services and home support, and access to services in English. This conglomeration of files may explain why in three of the 11 RHSSBs—in Bas-Saint-Laurent, Chaudière-Appalaches and Montérégie—the coordinator spends less than 10 per cent of her time on status of women issues. The proportion of time varies from 20 per cent to 50 per cent in four of the 11 RHSSBs (Québec, Outaouais, Abitibi-Témiscamingue and Gaspésie-Îles-de-la-Madeleine), and it exceeds 50 per cent in the Lanaudière RHSSB. One RHSSB—that of Mauricie-Centre du Québec—reported that the status of women coordinator devotes all of her time to this portfolio. The Estrie and Laurentides RHSSBs did not answer this question.

Many (12) of the 16 RHSSBs have a status of women advisory committee. In the vast majority of cases (nine out of 12), these committees have been in existence since the mid-1980s; in some regions they were created at the request of women's groups. They have between eight and 15 members representing women's organizations and health and social services institutions in the region, who are appointed by the RHSSB in consultation with the community. In three of the 12 regions, however—Abitibi-Témiscamingue, Chaudière-Appalache and Gaspésie-Îles-de-la-Madeleine—the committee is more like a regional grouping of women's organizations invited to provide advice to the RHSSB. Four regional boards responded that they do not have a status of women advisory committee: Montréal-Centre, Montérégie, Côte-Nord and Baie-James (Nord-du-Québec).

Overall, the information on the status of women coordinator position corroborates the data compiled by the Conseil du statut de la femme du Québec in April 1995, indicating little change over the past six years. Nine RHSSBs that already had a status of women coordinator

have retained this position. There have been changes in some RHSSBs, with the Mauricie-Centre-du-Québec and Lanaudière RHSSBs creating such a position and the Montréal-Centre, Côte-Nord and Baie-James RHSSBs discontinuing it in the time between the two surveys. The 1995 CSF survey stated, "The most significant changes were noted in the authority attached to this mandate and the related intervention practices. In most regions, the status of women mandate now falls under the responsibility of a branch that handles a variety of files" [Translation] (Quebec, CSF, 1995b, p. 7). The CSF concluded from this that there was "a decrease in the importance of the status of women portfolio in the regional health and social services boards in terms of allocated time/personnel . . . administrative level . . . and division of the mandate" [Translation] (Quebec, CSF, 1995b, p. 8).

If there have been developments since 1995, they have been in the number of status of women advisory committees, rising from five in 1995 to 12 in 2000, when data were collected for this study.[24] The main reason for the increase is that most (five out of six) of the RHSSBs created by the division of the health and social services regions after the passage of the 1991 legislation formed their own advisory committees.[25] The information provided by representatives of the regional committees of women's groups as follow-up to our survey indicates that these new RHSSBs chose this method to respond to demands from women's groups in certain regions.

The information collected on regional consultation procedures for the 1998–2002 RSOPs is not sufficient to establish a link between the number of means used by the regional boards to consult the population on the plans and the participation of women's groups in these consultations. Several of the briefs from women's groups were prepared and presented by cross-sectoral networks (e.g. regional committees of women's groups) or by sectoral networks representing organizations working in the same field (e.g. shelters for abused women or centres to combat sexual assault).

Case Studies in Four Regions of Quebec

For each of the four regions selected for the case studies, we analyzed the contents of the discussion groups and the interviews with women members of the boards of directors, managers and staff of the RHSSBs. Our purpose was to contrast intra-regional dynamics and to identify indices for understanding the observed differences in the RSOPs. We also sought to understand relations between the RHSSBs and the regional coalition of women's groups in terms of the implementation of programs and services responding to the specific needs of women. For each of the four regions, the results are presented by theme: concerns of the women consulted, the procedure for developing the RSOP and the RHSSB's organizational structures relating to the status of women, as well as the interactions between the regional board and the region's women's groups.

The assessment of relations between women's groups and the RHSSBs and the responses to the various needs of women in the four selected regions is based mainly on the perceptions of practitioners from organizations working with women in each region. To help us understand their concerns in the context of the organization in which they are active, we

asked participants in the discussion groups to complete a short questionnaire in advance, which would allow us to develop a profile of the organizations to which they belong.

Profile of Organizations to which Discussion Group Participants Belong

The participants in the discussion groups and those who granted individual interviews completed a short questionnaire (see Appendix D) that enabled us to draw up a profile of the organization to which they belong. The answers to these questionnaires were processed using SPSS software.

In terms of the organizations' fields of activity, categories were established after the meetings to sort the data collected from an open question in the questionnaire completed by the participants (see Table 3). These organizations work in the status of women field in general (notably through regional committees of women's groups); in the areas of spousal or sexual violence, or both; in physical or mental health, or both; some work more specifically with immigrant populations or marginalized women, or in sectors of activity that do not solely concern women (family response team, food bank, volunteer service).

Table 3: Areas of Activity of Community Groups to which Discussion Group Participants Belong

Area of Activity	Region A	Region B	Region C	Region D	TOTAL
Status of women in general	2	2	1	3	8
Spousal or sexual violence, or both	2	4	2	2	10
Physical or mental health, or both	1		1	1	3
Marginalized women			2		2
Immigrant population			3	1	4
Other (family, volunteers, etc.)	3				3
Total by region	8	6	9	7	30

Of these 30 organizations, most (21) have existed for 10 to 25 years. Of the organizations that have been in existence for more than 25 years, four deal with status of women issues in general. The five organizations that have existed for under 10 years are found in the less urbanized regions, except for one organization that works with marginalized women in an urban area.

Among the organizations represented, some eight have a total annual budget of $250,000 or more; they include four working to combat violence against women, two women's health centres, a women's mental health residential centre and an organization active in several areas related to the status of women. With the exception of the health centres, all of the organizations that receive this higher level of funding offer accommodation. Of the nine organizations operating with a budget of from $100,000 to $250,000, most also offer accommodation services; they include four centres for women and children who are victims of violence, a women's centre equipped with a crisis centre, and an organization that serves homeless women. This category also includes a centre working to combat sexual assault, a service working with the immigrant population and a food bank service. The seven organizations with incomes of $60,000 to $100,000 include four working in the area of

status of women in general, one working with the immigrant population and two working in other areas of activity. The four organizations with annual budgets below $60,000 are found mainly in urban areas and work with immigrant populations or disabled or homeless women. Two participants did not provide information on the level of funding of their organizations.

In the questionnaire used to prepare the profile of the organizations and the women that they serve, the results on the socio-demographic characteristics of the women served must be interpreted with caution. The analysis revealed that the meaning of the term "women served" could be interpreted quite differently from respondent to respondent. For example, for an AFÉAS representative,[26] this term included all women in the region possibly affected by the association's activities. For a respondent from a residential facility, the term "women served" referred solely to women sheltered during a given year. However, based on the information collected, we can say that in the vast majority of cases the women served are aged from 25 to 50, and of low income. Most of the organizations (22) serve Francophone women; exceptions are the four groups working specifically with the immigrant population. In addition to Francophone women, however, 11 organizations serve Anglophone women, nine serve immigrant women and three serve Aboriginal women.

Moreover, a majority of the organizations (70 per cent) are involved in activities with the RHSSB, and this applies to all of the regions selected for the case studies. These contacts are sometimes regular (44 per cent of cases) and sometimes occasional (52 per cent of cases). The most common activities conducted with the RHSSB are joint board-community committees, and training activities or participation in conferences. The perception of the participants as to the quality of the collaboration with the RHSSBs varies from region to region. It is clearly positive in Region A, while reports were less positive in Region B. Opinions were mixed in Regions C and D. The responses to the questionnaire administered prior to the interviews agree with the content of the discussions analyzed later on.

A large number of the community organizations (70 per cent) to which study participants belong were involved in the 1998–2002 RSOP consultations in their regions. In interpreting this result, it must be pointed out that some of the organizations were represented in the consultations through a regional sector committee—notably, organizations working in the area of spousal and sexual violence. Region C stood out for the small number of women's groups involved in the RSOP consultations, and this is reflected in the responses of participants in this region's discussion groups. This finding may be a sign of weaker identification with the region in a major urban centre and less structured interactions between the RHSSB and women's groups in the region.

Region A

Concerns of the Women Consulted

Francophones form the vast majority of the population of this region; Anglophones account for less than 2 per cent and the few Aboriginal communities make up the rest. The region includes an urban centre with more than 100,000 inhabitants and five regional centres around medium-sized towns, with the majority of the territory being rural.

The main concerns of participants in the discussion groups were women's poverty and isolation. Lack of means of transportation was also mentioned as a factor that increases the isolation and dependence of the female population and restricts access to health and social services, as well as to mutual aid and support groups. However, the shortage of physicians ranked first among the concerns expressed with regard to access to health services. Mention was made, for example, of the lack of obstetrical services, which forces women to leave their families and even the region to give birth. According to several participants, service quality is affected by sexist bias in the practices of certain physicians. Of particular concern were the lack of attention given to women's living conditions and the tendency to prescribe anti-anxiety medication for them more often than for men. Shortcomings of the LCSCs as entry points to the health and social services network are also a source of dissatisfaction, but the recent development of the LCSC Info-Health telephone service was mentioned as improving access to health advice for women who are generally responsible for giving care to family members.[27]

The RSOP for Region A

In its consultations on the RSOP, the RHSSB used several means to encourage the population to express its needs. Notably, it sent a questionnaire to all institutions and community groups in the region, it received briefs, and it held public hearings and cross-sectoral consultations organized by the LCSCs with various partners in their territory. The RHSSB also used working sessions with various user committees as forums for discussion. The various coalitions and associations of women in the region actively participated by submitting approximately 20 of a total of 120 briefs. This planning approach was seen as relatively open and transparent by the women's group representatives whom we consulted, which was not the case with other consultations conducted in the region.[28]

In addition, women members of the RHSSB's board of directors pointed out that the board was closely involved in the entire consultation process and had requested changes to respond more effectively to the public's expectations. In their view, despite sometimes heated debates, the board of directors' work reflects relationships of trust between its members, and features regular discussions in plenary session, openness to the participation of the public in public sessions, and easy access to the RHSSB's president and executive council.

The 1999–2002 RSOP for this RHSSB includes a section on the health, well-being and living conditions of women. In it the regional board undertakes to "increase its efforts to ensure that the services offered respond to the specific needs of women" [Translation] by adopting nine measures that align, for the most part, with the major strands of the government's status of women action program: gender-based analysis; combatting spousal violence and sexual assault; planned parenthood; combatting breast cancer; preventing an increase in the burden on caregivers; midwife services; creating a birthing centre; and support for the status of women advisory committee. These commitments are largely the result of the involvement of the region's women's groups:

> *At the time there were a lot of consultations relating to women. Initially, what they wanted, it was not certain they wanted to put us in a section. . . . But finally we decided to have [a section] on the health, well-being and living*

> *conditions of women. . . . We were concerned about being so spread out that they would succeed in completely watering down what we had.* [Translation] (member of the advisory committee)

Status of Women Advisory Committee

In this region, the RHSSB's status of women advisory committee is one of two standing committees reporting to the executive council; the other is the committee for access to services in English, established by provincial statute. The assistant executive director must see to the smooth operation of the advisory committee, provide it with necessary support and ensure that it is consulted on major issues relating to the appropriateness of services to meet the specific needs of women.

The operation of the status of women advisory committee and its position in the structure of the RHSSB has varied:

> *In the beginning . . . we were part of the social health [sector]. . . . That did not work very well. . . . Then we said that it would be much better if we reported to the executive council because if things did not work out, that was where we had to report it. . . . This request was accepted by the board of directors. We were successful, it has been two years now.* [Translation] (member of the board of directors*)*

This repositioning was an opportunity to clarify the role of the advisory committee, to set its rules of operation (by-laws and regulations) and to diversify its membership to include cross-sectoral representation. The members of the advisory committee are appointed for a three-year term by the RHSSB's executive council, from a pool of nominees proposed by partner organizations, taking into account individual expertise and representation from the various geographic sectors of the region. The committee has five members from institutions, five members from women's groups or community organizations working specifically with women, two members from organizations involved in sectors other than health and social services but whose activities affect women's living conditions, and two co-opted members who can provide additional expertise to the committee. The co-opted members are recommended jointly by the RHSSB and the other members of the advisory committee. The committee meets at least six times a year; recommendations are passed on a consensus basis or if necessary, by simple majority vote.

