

POPULATION HEALTH DATA THROUGH A GENDER LENS

A GENDER ANALYSIS OF *TOWARD A HEALTHY FUTURE: SECOND REPORT ON THE HEALTH OF CANADIANS* AND SELECTED OTHER POPULATION HEALTH DOCUMENTS

Lissa Donner
Tammy Horne, PhD
Wilfreda Thurston, PhD
Prairie Women's Health Centre of Excellence

April, 2001

This is a working document prepared for the F/P/T Status of Women Forum. It expresses the views and opinions of the authors and does not necessarily represent the official position or opinions of the members of the FPT Status of Women Forum.

TABLE OF CONTENTS

I. Executive Summary.....	Page 1
II. Introduction.....	Page 4
III. The Place of Gender-based Analysis in Health Planning.....	Page 5
IV. Adaptation of the <i>Invisible Women</i> Framework.....	Page 7
V. Analysis of <i>Toward a Healthy Future: Second Report on the Health of Canadians</i>	
1. Introduction.....	Page 8
2. Applying the Revised <i>Invisible Women</i> Framework.....	Page 9
3. Summary of External Data Sources Cited and Not Cited in <i>Toward a Healthy Future - Main Report and Statistical Summary</i>	Page 27
4. Conclusions:- Strengths and Weakness of the Consideration of Gender in <i>Toward a Healthy Future</i> and Suggestions for the Future. Page	36
VI. Analyses of Documents from Canadian Institute of Health Information....	Page 38
1. National Consensus Conference on Population Health Indicators.	Page 39
2. <i>Health Care in Canada: A First Annual Report, 2000</i>	Page 53
3. <i>Roadmap Initiative...Launching the Process</i>	Page 55
4. Conclusions: The Consideration of Gender in the CIHI Reports Reviewed.....	Page 57
VII. Analysis of Health Canada's <i>Taking Action on Population Health</i>	Page 60
Appendix 1 Revised Framework for Gender Analysis of Health Planning Documents	
Appendix 2	Data Selection in <i>Toward a Healthy Future</i>
References	

I. Executive Summary

This document was prepared for the Working Group of Officials Reporting to Federal/Provincial/Territorial Ministers Responsible for the Status of Women, following their decision to review *Toward a Healthy Future: Second Report on the Health of Canadians*, of the Federal, Provincial and Territorial Advisory Committee on Population Health.

The review project also includes the following key documents from Health Canada and the Canadian Institute for Health Information:

National Consensus Conference on Population Health Indicators Final Report (Canadian Institute for Health Information, 1999)
Roadmap Initiative...Launching the Process (Canadian Institute for Health Information, March 2000)
Health Care in Canada 2000: A First Annual Report (Canadian Institute for Health Information)
Taking Action on Population Health (Health Canada, 1998)
Women's Health Surveillance: A Plan of Action for Health Canada (Health Canada, 1999)

This report analyzes each of these documents, using gender-based analysis (GBA). The GBA framework used is an adapted version of the *Invisible Women* framework, originally developed by the authors for a research study entitled *Invisible Women: Gender and Health Planning in Manitoba and Saskatchewan and Models for Progress*, (Prairie Women's Health Centre of Excellence). *Invisible Women* examined the degree to which women's health needs and concerns had been addressed by the newly formed regional health bodies in each province, in their community health needs assessments and health planning.

Gender-based analysis is important in health research and planning because:

- it promotes refinement of health risk identification;
- it provides clarity around disease and illness prevalence, understanding the differences in patterns of disease and injury experienced by women and men, boys and girls;
- it can enrich the analysis of risk management and treatment options;
- it can better inform researchers and policy makers about the differences and similarities in the social, economic and biomedical conditions experienced by men and women; and
- it can increase knowledge about women's and men's health.

At the same time, there are problems associated with not applying GBA to the analysis of health care issues, including:

amalgamating information by sex does not serve either men or women well, as important differences may not be noted;
applying research conducted on men to policy or treatment options for women may lead to inappropriate interventions; and
failure to refine information diminishes the accuracy of health surveillance and health promotion efforts and affects the quality of information available for health policy, program design, clinical decision making and evaluation of health interventions.

It is timely to work on inclusive population health indicators that reflect the diversity of Canadians. Governments committed to implementing a population health approach and the Canadian Institutes for Health Research (CIHR) will need such indicators. Although data that is disaggregated by sex is increasingly available, the next of step of linking the data with a GBA is not yet being done as a matter of course. There are some excellent models of using sex disaggregated data and GBA to strengthen health planning and the development of population health indicators which are sensitive to gender issues, particularly the 1999 Report of Health Canada's Advisory Committee on Women's Health Surveillance.

Toward a Healthy Future marks an important step forward in the way in which gender in general, and women's health in particular, are considered in the Canadian population health literature. It contains much more information about the health situation and needs of women than did the first *Report on the Health of Canadians*.

In this report the reviewers give make five recommendations to improve gender analysis in future documents on the health of Canadians:

include gender as a determinant of health;
include culture as a determinant of health and present data which include a recognition of diversity among women;
include an analysis of gender discrimination and its many impacts on women and men, boys and girls, and on the health of Canadian society as a whole;
use the data already being collected to assist in the work of recommendations two and three above; and
include more gender analysis of health policies and programs.

Work is now underway by the Canadian Institute for Health Information (CIHI) to develop population health indicators for Canada. The data collected, and the manner in which it is presented will determine what information is available to

federal, provincial/territorial and regional decision-makers. Including sex disaggregated data, and applying a gender analysis to the selection of indicators and to the interpretation of the data, is therefore critically important.

None of the three CIHI documents reviewed gave issues of gender in general or women's health in particular serious consideration. This is problematic for a number of reasons, including:

1. Ignoring gender in the development of population health indicators and reports diminishes the quality of research.
2. Ignoring gender is contrary to Canada's stated commitments to gender equality.
3. The Canadian Institutes of Health Research (CIHR) will require gender-based analyses of data in order to determine research priorities.
4. The lack of attention to gender has resulted in the total exclusion of the informal caregiving sector from CIHI's proposed population health indicators.

As part of its mandate, CIHI is to:

*deliver the knowledge and develop the tools to advance Canada's health policies, improve the health of the population, strengthen the health system and assist leaders in the health sector make informed decisions.*¹

For the reasons noted above these important tasks cannot be realized without adopting a gender and diversity health framework and applying that framework to consider all the determinants of health, including, the social and economic determinants of the health of women and men.

Since CIHI's population health indicators project is a work in progress, this is an opportune time to actively work to include gender in the development of its population health indicators.

Canadian Institutes for Health Information, *What We Do*, available at:
<http://www.cihi.ca/wedo/do.htm>

II. Introduction

In November, 1999, the Prairie Women's Health Centre of Excellence (PWHCE) published a research study entitled *Invisible Women: Gender and Health Planning in Manitoba and Saskatchewan and Models for Progress*, by Tammy Horne, Lissa Donner and Wilfreda Thurston. The report examined the degree to which women's health needs and concerns had been addressed by the newly formed regional health bodies in each province, in two specific areas: Community Health Needs Assessment and Health Planning. The authors developed a framework for conducting the examination, looking for specific references to gender and women. The report found that in both provinces, there was little evidence of gender analysis or gender-sensitive strategies in place.

Concurrently, the Women's Health Working Group of Senior Officials Reporting to Federal/Provincial/Territorial Ministers Responsible for the Status of Women made a decision to review *Toward a Healthy Future: Second Report on the Health of Canadians*. The Working Group contracted with the PWHCE to do this work. The PWHCE retained the research team who produced the *Invisible Women* report to conduct this analysis, the project was expanded to include the following documents:

- \$ *National Consensus Conference on Population Health Indicators Final Report* (Canadian Institute for Health Information, 1999)
- \$ *Roadmap Initiative...Launching the Process* (Canadian Institute for Health Information, March 2000)
- \$ *Health Care in Canada 2000: A First Annual Report* (Canadian Institute for Health Information)
- \$ *Taking Action on Population Health* (Health Canada, 1998)

This document is an analysis of each of these four documents, using an adapted version of the *Invisible Women* framework. The revised framework is presented in Appendix 1. In all cases, the *Invisible Women* charts are applied to the document in question, followed by a brief description of the implications.

The analysis of *Toward a Healthy Future* is presented first, followed by a summary of the data which it includes, and that which it does not include. Conclusions about the consideration of gender in *Toward a Healthy Future* are then presented. Appendix 2 contains more detailed information about the data selection in *Toward a Healthy Future*.

The next section of this report presents a gender analysis of the three documents from the Canadian Institute of Health Information, followed by conclusions about the consideration of gender in these documents.

Finally, a brief discussion of Health Canada's *Taking Action on Population Health* is presented.