The RHSSB officials stress the committee's advisory role by pointing out that it is not a forum for negotiation or representation, and that the members are appointed for their expertise relating to the specific needs of women. This opinion is shared by the members of the advisory committee, who believe that their role is "to provide advice on orientations and the consequences for women" [Translation]. They view as a victory the RHSSB's openness to them and the fact that the "advisory committee is practically an institution within the regional board" [Translation]:

> *We are one of the only regional boards where the status of women advisory committee has regular meetings. And we also have some power. To my*

> *knowledge . . . every decision that comes along, such as organizational plans, whatever comes to the board of directors—always as part of the process, you often have the regional medical commission and the status of women advisory committee. We are always among the people asked to give their opinions.* [Translation] (member of the advisory committee)

The advisory committee is well known to the members of the RHSSB's board of directors, who welcome its advice. One woman who sits on the board of directors even maintains, "It is easier to exert influence through the advisory committee because we select the files and we push them" [Translation].

The advisory committee's credibility also stems from the work of the status of women coordinator, who visited the various departments of the RHSSB to explain the committee's restructuring, clarify its role and remove the vindictive image that had been attributed to it prior to these changes: "Portfolio coordinators did not want to come to the committee for fear of getting into a wrangle. We were always expected to react." [Translation] (member of the board of directors)

The advisory committee sets its own priorities each year based on the measures announced in the RSOP and the issues being addressed in the health and social services network, as well as the issues on which it may have some influence with regard to women's health and living conditions. In this way, the measures formally included in the RSOP are supplemented by anti-poverty efforts, mental health orientations, and the issue of women and drug abuse.

The Status of Women Coordinator

Between the advisory committee and the officers responsible for a specific file in the RHSSB's various departments, the status of women coordinator acts as a liaison on the programming aspects that affect the health and living conditions of women. When necessary, this liaison work is done in collaboration with the assistant executive director or the manager of the unit to which she is attached:

> *She acts as an interface . . . between the regional board and the committee. She is not a member of the committee; she is a representative of the regional board who liaises with the committee. It is her responsibility to inform the advisory committee of current files, to make contact with the various departments to ensure that orientations affecting the different components take into account the status of women. . . . She functions as an interface with all of the departments to build bridges and to ensure that the departments concerned come to discuss matters with the status of women advisory committee, and she herself also brings women's concerns to the committee if they are not raised by other officers.* [Translation] (RHSSB manager)

On occasion, this coordinator may be asked to present the work of the advisory committee to the strategic policy committee, which consists of representatives of the various departments in

the RHSSB; she may be accompanied to such meetings by members of the advisory committee, if required. She also looks after coordination of files relating to the practice of midwives and actions to combat violence against women that fall into the "social health sector." In addition, she represents the RHSSB on various regional status of women cross-sectoral organizations (Regional Administrative Conference, Conseil régional de développement, consultations of the Conseil du statut de la femme). Joint cross-sectoral activities are useful but limited resources mean that the coordinator does not always have the time to go into these matters in the desired depth: "She would need an assistant" [Translation], one of the members of the advisory committee commented.

Interactions between women's groups and the RHSSB

Overall, the assessment of the interactions between the RHSSB and women's groups is quite positive—both among members of the advisory committee, who believe that "having an advisory committee opens doors, is beginning to create a climate conducive to collaboration" [Translation], and among women's groups, who are not directly involved in interactions with the RHSSB: "Relations over the past two years with the regional board have been good. I mean that they are listening" [Translation].

According to several of the people consulted, the position of the advisory committee in the RHSSB's organizational structure confirms its credibility:

> *The main asset is having it associated with the executive council. That sends a clear message about its importance. . . . It also makes it easier to resolve issues that may still arise within our own organization in view of the importance, the seriousness, the follow-up to be given to files related to the status of women.* [Translation] (RHSSB manager)

Even when advice from the advisory committee is accepted by management or by those in charge of the RHSSB's programs, the members of the advisory committee must still ensure follow-up:

> *There are two reactions from the board: one that is official and seems positive, that says yes, except that nothing happens. Afterward, those of us on the advisory committee, we have to apply pressure, again return to the attack so that things start moving. It's a slow process. We still have to follow it through the channels, to have special agreements.* [Translation] (member of the advisory committee)

The advisory committee operates effectively because there is a common understanding of its role. Other factors noted as contributing to its success are the creation of a common language, resource support (although limited) allocated by the RHSSB, and the definition of clear targets leading to concrete results:

> *Another thing that is very important is to properly clarify the targets, the issues on which you will work, because it is important that people feel that they are being effective. . . . If you get together to talk about disparities*

> *related to women without really having any specific goal, it's a bit discouraging. . . . So we set priorities.* [Translation] (RHSSB officer)

Our respondents also pointed out the importance of using the levers in the RSOPs and in the government's health, well-being and status of women policies as tools to move matters forward: "Not everything is in the plan. . . . We also use provincial measures depending on the issues" [Translation].

Among the difficulties encountered, it is important not to overlook the limited financial resources of women's groups, given the contribution they are required to make to the work of the advisory committee, even though travel expenses and meals are covered:

> *When someone leaves to take part in consultations, someone else has to replace her. We are not on an equal footing, which means it is not an equitable partnership.* [Translation] (women's group worker)

According to the opinions provided, the position of the status of women coordinator in the RHSSB can become a delicate one if she is not well supported by management and if she does not have a clear understanding of her role. The role requires someone who has an interest in the issues addressed by the advisory committee and who still keeps the distance appropriate to an intermediary between the committee and the RHSSB:

> *We still have some way to go in terms of considering the situation of women, how to intervene and gendered analysis. The advisory committee requires us to be vigilant. It is an important additional benefit.* [Translation] (RHSSB manager)

Moreover, the women's movement in this region is focused on the challenges associated with considering women's specific needs in regional health and social services planning. Despite limitations, some women's group workers see concrete results from this joint effort in terms of recognition and funding for some services for women. But they point out that progress is slow and requires persistence and perseverance by the women involved.

The adoption in June 2001 of Bill 28, which amended the governance of the health and social services system in Quebec, worries the members of the advisory committee because it alters the composition and appointment process of the board of directors and the executive council of the RHSSB: these appointments are now to be made directly by the Ministre de la Santé et des Services sociaux:

> *At present, there is a sort of energy-sapping uncertainty. It's a bit destabilizing because we don't know whether it's a provincial or regional [responsibility]. I no longer feel as though anything is happening here in the region, that there is any power. Budgets are simply handed down to the board. The board has an administrative role, not a decision-making one. . . . It's hard to believe that they have any real influence at this time in terms of women's issues.* [Translation] (advisory committee member)

These legislative changes are taken into account in the recommendations presented later in our report.

Highlights
Relations between women's groups and the RHSSB in Region A are characterized by:

- an active and recognized status of women advisory committee;
- co-operation with community representatives, who provide continuity within the board of directors;
- the position of the status of women coordinator in the RHSSB's organizational structure and management's support, which together enable her to exercise some influence over programming; and
- the work of this coordinator to strengthen the advisory committee and to make RHSSB officers aware of the gender-based approach.

These characteristics make it easier to follow up on the commitments in the RSOP and to ensure consideration of the concerns of women's groups when implementing health and social services.

Region B
Concerns of the Women Consulted
This vast region far from major urban centres is a resource-producing area. The population is grouped in regional county municipalities (RCMs), an arrangement that defines the regional dynamics and is reflected in the organization of the public health and social services network. For the RHSSB, "All of the basic services and most of the specialized services must be accessible in each of the RCMs" [Translation]; this means that there are health institutions in most of the RCMs with combined missions (general hospital, LCSC, residential and extended care centre).

Francophones make up the vast majority of the region's population, the proportion of Anglophones being under 5 per cent. The population includes one of the highest proportions of Aboriginal persons in Quebec. All health and social services in the region need to be adapted to meet the specific needs of Aboriginal women:[29]

> *The board, women's groups and institutions are not too sure whether they should work [with the Aboriginals]. When we think we should, we do not really know how. They are increasingly taking charge of their own services, which means the hesitation is even greater*. [Translation] (regional board officer)

Women's poverty and spousal violence were among the key concerns expressed by the women interviewed. Also seen as important is training in non-traditional sectors to promote women's access to the labour market and, consequently, their financial independence. Access to medical services is very difficult because of the shortage of physicians in the region; waiting times are so long that many people have given up seeing a family physician.

Another concern is the long distance to be travelled and the lack of public transportation services; these add to the isolation and vulnerability of women, especially those with disabilities, who have no choice but to rely on volunteers to get around. Our respondents told us that waiting lists for social or psychological services at the LCSC are long, and that people who have individual or group insurance coverage use professionals in private practice to circumvent the lack of public services.

As a result of financial cutbacks in the public system, community organizations are increasingly called upon to handle complex problems—a phenomenon that is of concern to women's groups:

> *Women have few choices. The community centre is no longer an option because of the memorandums of understanding. The LCSCs want to reduce their waiting lists; they have quotas to meet and would like to turn us into intermediary groups*. [Translation] (member of the health committee of the regional coalition of women's groups)

In these circumstances, relations between women's groups and the public health and social services network are strained.

The RSOP for Region B

The process of preparing the RHSSB's 1998–2002 RSOP was highly unsatisfactory to the women consulted because there was very limited consultation:

> *A report was prepared [by the RHSSB], verified and submitted to people in [one-day] workshops. Everyone was grouped by program or by portfolio. There was no separate meeting on the status of women: it was included as part of public health*. [Translation] (RHSSB officer)

One woman active in the region's women's coalition explained the pressure it exerted on the RHSSB to ensure that the coalition could participate in the consultations:

> *The consultation . . . what a farce! If we had not acted, we would not have been consulted. [The regional board] had not planned any consultations. The community groups, including the committee [of women's groups] said: "We have to be in the plan." That was when they [the regional board] quickly organized consultations, but it was hard to get documents. The consultations were by program. Since we did not have a program [for women], we were spread throughout all the programs. . . . There were no public hearings to receive briefs. So we sent it [the brief from the women's groups] to all members of the BoD and asked that it be discussed by the BoD.* [Translation] (member of the health committee of the regional women's coalition)

The addition of a section on the status of women to the 1998–2002 RSOP was therefore seen by some respondents as a compromise by the women's groups who had been asking for a specific "women's" program since 1996. Others felt that having a section on the status of

women in the RSOP was "an asset, especially since the regional board indicated that it needed a full-time resource person to carry it out" [Translation].

In fact, the 1998–2002 RSOP reiterated the previous plan's commitments on the status of women and called for the development of a regional profile, followed by an action plan to adapt services to the needs of women. The women consulted are worried about the length of time this process is taking:

> *The status of women plan was supposed to be prepared under the first transformation plan in 1997, but it never was. For three years, all there has been is a table of contents. We seem to be getting no further. It may still be on the drawing board.* [Translation] (member of the health committee of the regional coalition of women's groups)

In the RSOP, the RHSSB blames the situation on a lack of resources and indicates that adding a new full-time resource person will be necessary to follow through on the goals set out in the RSOP regarding the status of women; this requires recurring funding of $70,000 from MSSS.

The Status of Women Coordinator

Several respondents mentioned that there is no member of the RHSSB staff whose primary concern is the status of women. In the program department, one officer spends about one day a week on the violence against women file. Another officer attached to public health is responsible for developing the regional profile and the status of women action plan. However, most of her time is spent on the suicide prevention portfolio, so she does not have much time to prepare the status of women action plan:

> *When I arrived . . . there was a table of contents. I did not have a researcher working with me. I prepared a fairly general profile and after that I will go back to each program and try to document it in relation to the differences between men and women. We have to do a gender-based analysis and organize services accordingly. That is my goal but I have so little time to devote to it and not much support. It is not a popular portfolio in the regional board. It is kind of invisible within the board*. [Translation] (RHSSB officer)

RHSSB managers share this perception.

Moreover, there is no status of women advisory committee attached to the RHSSB's organizational structure:

> *If there was a more internal or more official advisory committee in the board's structure, I think it would help among those with influence. If there is no one inside motivated enough by this portfolio, the pressure comes from the outside . . . when groups lobby*. [Translation] (RHSSB officer)

Given the lack of an advisory committee to the RHSSB and the limited resources allocated to the development of an action plan on women's health, well-being and living conditions, some respondents see the situation as an expression of the lack of interest in the status of women on the part of the RHSSB's management.