III. The Place of Gender-based Analysis in Health Planning

Public health has traditionally focussed on the impacts of environmental factors on health. Unpolluted water, air and soil, as well as housing conditions are physical factors important to good health status (Macintyre, et al., 1993). Local environments can also be characterized by the availability and accessibility of resources that prevent disease and promote health and well-being; for instance, health and other social services, businesses, and infrastructure like roads. More recent research focuses on a third aspect of local environments, that is the organization of social life, that also affects the health status of the population (Berkman & Kawachi, 2000; Hawe & Shiell, 2000; Kreiger, 2000; Link & Phelan, 1995). Social cohesion, social capital, public participation, discrimination based on race, sex, sexual orientation, ability or age, are all concepts used to describe the organisation of social life.

Health Canada, in its *Gender-based Analysis Policy*, has defined sex and gender as follows:

SEX refers to the biological differences between females and males. The health sector has focussed largely on reproductive differences, particularly maternity, but physical distinctions between females and males shape a much broader range of health issues. The health sector is slowly recognizing the extent of anatomical and physiological differences and incorporating them into science and treatment. Reliance on male standards is being questioned, for example in recognizing and treating heart disease and in understanding the different effects of anaesthetics on women and men, boys and girls.

GENDER refers to the array of socially constructed roles and relationships, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis. Gender is relational - gender roles and characteristics do not exist in isolation, but are defined in relation to one another and through the relationships between women and men, boys and girls....gender is the root of a power imbalance that favours men in most societies.

Gender relations are embedded in societal institutions such as the family, schools, workplaces and governments. They shape social systems and organisations, including the health system, and are supported by values, rules, resource allocation and routine activities.

Gendered norms shape the nature of health issues and influence

the health system's practices and priorities. For example, women are more likely to assume responsibility for home care and are more at risk of depression than men. Men, on the other hand, experience higher rates of accidents and injuries. Typically, the health system has addressed these issues without taking into account their gendered nature. Doing so will improve the health of both populations. (Health Canada, 2000, pages 14 -15)

Gender is a central organizing feature of social life. It can be described as a social institution that orders other institutions B the economy, family, politics and religion, for instance, as well as how individuals develop expectations and identities. Gender is normalized in a society. Gender roles are assumed to be “natural”. Gender can therefore only be made explicit by asking questions about roles, expectations and behaviours (Lorber, 1996). Data clearly shows that women in Canada have not attained equality of opportunity with men in terms of employment, income, participation in public life and other key indicators. Gender based analysis in health is a tool used to identify the processes of gender and it's effect on the health of women and men, boys and girls. Gender-based analysis “helps bring forth the differences between women and men, the nature of their social relationships, and their different social realities, life expectations and economic circumstances” (Health Canada, 2000, p.1).end of pp change

Gender equity and gender equality are related but separate goals of gender-based analysis (Health Canada, 2000). Equality in status can only be achieved in some instances by addressing historical inequities. The greater proportion of time devoted by women to care of the family's health, for instance, may have a negative impact over the long term on their economic well-being which will be damaging to their health if not recognized in other social policies. The time spent by women in caring and vigilance over health, however, may result in earlier identification and treatment of women's own health problems as well as that of the other members of their families. If more men spent time with children and other family members attending health services, men's knowledge of health and the health care system would increase. Health planners and professionals would also have to reexamine their assumptions about the roles men and women have caring for other members of families and society.

IV. Adaptation of the *Invisible Women* Framework

The original *Invisible Women* framework was designed to be used to examine local health planning documents. Many of the categories originally used were not appropriate for use with the documents under consideration in this project. The original framework project was therefore adapted to be useful in the analysis of the more general health policy documents.

The revised framework, like the original, is designed to find the strengths and weaknesses in gender analysis, and in the authors' understanding of women's health issues in particular, in the documents reviewed. It is rooted in a population health perspective, which acknowledges gender as one of twelve determinants of health which are currently recognized by Health Canada.

The framework emphasizes:

- \$ the ways in which gender is connected with the other determinants of health;
- \$ the ways in which gender differently affects diverse groups of women;
- \$ recognition of the structural barriers which women face in both their personal health practices and in gaining access to health services;
- \$ a broad definition of women's health, including more than just diseases and conditions specific to, or more common among, women (e.g. endometriosis or breast cancer);

The revised framework appears in full in Appendix 1.

V. Analysis of *Toward a Healthy Future: Second Report on the Health of Canadians*

1. Introduction

Toward a Healthy Future is produced by the Federal, Provincial, Territorial Advisory Committee on Population Health. It builds on the first *Report on the Health of Canadians*, published in 1996.