Interactions Between Women's Groups and the RHSSB

The regional coalition of women's groups is very active on issues connected with women's health and well-being, and its health committee is consulted informally by those in charge of the status of women portfolio in the RHSSB:

> *It's as though the committee [of regional women's groups] is an advisory committee for [the regional board]. It is not officially appointed as such but it plays that role. . . . I went to the meetings regularly but recently I have had a period set aside for matters that concern the regional board. I am not there for their discussions among themselves*. [Translation] (RHSSB officer)

The role of the regional coalition of women's groups is explained by the fact that it has been in existence for a long time. Since the creation of the RHSSB, women's groups have exercised leadership in mobilizing the community movement so that it can take its place in regional health decision-making bodies. A seat is reserved for women's groups among community representatives on the RHSSB's board of directors,[30] and this has enabled the women's movement in the region to bring its concerns directly to the table, although there has been some resistance:

> *In this area the RCCO [regional coalition of community organizations] was established by the women's groups. Other organizations believe that women's issues are too prominent, that they have too much funding. It is not necessarily easily to get their support. We have a strong voice in several areas and we can be disruptive.* [Translation] (member of the health committee of the regional coalition of women's groups)

According to the members of the board of directors interviewed, the dynamics within the RHSSB's board of directors often amount to a power struggle between the region's RCMs. One of the members expressed her scepticism about the possibility of exercising any real influence within this body:

> *The primary outcome of the position on the BoD has been to raise the credibility of women's groups. It has highlighted how we work. The competence of the individuals is acknowledged, but not the fight itself nor feminist action. . . . It might be assumed that from the BoD, women would be able to change practices, but it takes two. There are no facilitating conditions.* [Translation] (member of the health committee of the regional coalition of women's groups)

Some of the women consulted prefer to lobby the RHSSB's management more directly for action on the status of women portfolio:

> *At present, there are not many other channels, except that the [women's] groups often go directly to the ED [executive director]; this has been happening for some time. I think it is a good strategy because he is interested in what is being done in the status of women portfolio. Although he is a little uneasy at times, I would say, about what women's groups can do. He is listening.* [Translation] (RHSSB officer)

Several members of the health committee of the regional coalition of women's groups believe that their efforts to influence regional planning have been somewhat unproductive. In their words: "If we go back five or 10 years, there has been some progress, but we had to fight for it and we still have to fight to keep what we have. . . . I think we can no longer be ignored." "It is unclear whether there has been any progress. We have just changed the terms of discussion . . . because nothing comes of it" [Translation]. Given the extensive and lengthy work of the women's movement in this region in matters relating to women's health, our respondents are also concerned about the re-centralization launched by MSSS under Bill 28, which reduces the flexibility allowed to the RHSSBs and the possibility of having influence at the regional level.

Highlights

In Region B, relations between women's groups and the RHSSB waver between co-operation and lobbying. The regional coalition of women's groups took action to obtain from the RHSSB a commitment in the RSOP to develop a women's health action plan. However, the regional board has been slow in acting on this commitment, despite the pressure applied: "Honestly, we will be frank, we were told by a manager, 'I think the awareness is there in each of the programs, especially given the lobbying that has been done'" [Translation]. The health committee of the regional coalition of women's groups does not have any mechanisms that would enable it to ensure systematic monitoring of the commitments in the RSOP. The RHSSB's commitment is undermined by the lack of a status of women advisory committee associated with the RHSSB's decision-making bodies and the fact that the officer assigned to develop the women's health action plan has little time to give to this project because of her other responsibilities. In short, external pressure is not enough; what is needed to guarantee the development and implementation of the proposed action plan is the commitment of management, along with the allocation of adequate resources to follow through.

Region C

Concerns of the Women Consulted

This is a highly urbanized region with a large population that is diverse in socio-economic and ethnocultural terms. The diversity is a challenge for the health and social services network, which offers a wide variety of services ranging from local community programs to highly specialized activities accessible to people from outside the region.

The proportion of single-parent families and persons living alone is higher in this region than elsewhere in Quebec. Often falling into these groups are women heading single-parent families and elderly or marginalized women living in poverty. The problems of poverty and violence against women were often mentioned as key issues by the women consulted.

According to workers with community organizations active in ethnocultural communities, the immigrant population is experiencing a number of problems: isolation because of the language barrier, discrimination when seeking housing, lack of recognition for training acquired in their home country, job insecurity, and spousal and family problems arising from culture shock in both relations between women and men and between parents and children (Zambrana, 1988; Vissandjée et al., 1998). Recent immigrants are often disconcerted by the complexity of the health system and their lack of knowledge about how it works:

> *More time is always needed to explain or to go find them because there are misunderstandings and sometimes it's not a matter of language.* [Translation] (worker with a group dealing with cultural communities)

However, there are different opinions on what to do to ensure that more consideration is given to the specific needs of these communities. Some suggest that positions be reserved on the decision-making bodies of the health and social services network for community representatives. Others prefer the comprehensive approach championed by women's groups.

Women's groups are concerned about the variety of situations experienced by women and some are working for recognition of the special needs of women living in marginalized situations, such as lesbians, women with disabilities or homeless women:

> *When we began talking about violence against women with disabilities . . . we were told by everyone that it was not possible. Fifteen years ago there was not even acknowledgment that homeless women existed, people had to be shown*. [Translation] (women's group worker)

Some of our respondents are worried, however, that an approach focused on "at-risk" clients leads to a fragmentation of services and to social control, especially over marginalized women.

The shift to ambulatory care is also the subject of strong criticism by the women consulted because of what they see as the negative consequences for women of inadequate resources. Some also believe that the services of the public network, notably the front-line services of the LCSCs, should be more accessible: "There are some LCSCs that are overly bureaucratized, that are not close enough . . . to the public." [Translation] (member of the RHSSB board of directors)

Some of the women consulted believe that the lack of attention given to women's needs leads to significant gaps in the range of services available in the public network. Here are a few examples:

> *There is a refusal these days to recognize the special needs of women, in everything related to mental health as well. . . . There is no women's crisis centre; women are often harassed, not just by male workers but by clients. . . . But there is no real consideration given to the safety needs of women in mental health services.* [Translation] (women's group worker)

> *There is a lot of talk about the ageing of the population, but no programs have been developed to take into account the ageing of the female population. While women are seeking safe and reliable information on menopause, for example, on hormone replacement therapy or alternatives . . . there is no program available under public health . . . to educate physicians and public institutions so that the information can then be passed on to women.* [Translation] (women's group worker)

Our respondents mentioned that women's groups have no choice but to make up for the shortcomings of the public system, despite their limited resources.

The RSOP of Region C

In the consultations on development of the 1998–2002 RSOP, the RHSSB used several means to reach different audiences: the general public, user committees, partners in the health and social services network, and numerous groups and organizations interested in health issues. In addition to receiving briefs and holding public hearings, the RHSSB organized forums on particular themes, and conducted telephone and Internet surveys; and representatives of the RHSSB, on request, participated in some meetings to explain the planned RSOP to citizen groups. These consultations were accompanied by a newspaper advertising campaign to inform the public.

The members of the RHSSB's board of directors whom we consulted confirmed the efforts at open consultation and the active involvement of the board of directors in the process. A report by the community members on the RHSSB's board of directors confirms this point of view:

> Everyone felt that the consultations and public hearings, including even televised hearings of the board, were conducted in a commendable fashion. The board's consultations were very democratic. The only criticism that could be made is that some of the issues that we felt might have warranted public consultations did not always get them. [Translation] (extract from the report)

However, we must note that of the 120 briefs, very few (three) presented during the public hearings came from groups working on the status of women.[31] There is only a cursory reference to gender-based analysis in the consultation report: "Specific consideration should be given to women in all programs and services" [Translation]. However, no action has been taken to follow up on the RSOP.

The 1998–2002 RSOP is based on continuums of service in physical and mental health, or on targeting specific clienteles or problems. It does not include a section on the status of women. Two programs specifically related to women are given particular attention: action to deal with violence against women and the fight against breast cancer. Except for these programs arising from provincial policy, the RSOP does not contain either an objective or specific orientation to consider the characteristics of the female population. As is pointed out in a notice from the Conseil du statut de la femme (Quebec, CSF, 1999b), the RSOP does not explicitly address the orientations of the Ministère on planned parenthood, perinatal

care, or the adaptation of health and social services to serve homosexual persons. Several of the continuums perpetuate the invisibility of women by ignoring the feminization of ageing and poverty, as well as the impact of the shift to ambulatory care on women caregivers in particular.

The Status of Women Coordinator

The questionnaire completed by the RHSSB in summer 2000 indicated that there was no status of women coordinator or advisory committee, and that this portfolio was managed on a corporate-wide basis. An RHSSB officer has been given the mandate to coordinate status of women issues; her job is mainly to assign the files to the various units responsible for one or another of the service continuums. Her primary responsibility is to implement the policy on violence against women and follow up with women's groups funded by the community organizations support program. Her position was transferred from the public health department to the programming-coordination department, where it remains. According to the position's incumbent, the new location within the regional board's structure fosters more frequent contact with community groups working on status of women issues.

This approach to managing the status of women portfolio by distributing it among various departments also offers increased opportunities for collaboration,[32] which are not without consequences in terms of the energy required by women's groups. Some of the women consulted feel they are being active but getting no concrete results:

> *In other regions, they may have listened more closely, because . . . at the regional board, they are closer to the community. [Here] it is truly enormous and so is the energy that it takes; the bodies and the forums . . . for collaboration and then the committees, it's phenomenal. It's not possible to keep track of all of it, for the same people to be asked to attend 25 committees; you end up no longer having any connection to your centre.* [Translation] (women's group worker)

Various regional women's groups' networks have pooled their efforts to change the way the status of women portfolio is coordinated within the RHSSB's organizational structure. Presentations were made at a meeting of the RHSSB's board of directors to ask that the status of women coordinator have clearer responsibilities and more direct links with the RHSSB's management.

In response, the RHSSB's board of directors asked for a progress report on status of women activities. The report to the board of directors stated, "Numerous status of women activities are under way or about to be launched in several continuums . . . despite the fact that they are not called for under specific measures in this plan to improve health and social services" [Translation]. The report listed various activities undertaken by the RHSSB itself or in conjunction with various partners under the different service continuums, notably services to seniors and screening/referral activities for young, pregnant, women drug users.

The women consulted shared their opinion of this report with us. They felt it reflected the lack of an integrated approach to the status of women, a situation that produces piecemeal measures:

> *When I saw the report from the regional board on what they had done to provide services to women, it was very much project-driven. . . . It's the way it is designed but if I had a suggestion to make, it would be to stop thinking this way. We will never find solutions to social problems in this manner. It is very simplistic.* [Translation] (women's group worker)

The RHSSB also provided the health committee of the regional coalition of women's groups with a list of about a dozen officers in the RHSSB's various departments who were identified as status of women coordinators—information that definitely does not correspond with the perceptions of the women's group workers whom we consulted:

> *If we look at the committee of women's groups and the health committee, what we see at present is that there is no status of women coordinator at the regional board, even if they say the opposite; and we do not have the capacity, within the women's groups, to identify people who may be able to respond to our needs*. [Translation] (women's group worker)

This initiative, which occurred during the time of our study, is also revealing of the lack of clear understanding of the mandate of the status of women coordinator by members of the RHSSB's board of directors and staff, as shown by the following comment:

> *Two years ago, I think, I was certain that the regional board had a status of women delegate. . . . Ultimately, I learned that there was no one and the file went back to the regional board, which was told to do something . . . but they glossed over it.* [Translation] (member of the board of directors)

Even though the result was not satisfactory to the women's group representatives, their efforts did start a debate on the importance given to the status of women portfolio in the RSOP.

Interactions Between Women's Groups and the RHSSB

Relations between the RHSSB and the regional women's group networks vary, and in some instances this situation is a source of tension. The activists consulted believe that it is difficult to be heard when projects are not part of regional priorities. Some even have the impression that implementation of MSSS policies on women's health, which are not included in the RSOP, does not receive the necessary attention:

> *We have asked for various projects but have received money only for breast cancer. In terms of everything related to prevention, planned parenthood, we have heard nothing. . . . That is why we say that if it is not part of the priorities, it is hard. . . . On the planning priorities waiting to be implemented since 1997, with the exception of second-trimester abortions*

> *. . . nothing has yet been done. There are fewer LCSCs . . . there are fewer hospitals that offer services. The waiting lists are getting longer . . . but still there is no movement*. [Translation] (women's group worker)

According to this woman, such experiences lead to the belief that "there is no interest in women's problems . . . if you do not have a project that is ready to roll and that fits neatly into their pigeonholes" [Translation]. Other respondents also fear that the work will have to be started all over again if the officers in charge of the portfolio are shifted because, in their view, management's lack of interest is a major barrier:

> *Even our coordinators at the regional board are often quite powerless because they are following guidelines. It's a very hierarchical structure. It's a political agenda pursued with MSSS orientations that they apply. They are told to follow certain policies and they do not.* [Translation] (women's group worker)

Other women consulted believe they have even lost ground in terms of recognition of gender differences and are critical of the lack of clear RHSSB policy on the status of women:

> *The concept of gender-based analysis has been completely removed. . . . We are being brainwashed to think that women are becoming violent and that men too need access to funding in this area. . . . We talk about abusive men as people with mental health problems . . . problems that can be solved through therapy. They want to send a person to therapy for breaking his wife's arm, for raping his daughter. . . . I find that strange*. [Translation] (women's group worker)

They are also thinking about the impact of passage of Bill 28, under which the expected role of the RHSSBs will be increasingly to translate MSSS policy into their RSOPs. Among the activists whom we interviewed, this issue raises strong concerns in terms of the relations between the RHSSB and women's groups.

Highlights

In Region C, the 1998–2002 RSOP contains few specific commitments on the status of women. Although the RSOP does not cover all of the RHSSB's activities, the commitments made in the plan are the ones to which decision makers pay attention. Moreover, as a result of the regional board's corporate-wide approach to managing the status of women portfolio, there are in fact no internal mechanisms to ensure the integration and systematic monitoring of this portfolio in the complex environment of the region's health and social services. The concerted efforts of various women's networks recently succeeded in reviving the debate within the RHSSB on integration of the gender-based approach in regional planning and the need for real coordination of status of women issues. However, this initiative will not ensure ongoing follow-up of the portfolio given that there is no status of women advisory committee.

Region D

Concerns of the Women Consulted

This vast region is located in the suburbs of a major centre and is experiencing rapid population growth. It includes several cities of more than 30,000 inhabitants and an outlying rural area. Anglophones make up close to 10 per cent of its population and diverse cultural communities account for slightly more than 5 per cent. One of the largest Aboriginal communities is located in the region.

With regard to the status of women, problems of violence and poverty were mentioned frequently by the women consulted, as was the case in the other regions:

> *The women come when they are on the brink of mental health problems, a lack of self-esteem, they are overloaded and impoverished following separation. . . .Women who have little education, who have been with their partner for 25 to 30 years and who are undergoing a separation, are very dependent on their spouse and experience a great deal of isolation.* [Translation] (women's group worker)

The community groups working with the different cultural communities play an important role informing this population about the various health and social services and programs available. Immigrant women are especially vulnerable because of their greater isolation and dependence on their spouses:

> *Sometimes the husband arrived a few years earlier, he has become integrated. . . . There is a question of communication between two people who have been separated, who may not, during those years, have developed the same way of behaving, the same attitudes. . . . The woman arrives with the children and it is unfortunate but it creates a break. . . . She has no members of her family, she does not speak the language, she does not know what services are available; she is living in a very small, narrow world.* [Translation] (worker with an organization dealing with cultural communities)

Problems finding a family physician and waiting times for psychological services in the LCSCs are common in the region. The coordinator of the region's women's group committee also mentioned the problem of accessing services experienced by women living in rural areas without transportation.

The RSOP of Region D

The preparation of the 1999–2002 RSOP was preceded by a report and a prioritization exercise, and included consultations by invitation.[33] The board of directors established an ad hoc committee of six members to oversee the preparation work. It decided to hold public hearings, which were not initially planned. Just over 60 briefs were presented at the hearings.

The consultations took place very quickly and women's group workers, who devoted much energy to formulating joint recommendations, feel their efforts to raise awareness among RHSSB decision makers produced meagre results. Women's living conditions are not subject to any specific analysis and the RSOP does not contain any structured commitments in this area:

> *The services are adapted on a hit-or-miss basis given that there is no consideration of the differences between men and women; it's not included in the 1999–2002 consolidation plan, there is no gendered data. There is data by age but not by gender.* [Translation] (women's group worker)

Acknowledgement of gender differences and women's particular circumstances are equally absent from all regional planning, according to the women consulted. In the component dealing with services for seniors, for example, gender differences are only mentioned in relation to the fact that women take more prescription drugs than men.

Spousal violence is one of several problems addressed in the section on "intentional and non-intentional trauma" included in the public health component. This approach is unsatisfactory to the region's women's groups:

> *We were consulted on the consolidation plan that was being adopted and we noted the disappearance of the violence against women program, which was changed into a general violence program. There was no longer anything specifically for women there. That was a major loss. As I mentioned, we participated, we criticized [the draft]. . . . A brief was presented. All of the women's groups were loud and clear in their comments opposing disappearance of the program. . . . There was no result.* [Translation] (women's group worker)

This change was seen as a setback and a rejection of the demands made by all of the region's women's groups. It raised concern among the women consulted that funds allocated for action to help women victims of spousal violence would be partly redirected to help violent men.

In the 1999–2002 RSOP, a manager described the RHSSB's preferred approach to status of women issues as follows:

> *What we wanted to do was to ensure that the status of women focus would be integrated fundamentally into our client programs so as not to be an isolated concern. . . .We deal with health problems, each involving a variety of clienteles that are then identified by age, gender or maybe nationality. In the public health approach, the age category is especially useful because it defines populations, and at the same time it can define where action is needed: schools, workplaces*. [Translation] (RHSSB manager)

Another RHSSB officer states:

> *The gender variable is considered . . . but I would say that it is perhaps taken into account indirectly through indicators such as poverty or mortality. . . . [Women are] a clientele that may be considered to a greater or lesser extent depending on the issue*. [Translation] (RHSSB officer)

In the opinion of the women consulted, the RSOP simply reiterates MSSS priorities, such as the *Priorités nationales de santé publique 1997-2002* (Quebec, MSSS, 1996):

> *Even in the case of spousal violence, the talk is of intentional trauma—but that, that comes from Québec City, for example. That is important because I leafed through the consolidation plan and I also leafed through the entire [MSSS] public health plan.*[34] *They agree word for word, I found a copy inserted into the consolidation plan.* [Translation] (women's group worker)

To summarize the actions taken by the RHSSB in the area of status of women, we were referred to the regional report on implementation of the *Programme d'action 1997-2000 pour toutes les Québécoises* (Quebec, SCF, 1997a) prepared by the Regional Administrative Conference (RAC). This report lists health and social services activities relating to: support, assistance and respite measures for female caregivers; the development of practices and protocols for short perinatal-obstetrical stays; the monitoring of the spousal violence policy; and actions to implement the *Orientations gouvernementales en matière d'agression sexuelle* (Quebec, MSSS, 2000c). Under the government's policies on spousal violence and sexual assault, cross-sectoral committees were established by the RHSSB and some have produced satisfactory results, according to the respondents: "We were able to see all the memorandums of understanding [on spousal violence] signed in the regions as a result of the efforts of this committee" [Translation].

The RAC's report indicates, however, that some of the targets for sectoral action have not resulted in any action by the RHSSB, whether in terms of adapting support services to women in vulnerable situations, evaluating the impact of network changes on family and friends, or defining specific indicators for women. Given the results of this report on government action in the region with respect to the status of women portfolio, the RAC recommended that each participating government department and agency designate a person within its organization to act as a status of women coordinator.

The Status of Women Coordinator

The RHSSB is not following the recommendations of the RAC, as confirmed by one of the institution's managers:

> *In reality, within the regional board, there is no one formally assigned to the status of women. It is not a portfolio, a client program for example, that entails a specific responsibility for the board, dictated to us by MSSS. As for the concern, it is an underlying element of each of the client programs.* [Translation] (RHSSB manager)

Until recently, two RHSSB officers were assigned to the status of women portfolio: one in the services department and the other in the public health department. They shared monitoring of the various files related to the status of women and provided ongoing points of contact for the region's women's groups:

> *There was a status of women coordinator in place informally, but she was there and was concerned. However, we were told that it was not part of the structure, that it was something informal.* [Translation] (women's group worker)

In this context, there was a breakdown in the channels of communication between the RHSSB and the regional committee of women's groups. This situation fed feelings of dissatisfaction and encouraged the use of pressure tactics targeting the management of the RHSSB, which did not have a status of women advisory committee either, despite repeated requests from the region's women's groups.

Interactions Between Women's Groups and the RHSSB

Relations between the RHSSB and women's groups are marked by an accumulation of negative experiences. One example cited by more than one respondent is the fact that the regional board ignored recommendations from a one-day study session on the theme "Natural caregivers: a choice or an obligation," attended by some 100 community group representatives, nurses and officers in institutions of the public network:

> *[This study day] was as open as possible in order to reach recommendations . . . that did not come solely from women's groups, but that sought broader acceptance. . . . We came up with nine recommendations, which were sent to each of the LCSCs, and we identified the recommendation that concerned that facility in particular, and asked for a response. . . . The same recommendations were sent to the regional board. . . . A letter of reply was received from most of the LCSCs, telling us that it was interesting, that it would be circulated, that it would be considered. . . . No response came from the regional board.* [Translation] (women's group worker)

In light of this situation, the regional committee of women's groups chose to adopt a lobbying approach toward the RHSSB's board of directors. Women's groups made a concerted effort to obtain financial support from the RHSSB for organizing the World March of Women 2000; the pressure they applied produced results:

> *Initially, the request was bluntly refused by the executive council. . . . It was even viewed as frivolous; out of the question to seek funds for the Women's March. Ultimately, we turned to the board of directors, I think there were maybe 125 women who showed up, after preliminary awareness work with the members of the BoD, and we were able to get $50,000 from the board of directors. What I learned from this example . . . [was that] we are capable of making some headway when we are well organized, when we make our opinion known.* [Translation] (women's group worker)

The members of the regional committee of women's groups who interact more with the RHSSB think that pressure tactics may accomplish more than collaboration: "Consensus is great when it works, when the other party is prepared to be flexible. . . . While working that way, we're not coming together" [Translation], one of the women told us. For some, the lobbying approach is necessary to get regional planning to reflect women's specific needs. The assessment of the coordinator of the regional committee of women's groups of her contact with the RHSSB reflects this opinion, despite the effort needed to carry it out:

> *The women's question is upsetting here, it is not something that is very popular in the regional board, it is not something they want, that they promote, and we have to wake them up about it, but they do not respond. As for broader community groups, it is easier because there had been intensive work by the RCCO [regional coalition of community organizations] four years ago. They are relentlessly pursuing the board. As for those of us working on the status of women, what is difficult is that we do not have time for any of the files we are dealing with.* [Translation] (women's group worker)

The fact that the 1999–2002 RSOP follows the frameworks set out by MSSS accentuates the perception that the RHSSB's board of directors has virtually no flexibility in decision making:

> *In the plan, I find the public health department's vision is very strong; this means that the RHSSB board of directors has minimal flexibility to change things, to move things along. . . . In the case of the board of directors meetings that I attended, any time that members of the BoD tried to change something . . . it was very difficult.* [Translation] (women's group worker)

An RHSSB officer confirmed the major influence of MSSS on regional planning:

> *A lot of the policies are now sent to us from MSSS and they have major impacts on regional action. . . . MSSS thinks along program lines. . . . More and more over the past two years, the MSSS approach has been mainly directive. . . . It is quite prescriptive at this point. If there are choices, I would say, around allocation, budget distribution, the choices are fewer, it is more difficult than in the past.* [Translation] (RHSSB officer)

The respondent acknowledged that relations between the RHSSB and community organizations, especially women's groups, take the form of lobbying tactics directed toward the RHSSB's managers: "The major challenge is not at the documentation level. It is at the level of lobbying, exerting influence, governance." [Translation] (RHSSB officer)

In light of the problems encountered in relations with the RHSSB, some women's group workers have reached the following conclusion:

> *The only way there could be any change is for someone to actually bring women's health issues to the department's attention, if there was a status of women position or women's portfolio.* [Translation] (women's group worker)

Several opportunities for collaboration appear to have been put on hold by the RHSSB,[35] which launched consultations on participatory structures a few years ago. At that time, women's groups again asked for the creation of a status of women advisory committee. This initiative was abruptly suspended because of changes in the governance of the health and social services network adopted by MSSS. The changes increased centralization, adding to uncertainty about the role to be given to the RHSSBs in a framework where the choice of priorities for action will increasingly be made by MSSS.