Two points are important to note at the outset. **First, this Report contains significantly more gender analysis, and analysis of women's health, than the *First Report on the Health of Canadians*.** In both of these ways, it marks a major step forward and has set a new benchmark for other population health reports. **Second, it is important to note that despite these positive steps, the authors of the Report did not use the opportunity to include gender as a determinant of health.** This is implicitly stated early in the Report:

In 1994, the Federal, Provincial and Territorial Advisory Committee on Population Health (ACPH) released a document entitled "Strategies for Population Health: Investing in the Health of Canadians" that expanded on this concept. This paper identified the following key influences or "determinants" of health: living and working conditions (the socioeconomic environment), the physical environment, health services, early childhood development, social support, personal health practices and coping skills, and biology and genetic endowment...

In addition to the factors mentioned above, gender, culture and membership in specific population groups have significant effects on health status. Within the limits of data availability, every attempt was made in this report to comment on the influence of these factors on health status and the determinants of health. (page 3)

This description is interesting because, while acknowledging the impacts of gender and culture on health, it fails to mention that following the report of the 1997 National Forum on Health, both gender and culture were added by Health Canada to its listing of the determinants of health. It would be interesting to learn why the ACPH took this approach.

2. Applying the Revised *Invisible Women* Framework to *Toward a Healthy Future*

A. Recognition of the Connections Between Gender and Each of the Other

Determinants of Health (i.e., sex-disaggregated data plus discussion of how these may operate differently for women and men)

Determinants	Extensive	Some	Few	None
Income and social status		✓		
Social support networks			✓	
Education			✓	
Employment and working conditions			✓	
Social Environments		✓		
Physical environments		✓		
Biology and genetic endowment	✓			
Personal health practices and coping skills		✓		
Healthy child development		✓		
Health services		✓		
Culture				✓

ANone@ no reference to the connection between gender and the determinant in question; no sex disaggregated data presented

AFew@ one to two references to the connection between gender and the determinant in question or instances of sex disaggregated data

ASome@ more than two references to the connection between gender and the determinant in question or instances of sex disaggregated data

AExtensive@ either more than two references to the connection between gender and the determinant in question or more than two instances of sex disaggregated data plus at least one analysis of the issue from a gender perspective

Discussion

Socioeconomic Status

Toward a Health Future notes the importance of the effects of socioeconomic factors on health status. For example, in Chapter 1, the authors state:

Canadians with low incomes are more likely to suffer illnesses and to die early than Canadians with high incomes...

Inequities in income distribution and literacy downgrade Canada's rank from first in the world to tenth on the United Nations Human Development Index. (page 14)

Yet the Report contains little by way of an analysis of the gendered distribution of poverty in Canada. In both Chapter 1, "The Health Status of Canadians" and Chapter 2, "The Socioeconomic Environment", many opportunities to make explicit connections between gender and poverty were missed.

Consistent with this approach, the Report also gives little consideration to the greater burden of poverty borne by women in marginalized groups including Aboriginal women, visible minority women and women with disabilities. The Report does include references to the greater risk of poverty in families headed by single mothers, compared to those headed by single fathers (page 45). The report contains little in the way of analysis or discussion of these facts.

This lack of gender analysis influences the way in which data is presented, or not presented. For example, the Report states:

It should be noted, however, that in 1995, one senior out of five (mostly unattached women) still lived below the LICO. (page 43)
(“LICO” refers to the Statistics Canada low income cut off)

Presenting the data this way neglects several important facts about poverty among senior women.

First, while the poverty rate for seniors is 19%, the poverty rate for senior women is 24% and **the poverty rate for unattached senior women is 49%**. Secondly, while unattached senior men constitute 15% of poor seniors, **unattached senior women constitute 63% of poor seniors.**¹ This is the result of several issues including women's longer life expectancy, which is discussed

¹ Statistics Canada, *Low Income Persons*, 1980 to 1997, Table 5.

in the Report, and factors affecting income-security across the lifespan, including, for example, labour force and pension issues, which are not discussed in the Report.

This is a good example of the need for gender based analysis (GBA). Without applying a gender analysis to the issues of income and poverty among seniors, policy makers will not have the information which they need to reduce poverty among senior women and men, and to ameliorate its effects. This is critical in order to understand the ways in which gender and low-income together affect, and interact with, the other determinants of health, including culture.

Gender and Culture - the Health Status of Aboriginal Women

As with gender, the Report does not consider culture as a determinant of health. Notably, this means that there was no analysis of the health status of Aboriginal women, compared to that of Aboriginal men². The Report notes that “Aboriginal people are at higher risk for poor health and early death than the Canadian population as a whole” (page 14).