Highlights

Relations between the committee of women's groups and the RHSSB reflect communications problems in a context marked by the lack of a status of women advisory committee or coordinator. Women's groups are acting on health and social services issues but the context fosters dynamics of lobbying and conflict. Women more directly interacting with the RHSSB reported a number of negative experiences. The RHSSB's planning framework gives little consideration to policies on the status of women. Moreover, consultations on participatory structures, launched by the RHSSB, were suspended because of the changes announced in the governance of the public health and social services network.

5. CLARIFYING STRATEGIC ORIENTATIONS

The case studies in the four regions illustrate the relations between the RHSSBs and the regional committees of women's groups in Quebec in terms of planning women's health, well-being and living conditions. Some features are evident from analysis of the data collected.

In the four regions, women's groups are working to ensure that regional health and social services planning takes into account the specific needs of women. The concerted action of women's groups is led by the health committee of the regional coalition of women's groups in Regions B and C; in Region A, interactions between women's groups and the RHSSB are managed through an advisory committee involved in the RHSSB's decision-making process, and its work is closely tied to regional programming. In Region C, the lobbying of various women's networks revealed the ambiguity concerning responsibilities for coordinating status of women files, and this led the RHSSB to clarify its orientations and activity in this area. In Region D, the regional committee of women's groups met resistance from the RHSSB, which no longer has a status of women coordinator. According to the women consulted, the RHSSB pays little attention to the concerns of women's groups and is slow to incorporate their knowledge of the specific needs of women into regional planning.

The RSOPs in Regions A and B include a section dealing with the status of women, while the RSOPs of Regions B and C do not. However, MSSS orientations, policies and programs regarding women's health, supported by transfers of resources to ensure their implementation, are reflected in the RSOPs.[36] Nevertheless, the MSSS *Plan d'action 1997-2000 : santé, bien-être et conditions de vie des femmes* (Quebec, MSSS, 1998) is seldom mentioned in the RSOPs analyzed. The use of GBA, which is still at the testing stage in MSSS, has not yet had any impact on health and social services planning overall. The RSOPs draw on the Policy on Health and Well-Being (Quebec, MSSS, 1992) and are structured according to service continuums targeting mainly vulnerable populations.

The commitments regarding women's health, well-being and living conditions in the RSOPs do not necessarily ensure that they will receive the attention of management or that their implementation will be given any priority. According to the majority of people consulted from women's groups and from the RHSSBs, implementation of the commitments depends on the vigilance and perseverance of women's groups to ensure follow-up. Since there are no implementation indicators relating to the status of women orientations in the RSOPs, it is more difficult to determine the degree to which commitments are fulfilled and objectives achieved in this area.[37] The RSOP can be a mechanism for moving issues forward without necessarily ensuring by itself achievement of the results announced, since mechanisms for regular communication with women's groups are not built into the organizational structure of the RHSSB.

In Region A, regional planning on women's health is focused mostly on establishing a process to foster the ongoing contribution of women's groups to the programming process. A status of

women advisory committee, reporting to the RHSSB's executive council, has been strengthened and officially recognized by a decision of the board of directors. Within the RHSSB, the focus is on corporate-wide coordination of status of women issues. The coordination is undertaken by a status of women coordinator who acts as a liaison between the advisory committee and the various departments of the RHSSB, with ongoing support from management. This approach promotes open dialogue, the creation of common language, heightened awareness of officers working in the various programming areas, and a climate of co-operation that produces results, despite differences of opinion upon occasion. For example, the status of women advisory committee provided advice on women's circumstances and special needs in connection with anti-poverty efforts and mental health orientations. These elements were not part of the 1998–2002 RSOP on women's health but did receive attention.

In Region B, the 1998–2002 RSOP reiterates the commitments made in the previous period; it essentially provides for development of a profile of women's health, to be used to produce an action plan. The officer responsible for the portfolio in the RHSSB is attached to the public health sector and she has little time to carry out this mandate. In addition, she is somewhat removed from the ongoing process of implementing programming in the RHSSB. In her opinion, the delays in fulfilling the status of women commitments included in the 1998–2002 RSOP are not being addressed because there are no available resources. This situation is a source of tension in relations between the RHSSB and the women's movement because it creates scepticism within the regional committee of women's groups about whether the RHSSB is genuinely interested in fulfilling its commitments.

In Region C, the RHSSB prefers a corporate-wide approach to taking the status of women into account in its regular programming activities for health and social services. However, in reality, the mandate of the status of women coordinator is essentially to distribute status of women files to the various departments, as they appear. Regional organizations working with women, having expertise in identifying their specific needs and varied ways to respond to them, are active on sectoral committees. But the regional committee of women's groups is generally unable to influence regional programming in a concrete way and is asking the RHSSB to put in place coordination mechanisms attached to the executive council.

In Region D, despite the efforts of the committee of women's groups to make its concerns heard with the collaboration of the community network, communicating with the RHSSB is difficult. Since the RHSSB had neither an advisory committee nor a status of women coordinator at the time of the study, the regional committee of women's groups chose to lobby the board of directors. In addition, RHSSB managers with whom we met had little knowledge of gender-based analysis or of the RHSSB's programs or actions with respect to the status of women.

In the various regions, the women sitting on the RHSSB boards of directors as representatives of the community movement have made it possible to support action by women's groups and to contribute to the fulfilment and follow-up of the commitments of the RHSSBs with respect to the status of women. However, recent reforms in the governance of the health network have significantly altered the accountability framework of the RHSSBs, now that MSSS appoints members of the boards of directors as well as presidents and executive directors.

Lessons Learned from the Experience in a Fifth Region

One further interview with a women's movement activist who sits on the board of directors of an RHSSB that was not part of the case studies was added. In this region, the RHSSB prepared a status report on women's specific health needs and conducted regional consultations on the response to these needs, with the aim of developing an action plan. The purpose of this interview was to expand our understanding of some factors that promote fulfilment of commitments by RHSSBs in the area of status of women.

The commitment to develop a women's health action plan was stated in the 1998–2002 RSOP. It was the result of ongoing efforts by representatives of women's groups and women sitting on the board of directors. These efforts were also necessary to ensure that the commitment was fulfilled:

> *What was won when the consolidation plan was created. . . . It was the joint efforts of several women who were on the board of directors of the regional board at the time. . . . This was what ensured that we had a component on women's health in the board's consolidation plan. Of course, we also took part fully in the consultation process but in the end, it was the pressure that was applied . . . by everyone. . . . I spent a year on the board's BoD pushing the issue during question period: When will we get the women's health action plan done? And I sent documents. We had a series of small lobbying efforts targeting our board so that there would be action. And when the [new] director of service organization . . . was appointed, his executive director [of the RHSSB] told him: You look after the women's health component. . . . Something needs to happen. . . . It was after he took it in hand that things began to move in women's health.* [Translation] (member of the board of directors of a fifth RHSSB)

The responsibility for fulfilling the commitments made in the RSOP was therefore entrusted to a manager who received his mandate directly from the executive council and who held a position that allowed him to influence all of the service sectors within the RHSSB. This tends to confirm that clear direction from management and the position held by the person responsible for the portfolio within the organizational structure are key factors in achieving the RHSSBs' commitments to women's health.

The activist from the regional coalition of women's groups in this fifth region believes that her membership on the RHSSB board of directors gave her some influence, as it did the women who preceded her and who helped to ensure that commitments on women's health were included in the RSOP:

> *I believe that the gains were made because, as a member of the BoD, I did not have the same status in the regional board, it must be recognized. . . . I could not be ignored as a member of the regional board's BoD. Of course, I still had to build credibility. . . . It was therefore easier afterward to move things forward at the regional board, to obtain information . . . to obtain*

> *internal co-operation. . . . In that sense, I found it helpful.* [Translation] (member of the board of directors of a fifth RHSSB)

In this region it is the health committee, in collaboration with the coordinating committee of the regional committee of women's groups, that acts as the external spokesperson for the RHSSB with regard to developing a status of women action plan. The RHSSB's status of women advisory committee was disbanded and there are now only sectoral committees, such as the one on violence against women. In addition, according to our respondent, the mandate of the status of women coordinator is limited to monitoring the violence against women file.

Thus, the progress made in developing a status of women action plan in this region is the result of a combination of strategies: "In part it took the March of Women, and in part it was the well-placed women who used these initiatives" [Translation]. According to our respondent, the consultation period was only one step in the planning process and it was the entire planning effort that women's groups had to focus on:

> *Personally, I find you have to be on the inside with what is happening. For example, if the regional board is developing a three-year plan, then it is best to be in the centre of the discussion on the three-year plan, so that you integrate corporate-wide concerns throughout. On the other hand, I find that a corporate approach is not enough: there needs to be a watchdog to ensure that corporate-wide concerns are addressed everywhere because if something is just stated and you do not follow up . . . it will be their fifty-thousandth priority*. [Translation] (member of the board of directors of a fifth RHSSB)

The experience of this activist reveals a key element. The ongoing participation of representatives of women's groups in planning and programming helps ensure fulfilment of status of women commitments in the regional health and social services network. The dynamics vary according to the circumstances in each region, and the involvement may take the form of contributions by women to meetings of the RHSSB's board of directors or through a structure closely linked with the executive council, such as a status of women advisory committee. Among activists in regional coalitions of women's groups, there is greater satisfaction with the results and a more favourable assessment of interactions with the RHSSB when there is a clearly identified status of women coordinator and mechanisms for communicating directly with decision makers within the RHSSB's structures.

Governance Changes in the Health and Social Services Network in Quebec

Passage of Bill 28[38] by the provincial government in June 2001 changed the way members are appointed to the RHSSB boards of directors: they are now chosen by the Ministre de la Santé et des Services Sociaux from lists of individuals proposed by various regional organizations.[39] While the Act mentions that "all the lists of names . . . must tend towards gender parity" (s. 66),[40] the individuals must also be recognized for their "management skills" (s. 65). This type of criterion, if applied on the basis of training or professional experience only, may prevent diverse representation of women in the region. The changes reflect an evolution in modes of representation, shifting from an approach stressing

representation of partners and of the regional community to one stressing management expertise.

However, the Act does call for the RHSSB boards of directors to appoint people's forums with the mandate: (1) to consult the public on its satisfaction with the services provided and services organization requirements; and (2) to provide advice on the three-year strategic plan on services organization that is to be developed by each RHSSB. These forums, whose activities are to be coordinated by the president and executive director of the RHSSB, meet with the board of directors at least twice annually and have only advisory authority.

In this new context, what opportunities are there for ongoing dialogue between the RHSSB and women's groups familiar with the specific needs of women and possibly able to provide regional programming with expertise acquired from working with women in different environments? What's needed is to equip the RHSSBs with mechanisms to ensure the use of GBA application tools developed through pilot projects now under way, and to take into account the specific needs of women in various regions. This issue is of concern to the representatives of women's groups with whom we met in all of the regions covered by the case studies. Moreover, it is a matter of implementing government commitments on the status of women in a sensitive sector of society, namely the health and social services sector.

A status of women advisory committee linked to the RHSSB's decision-making bodies, as is the case in Region A, can be useful provided that the RHSSB has clear orientations on women's health, well-being and living conditions. Given the widely varying circumstances revealed by the case studies, this commitment to gender equality must be confirmed by a government orientation, along with the specific means for ensuring its implementation in the decision-making structures of the RHSSBs. There is already a precedent in the form of advisory committees to the RHSSBs' executive councils created by statute, which exist in all regions: these are the committees on access to services in English. Our observations suggest that this is a mechanism to explore to ensure collaboration between the RHSSBs and the regional coalitions of women's groups. In addition, a status of women coordinator linked directly with the executive council represents a mechanism that strongly favours productive communications with regional coalitions of women's groups and follow-up on the commitments in the RSOPs.