It is important to state that it is not Aboriginal “culture” which leads to the increased morbidity and mortality faced by Aboriginal women and men. Racism, systemic discrimination and the devaluing of Aboriginal cultures, all have negative impacts on the health and well-being of Aboriginal people.

The greater burden of ill health faced by Aboriginal women is masked by the approach taken in *Toward a Healthy Future*, which consistently refers to “Aboriginal people” as a whole. Similarly, in the concluding chapter, the Report lists Aboriginal people as one of three key population groups in whose health Canada should invest. The others are children and youth (page 178).

While the Report recognizes that “the subpopulations within the Aboriginal population are diverse” (page 183), the health status and needs of Aboriginal women are not discussed, nor are Aboriginal women considered as part of this diversity.

² “Aboriginal” here means First Nations, Inuit and Métis people.

Toward a Healthy Future makes reference to the *First Nations And Inuit Regional Health Survey*, and presents the following table (page 17)

Exhibit 1.4 First Nations/Canada Ratio of Age-Adjusted Prevalence for Selected Chronic Conditions, 1997

<i>Disease</i>	<i>Ratio:Men</i>	<i>Ratio:Women</i>
<i>Diabetes</i>	<i>3:1</i>	<i>5:1</i>
<i>Heart problems</i>	<i>3:1</i>	<i>3:1</i>
<i>Cancer</i>	<i>2:1</i>	<i>2:1</i>
<i>Hypertension</i>	<i>3:1</i>	<i>3:1</i>
<i>Arthritis/rheumatism</i>	<i>2:1</i>	<i>2:1</i>

3

This table usefully compares the reported prevalence of these conditions, comparing Aboriginal men with all Canadian men and Aboriginal women with all Canadian women. **The source document, the *Report of the First Nations and Inuit Regional Health Survey*, however, also included data which compared the situation of Aboriginal women and Aboriginal men. This data was not included in *Toward a Healthy Future*.**

Two charts are reproduced below, to illustrate the importance of considering both gender and Aboriginal status in any analysis of the health of Aboriginal people.⁴

3 *ibid*, page 17

4 These charts are reprinted from Donner, L, *Women, Poverty and Health in Manitoba: An Overview and Ideas for Action*, Women-s Health Clinic, Winnipeg, July, 2000

Table 1. Chronic Diseases by Sex for First Nations and Labrador Inuit People Compared to the General Canadian Population

Condition	Female		Ratio FN&/ Gen. Can.	Male		Ratio FN&/ Gen. Can.
	FN&I	Gen. Can.		FN&I	Gen. Can.	
Heart Problems	10%	4%	2.5:1	13%	4%	3.3:1
Hypertension	25%	10%	2.5:1	22%	8%	2.8:1
Diabetes	16%	3%	5.3:1	11%	3%	3.7:1
Arthritis/ Rheumatism	27%	18%	1.5:1	18%	10%	1.8:1

Source: Second Diagnostic on the Health of First Nations and Inuit People, page 7, based on data from *First Nations and Inuit Regional Health Survey* (1999) and *National Population Health Survey* 1994/95

The chart above presents the same data as in Exhibit 1.4 of *Toward a Health Future*, but also allows the reader to consider the differing burdens of ill-health faced by Aboriginal women and Aboriginal men, and how these differ from all Canadian women and men.

The *Report of the First Nations and Inuit Regional Health Survey* also included data about the burden of chronic disease experienced by Aboriginal women and men, as follows:

Table 2 First Nations and Labrador Inuit People Self- Perceived Health Status by Sex and Age

Health Status	15 to 29 Years		30 to 54 Years		55 and Over	
	Male	Female	Male	Female	Male	Female
Very Good - Excellent	67%	57%	51%	49%	31%	24%
Poor - Fair	33%	43%	49%	51%	69%	76%
No Chronic Conditions	77%	66%	56%	44%	20%	13%
At least One Chronic Condition	24%	34%	44%	56%	80%	87%

Source: "Activity Limitations and the Need for Continuing Care", page 161 in *First Nations and Inuit Regional Health Survey* (1999)

This clearly illustrates the greater burden of ill health experienced by Aboriginal women, more of whom, in every age group, reported living with at least one chronic condition than did their male counterparts. Yet the socioeconomic status, health status and health needs of Aboriginal women, as distinct from Aboriginal men and from other Canadian women, are not discussed in *Toward a Healthy Future*.

Social Support Networks

Toward a Healthy Future includes references to women's greater likelihood of both giving (pages 57 to 59 and page 62), and receiving, social support (page 60) (e.g., family and immediate community).

There is one reference to the consequences for women's health and well-being of providing unpaid, informal care in this section of the Report. The issue is described in the section on Health Services below.

Education

The Report presents some sex disaggregated data about women and men's literacy and educational attainment (pages 51 and 53). It makes the connection between low-income and literacy and presents sex disaggregated data which shows that "women with low literacy skills were particularly vulnerable" to low-income (pages 53 to 54).

Employment and Working Conditions

The Report presents some sex disaggregated data about labour force participation, unemployment, job satisfaction and work stress, unpaid housework and child care and work injuries (page 54 to 59). However, there is no discussion of the impact on women's health from their lower job satisfaction, higher work stress, greater responsibilities for child care and house work.

Social Environments

Toward a Health Future contains sex disaggregated data about the victims of violence at home, but not of violence outside the home. It contains one sentence about the impact of violence on women's health, stating that:

Women who are assaulted often suffer severe physical and psychological health problems; some are even killed. (page 61)

Physical Environments

Toward a Health Future presents sex disaggregated data to show that more single mothers than single fathers do not have sufficient food in their homes and that more women than men use food banks (page 103). The Report discusses the hazards of environmental tobacco smoke and notes that pregnant women are "particularly susceptible" to the hazards of environmental tobacco smoke (page 104).

The section of the Report which deals with transportation notes that fewer women drive to work than do men (page 105). While this has environmental benefits, the Report does not discuss the additional burden which this places on women where adequate, affordable public transportation systems do not exist. There is no discussion of transportation as a health issue for women and men with disabilities (page 105).

The section on homelessness cites other research on the connections between violence and homelessness for women (page 107).

The Report does not consider gender in its discussion of the following issues: Sustainable Development and Health, Ozone Depletion, Climate, Air, Environmental Toxins, Water and Affordable, Adequate Housing.

Biology and Genetic Endowment

This section of *Toward A Health Future* has the most thorough analysis of the ways in which gender operates, together with another determinant, to influence the health of women and men. Particularly noteworthy is the final paragraph of the section on Biology and Birth Defects, which states:

*Virtually all women want to have healthy babies. Most who smoke or drink during pregnancy do so as a consequence of addictions and/or high levels of stress caused by poverty, abuse or other factors. Pregnant women need the support of their partners, families and communities, as well as the **recognition that their own health is as important as that of the growing fetus.*** (page 161) (emphasis added)

This section of the Report also contains an analysis of the ways in which new reproductive and genetic technologies affect women, and makes the connection to income and social status by noting that:

Women's relative economic status also makes them susceptible to adverse consequences of these technologies such as the commercialization of human gametes and embryos. (page 161)

This section of the Report also deals with aging and presents sex disaggregated data on the health status of senior women and men. The informal care provided to seniors is described and it is noted that most of this care is provided by daughters and wives (page 166).

While this section of the Report does include a discussion of the “Effects of Other Determinants on Healthy Aging”, there is no discussion of the effects of gender, as a determinant of health, on aging. This is consistent with the uneven attention given to gender in the Report. The Report does note, in its discussion of social support and social isolation that:

Older ethnic women who are widowed may be triply disadvantaged. (page 167)⁵

The work done to include a gender analysis in this section of the Report is exemplary. It could serve as a model for future documents.

⁵

The authors most likely mean older women from ethnic minority groups.

Personal Health Practices and Coping Skills

Toward a Health Future notes that smoking is now more common among young women than among young men (page 114). It presents sex disaggregated data about physical activity, healthy eating, alcohol consumption, sexual practices, HIV testing, bicycle helmet use and the personal health practices of young people aged 15 to 24, including multiple risk practices (pages 118 to 129).

Having presented the data for women and men separately, the Report does not analyze these differences, by presenting an explanation of either their origins, or of their differential effects on women and men.

Healthy Child Development

This section of the Report makes several references to gender. First, it describes the link between maternal education and “several indicators of a healthy start in life”, including healthy birthweight (pages 76 and 89). Secondly, it notes that low family income has a negative effect on the health of children, and that children raised by single parent mothers are at particularly high risk of poverty (page 84). Third, it notes that young women (aged 15 to 19 years) are the most likely of any age-sex group to exhibit signs of depression (page 74).

The discussion of strategies to strengthen healthy child development includes the following statement:

Pay Attention to Gender Differences

When broad strategies for healthy child development are discussed, there is often no distinction made between the health status, capacities and needs of boys and girls. Certainly, all children require similar supports to grow up healthy. However, the data presented in this chapter suggest that a strategy for children must always take into account the differences in how girls and boys experience the process of development. For example, reducing injuries and behaviour problems appears to be a priority for boys; reducing family violence and the early onset of smoking is a priority for girls and young women. (page 90)

Such a gender analysis could also have been applied to the other strategies specified in this section.