The health and social services network must respond to multiple needs in an increasingly diverse society. The integration of GBA into health and social services planning would make for better understanding of the particular impact of women's and men's different status and social roles on their health and well-being, and on the use of services. It would also help to better identify the significant contribution of women to caregiving in the family, in the community, and in health and social services. The failure to recognize these differences—a source of gender inequality—resulted in changes to the health and social services system in the 1980s that negatively affected many women, especially the many female caregivers of persons with disabilities. Recognizing gender disparities is essential to correct the negative effects of these changes on the status of women and to foster gender equality.

6. CONCLUSION AND RECOMMENDATIONS

The various levels of government have made commitments concerning the application of gender-based analysis to policy development and evaluation. However, they have been slow meet these commitments, especially in the area of health and social services.

In Quebec, the mission of the RHSSBs is "to adapt health and social services to the needs and realities of the diverse clientele they serve" [Translation]. According to MSSS, they are the "architects of planning, organization and coordination of programs and services, and resource allocation" [Translation] (Quebec, 2002). All this is expressed in RSOPs developed every three years. Departmental policies that affect the status of women are seldom reflected in the RSOPs. Moreover, changes in the health and social services system implemented by the RHSSBs since 1995 have negatively affected women in various situations.

The purpose of our study conducted in 2000–01 was to explore the participation experiences of women's groups in the decision-making processes of the health and social services system at the regional level. Our goal was to reflect on the inclusion of objectives fostering gender equality in the RSOPs, while taking into account the diversity of women's circumstances. In fact, the experiences of the regional coalitions of women's groups reflect the difficulties in incorporating GBA into regional planning and in implementing services adapted to the specific needs of women.

The governance decisions made regarding the health and social services network in June 2001 (Bill 28) disrupt the framework of our recommendations. The new legislation introduces a new regime that amounts to re-centralization, returning management of the network to MSSS: it provides for the signing of management and accountability agreements between the RHSSBs and the Minister; it limits the public's involvement at the regional level by putting in place boards of directors appointed by the Minister, with people's forums appointed by the boards of directors of the RHSSBs and having advisory authority only. This new situation must be considered in analysing the strategies for promoting gender equality in regional health and social services planning, and it colours our recommendations to MSSS, the RHSSBs and women's groups.

Lastly, the funding of the health system, which is a matter of dispute between the federal government and the provinces, is an issue beyond the scope of our study, but it has a considerable impact on the resources required to implement these recommendations.

Recommendations to the Ministère de la Santé et des Services sociaux du Québec

The Policy on Health and Well-Being adopted in 1992 and the *Priorités nationales de santé publique 1997-2002* (Quebec, 1996) provide direction to RSOPs organized around service continuums. We note, however, the almost complete lack of mention of the MSSS 1997–2000 action plan on the status of women in the 1998–2002 RSOPs. The lack of GBA in some departmental orientations, notably mental health (Quebec, MSSS, 1997c) and

services for frail seniors (Quebec, MSSS, 2000), is not conducive to ensuring adequate services for the specific needs of women.

MSSS policies accompanied by specific targets and set-aside resources affect regional planning. Let us use as an example the *Politique d'intervention en matière de violence conjugale* or the *Programme québécois de dépistage du cancer du sein,* which are covered by specific measures in all of the RSOPs that we analyzed. Various women's groups are involved in regional committees responsible for implementing these policies and, in some cases, they help to adapt action to the situation of cultural communities.

MSSS will shortly be completing a pilot project on integrating GBA into services for frail seniors. This is a crucial area given the feminization of ageing in the population and given the impact of social roles that have placed a greater burden on women to assume responsibility for providing increasingly high levels of care to family members, without adequate support from the health and social services network. The lessons learned from this pilot project must be shared with the public and used to provide direction to regional health and social services planning in the future.

1. In the review of the Policy on Health and Well-Being and Quebec's public health priorities, we recommend that MSSS consider setting as a priority the reduction of gender inequalities, and that it ensure a better linkage of regional planning with existing policies related to women's health, while taking into account the diversity of needs among the female population. The revised Policy on Health and Well-Being should clearly state the strands of action and the objectives to be achieved in women's health, well-being and living conditions. In addition, the MSSS action plan on women's health, well-being and living conditions could also benefit from wider dissemination in the health and social services network.

2. We recommend that MSSS release as soon as possible the report on the pilot project on GBA application to services for frail seniors, and that it set objectives for implementation with adequate resources to achieve them.

3. To guide GBA integration into regional planning, we recommend that MSSS develop a practical application guide for officers in charge of regional health and social services planning, and that it prepare training on this topic for RHSSB boards of directors and officers.

4. Given the composition of RHSSB boards of directors and the new method of appointing members, as well as the relevance of contributions from organizations working directly with women in diverse circumstances, we recommend that MSSS and the Government of Quebec amend the legislation to create status of women advisory committees reporting to the executive councils of RHSSBs.

Recommendations to Regional Health and Social Services Boards

The review of the 1998–2002 RSOPs reveals serious shortcomings with regard to GBA in regional planning. Overall, there are few details regarding the specific commitments incorporated in the RSOPs with respect to the health and living conditions of women. The plans reflect the influence of certain policies or specific programs adopted at the departmental level, with resources allocated to support their application. This is the case in particular with the issue of violence against women or with breast cancer screening. RSOPs that include measures to reduce the impact of changes in the health and social services on the status of women are the exception. Overall, we noted the absence of an integrated approach to fostering gender equality and a lack of focus in women's health activities in regional planning.

Five of the 16 RHSSBs examined included in their RSOPs a section on the status of women; three of them refer to a status of women advisory committee to define and update their priorities in this field, and two others commit to developing a profile and action plan on the status of the female population. The choice of preparing an action plan rather than a specific program on women's health may favour a corporate-wide approach that sets objectives in various programs and avoids creating a specialized unit lacking an overall service perspective. In fulfilment of government commitments to the status of women, the RHSSBs should include in their RSOPs precise commitments to meet the specific needs of women and to reduce gender inequalities, and they should assign a variety of means and adequate resources to ensure that these commitments are fulfilled.

In response to a question in the questionnaire for RHSSBs, 12 of the 16 RHSSBs reported that they had a status of women advisory committee. This type of committee makes it possible to involve representatives of women's groups, or of other organizations working directly with women in diverse circumstances, in the development of regional planning, and to benefit from their expertise. However, the status of these advisory committees and the modes of interaction between the RHSSB and the regional coalition of women's groups vary greatly from region to region. In this regard, the role of a status of women coordinator reporting to the executive council is a vital asset to ensure productive collaboration with the region's women's groups.

These mechanisms were proposed in 1997 with the addition of a fifth orientation to the Government of Quebec's policy on the status of women, entitled *La place des femmes dans le développement des régions* (Quebec, 1997b). However, the orientations were not embraced by the RHSSBs. Incorporating GBA into regional health and social services planning requires not only concrete application tools but also the establishment of status of women structures and resources in regional institutions, along with active and ongoing use of the expertise of local and regional women's groups.

5. We recommend that the RHSSBs include precise commitments on the status of women and the reduction of health disparities between men and women in future RSOPs, in consultation with the networks of organizations that work directly with women and that are in a position to help identify the key specific needs. The RSOPs should also include indicators of follow-up on the commitments made.

6. The creation of a status of women advisory committee reporting to the executive council of each RHSSB is also recommended. Given the legislative changes amending the composition of boards of directors and the method of appointing members, such a committee, composed of representatives of women's groups and organizations working with women from diverse communities, would be even more useful in identifying responses suited to the specific needs of women. The advisory committee would set its priorities based on the regional situation and current health and social services policy, in order to incorporate its recommendations into the ongoing process of implementing the RHSSB's programming, with the aim of achieving concrete results in adapting services to the specific needs of women.

7. We also recommend the appointment within the staff of each RHSSB of a status of women coordinator reporting to the executive council, to provide support to the status of women advisory committee. The primary role of the coordinator would be to ensure follow-up on the advisory committee's recommendations and to maintain regular communication with RHSSB departments and officers responsible for the various components of regional planning. This coordination role will foster collaboration with regional coalitions of women's groups and fulfilment of status of women commitments in the RSOP.

8. We further recommend that the RHSSBs organize training and awareness activities for the various officers of the regional board and the health and social services network on GBA, on the specific needs of women from various communities and on the status of women commitments in the regional action plan. This training is a prerequisite for providing services that appropriately respond to the diverse needs of women.

Recommendations to Women's Groups

In the four regions examined, the regional coalitions of women's groups played an active role in ensuring that status of women commitments were included in the RSOPs and were fulfilled. In addition, groups or networks working on women's living conditions were involved in the implementation of sectoral policies targeting priority health and social service needs adapted to the specific requirements of women. The contribution of women's groups with expertise women's needs as well as how to address them can enrich regional planning related to the health, well-being and living conditions of women.

However, regional planning collaboration mechanisms that rely on groups to appoint representatives must be assessed in light of the investment by the RHSSBs and the potential results for promoting gender equality, as well as for developing services adapted to the specific needs of women. Given the limited resources of many organizations working with women, their contribution to regional health and social services planning must take place in a context that provides some assurance that their recommendations will be considered by the RHSSB's departments and decision-making bodies.

9. We recommend to networks of women's groups that they undertake joint action at the provincial level with the following goals: (1) integration of gender-based analysis into

the review of major policies that provide direction for regional planning, particularly the Policy on Health and Well-Being and Quebec's public health priorities, following completion of the pilot projects launched by MSSS; and (2) legislative amendments to establish status of women advisory committees reporting to the executive councils of the RHSSBs.

10. Given the consultation mechanisms to be established by the RHSSBs, we recommend that regional committees of women's groups:

- seek to obtain, in coming RSOPs, precise commitments from the RHSSB regarding gender equality and appropriate services to meet the specific needs of women in their regions;
- ensure that these commitments are accompanied by concrete measures and the resources to carry them out;
- ensure that the RHSSBs set up advisory committees and a status of women coordinator position, which report to the executive councils, to provide coordination and follow-up on the commitments stated in the RSOPs; and
- seek to obtain remuneration for women's groups representatives who are members of regional status of women advisory committees.

APPENDIX A: QUEBEC'S HEALTH AND SOCIAL SERVICES REGIONS

01 Bas-Saint-Laurent
02 Saguenay-Lac-Saint-Jean
03 Québec
04 Mauricie et Centre-du-Québec
05 Estrie
06 Montréal-Centre
07 Outaouais
08 Abitibi-Témiscamingue
09 Côte-Nord
10 Baie-James (Nord-du-Québec)
11 Gaspésie-Îles-de-la-Madeleine
12 Chaudière-Appalaches
13 Laval
14 Lanaudière
15 Laurentides
16 Montérégie
17 Nunavik
18 Baie-James (Cree Council)

Source: MSSS

APPENDIX B: QUESTIONNAIRE FOR REGIONAL BOARDS

Identification:

The Regional Health and Social Services Board of _____

1. 1999–2002 three-year planning process

What body, **within the regional board**, was in charge of the 1999–2002 three-year planning process?

_____

Did the regional board set up one or more ad hoc working groups to help the body responsible for the 1999–2002 three-year plan?

Yes:_____ No:_____

If yes:
Identify the committee(s) **and** specify the units or departments involved.

_____

_____

_____

Did the board carry out or contract any specific projects to identify problems or priority health services in the region?

Yes:_____ No:_____

If yes:
Specify the nature of this work (use of demographic data, epidemiological surveys, analyses of service utilization, consultation with experts, etc.).

_____

_____

_____

2. Consultation process for the 1999–2002 three-year plan

Did the regional board prepare a supporting document or information for the public or partner groups **prior** to beginning consultations on the three-year plan?

Yes:_____ No:_____

What methods did the regional board use to consult partner organizations and the public under the 1999–2002 three-year planning process?

Please indicate by yes or no all of the methods used:

(A) Public consultation with: (B) Survey with:

Written briefs or notices: _____ Opinion survey(s):_____

Public hearings:_____ Discussion groups:_____

Other (specify):_____

3. MSSS action plan: women's health, well-being and living conditions

In your opinion, are people in your regional board familiar with the 1997–2002 MSSS action plan on the status of women entitled *Santé, bien-être et conditions de vie des femmes?*

Yes:_____ No:_____

Was this action plan the subject of a presentation or discussion within your regional board?

Presentation only to:	Presentation and discussion with:
the board of directors?_____	_____
managers of the regional board?_____	_____
staff of the regional board? _____	_____

Was this action plan presented to internal or external working groups of the regional board?