Health Services

This section of the *Toward a Healthy Future* does note that there are unmet needs for home care services and that most of this care is provided informally by women. The Report states:

While most women who cared for others did not claim that this was a burden, some 27% said that their caregiving affected their own health and two-thirds of working women aged 25 to 44 reported job repercussions as a result of their caregiving activities. Further research on these issues is required. (page 138)

Later in this section, the Report notes that changes in hospital stay practices are particularly relevant to women, both as consumers and as informal caregivers at home (page 142).

The Report states that:

Women aged 18 to 54 were two to three times as likely as men in this age group to have seen a physician in the previous year...among those aged 75 and over, men (83%) were slightly more likely than women (80%) to report two or more visits to a physician...it is well documented that patterns of utilization are markedly different for women than for men. Further investigation into these differences is needed. (page 146)

These differences are in some measure explained by research done in Manitoba by Cam Mustard, Pat Kaufert and others and published in the *New England Journal of Medicine*. They demonstrated that, in Manitoba in 1994/95, the per capita cost of providing females with health care services funded by the medicare system was approximately 30% higher than for men. However, after removing the costs of sex-specific conditions (including, for women, normal and abnormal reproduction, and for women and men, diseases of the genitourinary system and of the breast.) and considering costs for both physicians' services and acute hospital care, that **the costs of insured health care services for women were about the same as for men.** That is, the female : male ratio went from 1.3 to 1.0.⁶

While this research was limited to one province, it serves as an example of the type of important new information which can be gained through gender based analysis of health services utilization data.

⁶ Mustard, Cameron, Kaufert, Patricia, Kozyrskyj, Anita and Mayer, Teresa A Sex Differences in the Use of Health Care Services @ *New England Journal of Medicine* 338 (1998) p 1678

This section of the Report discusses Pap smear tests to screen for cervical cancer among women and notes that women with higher incomes and higher levels of education are more likely to report having regular Pap smears and that women born outside of North America were less likely to report ever having a Pap smear than women born in Canada or the United States. The report also describes inter-provincial variations in the percentage of women reporting having had a screening mammogram for breast cancer (pages 146 to 147).

This section of the Report also notes that women have less access than men to uninsured health services, including dental care, eye examinations and corrective lenses, chiropractic care and mental health services. This is because women are more likely than men to work for low wages, or in jobs that do not have supplementary health benefits (page 148).

This section of the Report also discusses unmet health needs, and the use of alternative health services, and presents sex disaggregated data on these topics (pages 149 to 153).

These last three are good examples of applying gender based analysis to gain a better understanding of the health of the population.

B. Recognition of Barriers to Healthy Behaviour or Access to Services

Barriers	Yes	No
Lack of child care		✓
Lack of local services		✓
Lack of transportation		✓
Lack of flexibility of services (including health, social services, recreational opportunities, etc.)		✓
Cost of services	✓	
Safety concerns (e.g., risk of violence)	✓	
Language		✓
Preferred type of provider or service not available (e.g., midwife, smoking cessation program)		✓

Discussion

Most of the barriers to getting health care or services were not discussed at all in *Toward a Healthy Future*. While the Report included consideration of the importance of high quality child care (pages 74 and 87-88) for healthy child development, it did not consider the ways in which the lack of child care limit women's abilities to take part in health-promoting activities or to make use of health services.

The Report did contain a discussion of the problems faced by women, who earn on average less than men, in purchasing non-insured services. It also contains discussions of some of the effects of violence on women, including the fact that for some women, being homeless is preferable to living with violence.

C. Disaggregation of Data by Sex for the Following

Data type	Extensive	Few	None
Morbidity	✓		
Mortality	✓		
Service utilization	✓		
Others - United Nations Gender and Development Index, United Nations Gender Empowerment Index, data about employment and unemployment, social support, violence, volunteering, civic participation, personal health practices, prescription drug use, unmet health needs, activity limitations and food security	✓		

ANone® no sex disaggregated data presented

AFew® one to two instances of sex disaggregated data

AExtensive® more than two instances of sex disaggregated data

Discussion

Toward a Healthy Future presents much of its data in a way which allows the reader to see the similarities and differences between women and men. **This is a strength of the Report.** Unfortunately, most of the data about socioeconomic status and the health of Aboriginal people were not disaggregated by sex.