Name the committees	Presentation only	Presentation with discussion
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. Information on the status of women mandate

Is there a coordinator in the regional board responsible for the status of women portfolio?

Yes:_____No:_____

If yes:
Please attach the description of the mandate for this position.

What percentage of the person's time is devoted specifically to these files? _____

In what year was this position created? _____

To which department or service within the regional board does this person report?

_____

What is the position of the person to whom the coordinator reports directly?

_____

At present, what are the main files under the responsibility of the coordinator?

_____

_____

_____

If no:
Was there a coordinator for the status of women portfolio in the past?

Yes:_____No:_____

If applicable, identify the period when there was a coordinator: 19____ to 19____
To which department or service were status of women files assigned?

File:_____ Service:_____

File:_____ Service:_____

5. Status of women advisory committee

Is there an advisory committee in your region that acts as interlocutor with the regional board with respect to the status of women?

Yes:_____ No:_____

If yes:
Was this committee established at the initiative of the regional board?

Yes:_____ No:_____

In what year was the committee created? _____

How many people are members of the committee?_____

How are the members of this committee appointed?_____

_____

If no:
Was there a status of women advisory committee in your region in the past?

Yes:_____No:_____

If applicable, identify the period in which there was such an advisory committee: 19__ to 19____

What are the present modes of contact between your regional board and the region's women's groups?

No specific link:_____

Occasional contact with a few groups on specific files:_____

Regular contact with a few groups on specific files:_____

Occasional contact with a coalition of women's groups:_____

Regular contact with a coalition of women's groups:_____

Other (specify): _____

Please return the completed questionnaire:

By mail to: Jocelyne Bernier, Researcher
Centre of Excellence for Women's Health
Université de Montréal Consortium
Pavillon 3755, Jean-Brillant
P.O. Box 6128, Stn. Centre-Ville
Montréal, Quebec
H3C 3J7

By fax to: (514) 343-7078
Attn: Jocelyne Bernier (CEWH)

Thank you for your co-operation.

CONTACT INFORMATION

Regional Health and Social Services Board of

_____

RESPONDENT

Name: _____

Position: _____

Telephone: _____

Address: _____

_____

_____

ATTACHMENTS

Please indicate yes or no

Questionnaire: _____

Organizational chart for the regional board: _____

Mandate of the status of women coordinator: _____

1999–2002 three-year plan: _____

List of participants in the consultations on the 1999–2002 plan:_____

Thank you for your co-operation

APPENDIX C: SITUATION OF STATUS OF WOMEN COORDINATORS AND ADVISORY COMMITTEES IN THE REGIONAL HEALTH AND SOCIAL SERVICES BOARDS

Regional boards	**01 Bas-Saint-Laurent**	**02 Saguenay-Lac-Saint-Jean**	**03 Québec**	**04 Mauricie-Centre-du-Québec**
Coordinator	Yes	No	Yes	Yes
Date of creation or *previous dates*	1984	*1984–1988*	1980	1994
% of time on status of women portfolio	2%		20%–50%	100%
Main files	• Support to community organizations • Advisory committee		• Women's living conditions • Violence against women	• Advisory committee • Violence against women • Midwives
Status of women advisory committee	Yes	Yes	Yes	Yes
Committee created by	request of women's groups	the regional board	the regional board at the request of women's groups	the regional board
Date of creation or *previous dates*	1997	1994	1994	1994
Number of members	10 people	13 people	10–15 people	14 people
Appointed by	7: women's groups 2: regional board 1: Conseil du statut de la femme	Regional board calls for nominations from women's groups.	Members appointed by the regional board based on their expertise	Call for nominations and selection committee. Appointed by the executive council of the regional board.

Regional boards	05 Estrie	06 Montréal-Centre	07 Outaouais	08 Abitibi-Témiscamingue
Coordinator	Yes	No	Yes	Yes (2)
Date of creation or *previous dates*	1985	*1985–1996*	1996	1995/1999
% of time on status of women portfolio	???		30%	30%
Main files	• Violence against women • Collaboration with women's groups		• Advisory committee • Services in English • Shortcomings	• Violence against women • Living conditions of women
Status of women advisory committee	Yes	No	Yes	A committee of the women's coalition plays this role.
Committee created by	the regional board		the regional board	the region's coalition of women
Date of creation or *previous dates*	1986		1996	1990
Number of members	10 people		8 people	12 people
Appointed by	the board selecting from categories: institutions, women's groups		4: women's groups 3: institutions of the network, board's assistant executive director	women's groups

Regional boards	09 Côte-Nord	10 Baie-James-Nord–Québec	11 Gaspésie-Îles-de-la-Madeleine	12 Chaudière-Appalaches
Coordinator	No	No	Yes	Yes
Date of creation or *previous dates*		*1993–1999*	1992	1996
% of time on status of women portfolio	???		20%	10%
Main files	• Perinatal care • Violence against women • Sexual assault		• Alcoholism, drug abuse • Violence against women • Support to community organizations	• Violence against women • Sexual assault
Status of women advisory committee	No	No	Yes	A committee of the coalition of women's groups plays this role.
Committee created by	The women's coalition participates in various committees of the board.			
Date of creation or *previous dates*			1997	1996
Number of members			9 people	
Appointed by			the regional committee of women's groups	representation from women's groups

Regional boards	13 Laval	14 Lanaudière	15 Laurentides	16 Montérégie
Coordinator	No	Yes	Yes	Yes
Date of creation or *previous dates*		1995	1986	1999 The file has changed hands often.
% of time on status of women portfolio		60%	???	5% (1 day per month)
Main files		• Youth, family • Violence against women • Women's living conditions • Alcoholism, drug abuse • Mental health, suicide	• Services to seniors • Home care (transfer under study) • Info-Health and shortcomings	• Violence against women • Sexual assault • Abuse and neglect
Status of women advisory committee	Women's health programming committee	Yes	Yes	No
Committee created by	the regional board	the regional board	the regional board	
Date of creation or *previous dates*	1997	1997	1986 1997 in its present form	
Number of members	8 people	12 people	8 people	
Appointed by	women's groups, institutions or at the board's invitation	board's programming department on the recommendation of institutions and community groups	4: women's groups 1: LCSC 1: general hospital 1: CSF 1: regional board	

APPENDIX D: QUESTIONNAIRE FOR DISCUSSION GROUP PARTICIPANTS

HEALTH AND SOCIAL SERVICES REGION:
_____

1. How long has your organization existed?_____

2. What is your organization's main area of activity?_____

3. Approximately how many women are served by your organization in a year?_____

4. What is the size of your organization's annual budget?

   Under $30,000 — From $100,000 to $250,000

   From $30,000 to $60,000 — From $250,000 to $500,000

   From $60,000 to $100,000 — Over $500,000

5. In general, would you say that your organization serves MAINLY women with the following characteristics? (If checking off more than one characteristic, rank them starting from 1 for the most common characteristic.)

Age:	Under 25 25–50 50 and older	Income:	Low Middle High
Location:	Urban Rural	Origin:	Francophones from Quebec Anglophones from Quebec Immigrant women Others

6. Did you (or your organization) participate directly or indirectly in the regional board's consultations on the services organization plan for the 1998–2002 period?

   YES NO DON'T KNOW

7. Have you (or your organization) received information on the services organization plan prepared by the Regional Health and Social Services Board for 1998–2002?

   YES NO DON'T KNOW

   If yes, specify by what means (you may check more than one line):
   - Information pamphlet distributed by the board
   - Information pamphlet distributed by a health or social services organization

- Information pamphlet distributed by a community organization
- Information meeting organized by the board
- Information meeting organized by the organization you represent
- Information meeting organized by a network of community organizations
- Media
- Other means (please specify)

If yes, are you using the information received in your work with women?

YES NO NOT APPLICABLE

8. Did you (or your organization) participate in activities organized by the regional board during 1999 or 2000?

YES NO DON'T KNOW

If yes, was it generally: – at the invitation of the board?
– at the request of your organization?
– don't know

Please specify the activity(-ies): _____

9. Overall, how would you rate contacts between your organization and the regional board?

Frequency:

Regular contact Occasional contact No contact

Quality of co-operation:

Very positive Quite positive Somewhat difficult Very difficult

Don't know

10. Have you (or your organization) ever been a member of the board of directors of a public health or social services organization (LCSC, general hospital, youth centre, residential facility)?

YES NO DON'T KNOW

If yes, specify:_____

11. Aside from the organization you represent, are there other community groups active in health and/or social services in which you are personally involved?

If yes, specify:_____

12. Based on your experience, what are the main health or social problems experienced by women in your region?

(A) _____

(B) _____

(C) _____

Comments

_____

_____

_____

_____

Thank you for your co-operation.

APPENDIX E: INTERVIEW GUIDES

THEME	QUESTIONS
1. Perception of the role of the board of directors in preparing and monitoring the consolidation plan	(a) Can you define the responsibility and/or contribution of the board of directors in preparing the services consolidation plan? In consulting the public? - Please characterize the relations between the members of the board of directors and the staff of the regional board in the various stages of (1) preparing the plan and (2) consulting the public (decision-making support mechanisms) (b) How is the board of directors informed about implementation of the consolidation plan? - To your knowledge, is the consolidation plan used as a reference in decision making on how to organize services in the regional board? Among health and social services delivery partners in the region?
2. Perception of the regional board's consultation mechanisms (4–5)	(a) As a community representative, how do you evaluate the public consultations on the consolidation plan? - What were the barriers and facilitating mechanisms with regard to participation by the public, notably women, in these consultations? (b) Since the consultations, has the regional board used other methods to consult the public? In what context? If applicable, how do you evaluate these various consultation mechanisms?
3. Perception of the internal operation of the board of directors	(a) In the day-to-day work of the board of directors, how are decisions made (vote/consensus/approval)? What is the role of the chair of the board of directors? Of the executive council? - Does the board of directors have subcommittees? If applicable, what are their responsibilities? - What are the facilitating factors and the problems associated with decision making in the board of directors?
4. Perception of participation of the public at the board of directors	(a) What is your assessment of participation of the public—particularly women—from various communities in meetings of the board of directors? Normally, is there significant attendance? Normally, is question period used? (b) In your opinion, what are the outcomes of this participation? - Based on your perception, does the fact that sessions are public have an impact on the board of directors' decision making?
5. Perception of relations of the board of directors with partners	(a) Besides meetings of the board of directors, what are the channels for relations between the members of the board of directors of the regional board and partners from the institutions of the health and social services network? the community? other sectors of society? (b) Do you personally maintain relations with some of these partners?
6. Perception of the regional board's powers and constraints (6)	(a) What is your perception of the flexibility that the board of directors has regarding decisions on the services consolidation plan in relation to the orientations of the Ministère de la Santé et des Services sociaux?
7. Perception of the consideration of gender differences by the regional board (3)	- To your knowledge, what are the programs and services dealing in particular with the health and well-being of women in the consolidation plan? - To your knowledge, is the regional board's consolidation plan supported by an analysis of gender differences? Did the regional board use data specific to the status of women? - In your opinion, has the regional board taken steps to consider the specific needs of women in services planning and organization? Is it taking into account the diversity of the female population?

	- As a member of the board of directors, were you informed about the action plan of the Ministère de la Santé et des Services sociaux on the health, well-being and living conditions of women?
8. Perception of the primary needs of women in the region (1)	(a) To your knowledge, what are the main health and social problems of women in the region? - What are the main successes and challenges in meeting these needs? (b) What are the special circumstances of certain women's groups that require attention by the regional board?

GUIDE FOR INTERVIEWS WITH STATUS OF WOMEN COORDINATORS IN REGIONAL BOARDS	
THEMES	**QUESTIONS**
1. Clarification of mandate and internal operation	a) Mandate and level of the status of women coordinator. b) Communications network with various internal bodies: examine the routing of a file and the mechanisms for introducing gender-based analysis. c) Links with the 1998–2002 consolidation plan.
2. Perception of communications with women's groups	a) General methods of communicating with women's groups and/or networks. What are the benefits and challenges of the partnership in terms of processes? in terms of results? b) If there is an advisory committee: Identify method of appointment, mandate, frequency of meetings, operating procedures (priorities, agenda, measures for facilitating participation, follow-up on decisions). c) Other occasional contacts: Identify which files, the programs involved, the main partners in the network, and the community.
3. Perception of the powers and constraints of the regional board (6)	a) What is your perception of the role of the regional board in terms of departmental orientations? in terms of the MSSS action plan on the status of women? b) What is your perception of the role of the regional board in terms of the network's institutions? in terms of community organizations working with women?
4. Perception of the consideration of gender differences by the regional board (3)	a) What are the regional board's main activities or programs with regard to status of women? Does the regional board have specific data on the status of women? Overall, how does the regional board take into account the specific needs of women in the planning and organization of services?

GUIDE FOR INTERVIEWS WITH KEY REGIONAL BOARD RESPONDENTS	
THEMES	**QUESTIONS**
Mandates and responsibilities in regional planning	Please define the responsibility and contribution of the various entities of the regional board in decisions relating to the services consolidation plan. - Define the role of the board of directors, internal departments, ad hoc committees, etc. - What were the dealings with the Ministère de la Santé et des services sociaux in preparing the services consolidation plan?
Types of information used in support of planning	What were the main information sources used in developing the consolidation plan? - Specify the relative importance of reports/evaluations, health and social data, use data, and opinion surveys, if applicable. - What were the health determinants taken into consideration in analyzing the information? - In general, what means did the regional board use to take into account gender differences and population diversity in its decisions?
Public participation in regional planning	How does the regional board assess the means used to consult the public? - In your opinion, did the consultations make it possible to have a comprehensive view of the expectations of the region's population, or to determine whether services were appropriate to the diverse needs? - What might have impeded or facilitated the public's participation in these consultations? - What means did the regional board use to inform the public about the consultations? Did the regional board use special means to reach certain segments of the population? - How was the input from the consultations used in developing the regional board's consolidation plan?

GUIDE FOR DISCUSSIONS WITH WOMEN'S GROUP REPRESENTATIVES	
THEMES	**QUESTIONS**
Perception of the main needs of women in the region	1. Based on your experience, what are the main health and social problems of women in your region? - Are there special circumstances for certain women in your region?
Perceptions of whether services are appropriate for the needs of women in the region	2. To your knowledge, do the region's health and social services respond appropriately to the needs of women in your region? - What aspects need to be developed or changed in the operation of health and social services to respond more appropriately to the needs of women in your region? - Are there special circumstances for certain women in your region?
Perceptions of the consideration of gender differences by the regional board	3. In your view, how does the regional board take into account the specific needs of women in the planning and organization of health and social services? - How does it take into account the diversity of the population and the special circumstances of some women?
Perception of the regional board's consultation mechanisms in developing the consolidation plan	4. To your knowledge, did the regional board develop mechanisms to facilitate the participation of women or women's organizations in preparing its 1998–2002 consolidation plan? - If yes, what mechanisms did it develop? (e.g. support documents, preparation time lines, reimbursement of travel or child care expenses, special methods of communication, translation, etc.) - Were there barriers to the participation of women or women's groups? If yes, what were they? - Would you have ways to suggest for facilitating the participation of women or women's groups in these consultations?
Perception of the regional board's other methods of consultation	5. Outside the consultations on the 1998–2002 consolidation plan, in what other circumstances has your organization been invited by the regional board to offer its opinion on the organization and/or evaluation of specific programs or projects? - In what way did you participate? - What is your assessment of the consultations in terms of opportunities for participation?
Perception of the regional board's powers and constraints	6. Based on your experience, how do you see the role of the regional board in the organization of health and social services in your region in relation to the role of the Ministère de la Santé et des Services sociaux? - How do you see the board's role in relation to the role of the various organizations that provide health and social services (hospitals, LCSCs, youth centres, residential centres, medical clinics, etc.)?
Overall assessment of findings	7. If applicable, can you identify the impact of your organization's participation in health and social services? - In your own organization?

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NOTES

[1] The reform of Quebec's health and social services system in the 1990s is often referred to as the "shift to ambulatory care." This reorganization is discussed in Chapter 2.

[2] This is the second series of regional services organization plans produced by the RHSSBs.

[3] The Government of Quebec adopted an integrated health and social services policy with the passage of the *Health Insurance Act* in 1970 and the *Act respecting Health Services and Social Services* in 1971.

[4] The *Programme d'action 2000-2003 : l'égalité pour toutes les Québécoises* also refers to this context to explain the shift in services organization (pp. 89–90).

[5] This Commission, created in 1985 by the Quebec government to review the orientation and organization of the network, was chaired by Jean Rochon, who was later appointed Ministre de la Santé et des Services sociaux.

[6] With the creation of the RHSSBs, the Quebec government redefined the health and social services regions. The RHSSBs of Gaspésie-Îles-de-la-Madeleine, Chaudière-Appalaches, Laurentides, Lanaudière, Laval and Montérégie were created by subdividing the territory of the regional health and social services councils that had existed prior to this reform. However, a health and social services council serving the Cree communities of Northern Quebec was retained.

[7] Essentially, we focus on the regional services organization plans (RSOPs), even though the expressions "transformation plan" or "consolidation plan" are used throughout the text, depending on the regions and periods concerned.

[8] These reductions affected the Canada Assistance Plan (CAP), which covered part of the costs of social assistance programs and certain social services programs, and the Established Programs Financing (EPF), in place since 1977 to share the costs of provincial health and post-secondary education programs. Both of these programs were abolished in the 1995 federal budget and replaced by the Canada Social Transfer, with a major reduction in federal transfer payments.

[9] The idea that governments must have internal mechanisms to improve the status of women was presented for the first time at the International Women's Year World Conference on Women, held in Mexico City in 1975. See Williams, 1999, on this topic.

[10] Other provincial governments have moved in the same direction, notably the Ministry of Women's Equality in British Columbia (1997). For a comparative analysis of the initiatives of the governments of Canada and Quebec, see Kurtzman and de Sève, 2001.

[11] The Government of Quebec has prepared a 2000–03 action plan that extends this project but it was developed after the health and social services planning exercise examined in this study, which covers the 1998–2002 period.

[12] The interdepartmental committee formed in 1997 included the Secrétariat à la condition féminine, the Ministère du Conseil exécutif, the Secrétariat du Conseil du Trésor, the Ministère de la Santé et des Services sociaux and the Ministère des Finances.

[13] The regional committee of women's groups in Region D objected to a proposal of this nature made by the RHSSB concerning distribution by the government of funds from fines imposed on the nurses' union (FIIQ) following its "illegal" walkout in 1998—funds that were to have been distributed to women's groups.

[14] The RHSSB for Nunavik and the Cree Board of Health and Social Services of James Bay were not studied because of the special features of the health and social services network in these areas.

[15] In Region C, the information from the RHSSB and the regional coalition of women's groups indicated that there was no status of women coordinator at the time of contact. Subsequently, during the study, discussions began between the RHSSB and the regional networks of women's groups concerning the creation of such a position within the RHSSB structure.

[16] One RHSSB reporting that it did not have a status of women coordinator officially assigned this mandate to one of its officers while the study was under way.

[17] The initial plan called for individual interviews with women who had participated in the consultation or decision-making process of each of the RHSSBs, in order to identify successes and barriers encountered in their participation experience. During the study, we determined that the RHSSB consultations on the RSOPs might have gone back as far as 1997 and that several of the spokespersons were referring more often to more recent consultations, that is, those held as part of a review of a particular policy (e.g. mental health or sexual assault), or else those that were part of a commission of inquiry into health and social services (Clair Commission), which preceded our interviews by a few weeks. Comments on other consultations were not included in our analysis.

[18] Several lists were first cross-checked: member groups of the committee of women's groups in each region; women's groups listed by the Conseil du statut de la femme du Québec; and women's groups that are members of the regional coalitions of community organizations funded by the RHSSBs through the Community Organizations Support Program.

[19] In one region in particular, the discussion group was held at the same time as provincial action by women's centres, which reduced participation in the discussion group.

[20] This was the coordinator of the committee of women's groups in the region—also a member of the regional board's board of directors.

[21] Although there are some differences in the various RSOPs, generally the plans contain continuums for physical health, mental health, home support or services for seniors, children and youth, physical or mental disabilities, and alcoholism or drug abuse.

[22] In the case of the *Orientations en matière de planification des naissances* (Quebec, MSSS, 1995b), it should be noted that one of the objectives is reducing teen pregnancies.

[23] The Aboriginal population numbers slightly over 70,000 in Quebec. It is present in several regions, with larger representation in Côte-Nord, Montérégie, Abitibi, Lac-Saint-Jean, Mauricie and Gaspésie. In addition, the takeover by Aboriginal communities of their own health care was the subject of negotiations between First Nations and the federal and provincial governments and is in place in various communities, notably in response to the Erasmus-Dussault Commission. The RHSSB of Baie-James (Nord-du-Québec) serves the non-Aboriginal population only because the Cree population is served by its own health and social services network.

[24] The 1995 CSF survey (Quebec, CSF, 1995) listed advisory committees in the RHSSBs of Saguenay-Lac-Saint-Jean, Québec, Mauricie-Bois-Francs, Estrie, and Abitibi-Témiscamingue. The table in Appendix C presents the situation at the time of our study.

[25] These are the RHSSBs of Gaspésie-Îles-de-la-Madeleine, Chaudière-Appalaches, Laval, Laurentides and Lanaudière; the Montérégie RHSSB is the exception. The RHSSBs of Bas-Saint-Laurent and the Outaouais, which did not have a status of women advisory committee in 1995, have since formed one.

[26] The Association féminine d'éducation et d'action sociale (AFÉAS) consists of 450 local groups across Quebec. It is a movement of mutual aid, exchange and solidarity that champions the rights and claims of women before various entities.

[27] The satisfaction of women with the LCSC Info-Health service and its high rate of use by women are consistent across Quebec: eight of 10 people using the service are women (Hagan et al., 1998).

[28] Negative comments were received about the consultations connected with the commission of inquiry into health and social services (Clair Commission), which conducted a round of consultations during the time of our study.

[29] The regional committee of women's groups is seeking resources from the RHSSB so that every shelter for women victims of violence can hire an Aboriginal worker to better communicate with women from these communities calling on their services.

[30] Prior to the changes under Bill 28, adopted in June 2001, the board of directors of an RHSSB, under the *Act respecting Health Services and Social Services*, (RSQ, c. S-4.2), was

composed of eight people representing health and social services institutions, four representing community organizations, four representing socio-economic groups in the region, the municipal and school community, a few co-opted members, and the president of the regional medical commission, as well as the president or executive director of the RHSSB.

[31] The briefs were presented by a coalition of shelters and transition homes for women who are victims of spousal violence, by a support group for women with AIDS, and by a university research centre on women's health. Other briefs dealt with women's health but it was not their main topic.

[32] For example, three committees dealing with violence against women existed simultaneously in the region, bringing together virtually the same people—a situation arising from the dynamics within the region.

[33] We were told that about 1,000 invitations were sent out to various partners in the region to take part in the consultations.

[34] In fact, the reference is to the *Priorités nationales de santé publique 1997-2002* (Quebec, MSSS, 1996).

[35] Several respondents mentioned that there had previously been participatory structures based on seven sub-regional committees composed of people representing the health network, the community and cross-sectoral partners. According to one RHSSB officer, an external assessment found that the mandate of these committees was too broad and conflicts arose, notably around issues of budget distribution, which led to the withdrawal of some institutions from the committees and a weakening of these structures.

[36] Reflected in particular are policies on violence against women and the breast cancer screening program. Another example would be the "Naître égaux – Grandir en santé" program, which targets the well-being of newborns in families at risk.

[37] MSSS developed monitoring indicators for the Policy on Health and Well-Being (Quebec, MSSS, 1998), and several RHSSBs did the same to ensure follow-up on the RSOPs and the shift to ambulatory care.

[38] The reference is to amendments to the *Act to amend the Act respecting Health Services and Social services and other legislative provisions* (RSQ, c. S-4.2).

[39] Lists of people are provided by socio-economic organizations and the RCMs (4 positions), health institutions (3 positions), community organizations (1 position), organizations in the education field (1 position), organizations in the union field (1 position), plus the regional medical commission (1 position), the regional nursing commission (1 position) and the multidisciplinary board (1 position), regional professional bodies, and the board of directors (2 positions).

[40] The proportion of women in the RHSSB boards of directors, appointed by the Minister, has climbed from 36 per cent to 49 per cent. Since the change occurred in December 2001, it was not possible to take it into consideration in the context of this study.

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