D. Articulating Women's Health Issues

Types of Women's Health Issues	Extensive	Some	Few	None
Conditions related to reproductive system and associated services	✓			
Conditions more prevalent in women (e.g., breast cancer, osteoporosis) and related services			✓	
Family and child health issues (e.g., parent-child issues)		✓		
Woman-specific needs for diseases common among both women and men (e.g., heart disease)				✓
Women's health needs across the lifespan			✓	
Woman-specific "healthy lifestyle" promotion concerns (e.g., tobacco reduction, healthy eating, physical activity)		✓		
Holistic approach that goes beyond physical health (i.e., include mental, emotional and/or spiritual health)			✓	
Women's life situations (e.g., violence, poverty, child care responsibilities, housing, transportation, discrimination)		✓		

None	no reference
Few	one to two references
Some	more than two references
Extensive	either more than two references or more than two references plus at least one analysis of the issue from a gender perspective

Discussion

Toward a Healthy Future includes a good discussion of the issues surrounding new reproductive and genetic technologies and their impact on women (pages 161-162), as well as sex disaggregated data about sexually transmitted diseases and safe sexual practices (pages 126 to 128 and 162). Unfortunately, it does not contain a more general discussion of the sexual and reproductive health needs of women and men throughout their lives.

It is also noteworthy that the Report contains references to some issues in women's lives (violence, poverty, child care and elder care responsibilities and housework) which affect their health. Several other important issues were not considered from a gender perspective including housing (although there was a reference in the discussion of homelessness) and transportation. As noted above, the discussion of socioeconomic issues, particularly poverty among women, presents gender issues only superficially.

The Report considers women's health issues broadly and does not make the common mistake of considering "women's health" to be only those conditions specific to women (such as pregnancy, labour and delivery and cervical cancer) or more common to women (such as breast cancer).

The Report does present sex disaggregated data for healthy lifestyle issues such as tobacco reduction, healthy eating, physical activity, alcohol and illicit drug use (see pages 115 to 124), but does not present an analysis of the ways in which these issues are different for women and men and the implications of these differences for health.

E. Diversity

1. Recognition of Diversity as an Issue

	Yes	No
Acknowledgement of the diversity among women	✓	
Examples or acknowledgement ways in which diversity interacts with gender and the other determinants of health	✓	

2. Discussions of Diversity

Discussion of findings for women in any of the following groups:	Extensive	Some	Few	None
Aboriginal women				✓
Francophone women				✓
Women from cultural groups from outside North America or Western Europe			✓	
Rural				✓
Single Mothers		✓		
Adolescent girls and young women		✓		
Seniors		✓		
Women who have experienced abusive relationships		✓		
Women with disabilities		✓		
Women living on low incomes		✓		
Women with low literacy skills			✓	

ANone@ no reference

AFew@ one to two references

ASome@ more than two references

AExtensive@ more than two references plus at least one analysis of the issue from a gender perspective

Note: These categories were selected because they are consistent with data gathered for the National Population Health Survey, the major data source used in *Toward a Healthy Future*.

Discussion

The lack of attention to the health of Aboriginal, Francophone, ethnic and visible minority women, is a weakness in the Report. Culture, like gender, has been accepted as a determinant of health by Health Canada and some of the provinces, but as noted earlier, both were excluded from the determinants of health considered by the Federal/Provincial/Territorial Advisory Committee on Population Health which authored *Toward a Healthy Future*.

Considering culture as a determinant of health would lead to a stronger analysis of these issues, and, hopefully, to the important connections among gender, culture and the other determinants of health. Numerous other aspects of diversity, such as differences between rural and urban women, northern and southern women and the situation of lesbian women have also been given insufficient consideration in the Report.

The Report contains more than two references to the situations of single mothers, adolescents, senior women, women who have experienced abuse, women with disabilities, low-income women and women with low levels of literacy and has therefore been rated as “extensive” in these categories. This is commendable. However, while the Report presents some data on women in these groups, there is little analysis of what these circumstances mean for their health.

F. Inclusion of a Specific Focus on Women=s Needs or Concerns

Focus	Extensive	Some	Few	None
Focus on women=s physical health needs or concerns		✓		
Focus on women=s mental health needs or concerns			✓	
Focus on women=s social needs (e.g., social supports, financial issues)			✓	

ANone@ no reference

AFew@ one to two references

ASome@ more than two references

AExtensive@ either more than two references plus at least one analysis of the issue from a gender perspective

Discussion

Toward a Healthy Future describes the health status of women and men, but does not take the next step of identifying women=s and men=s health needs, except in a brief discussion of “unmet health needs” as reported in the National Population Health Survey (see page 152). Nor does it include suggested health services, or services outside of the health care system, which would improve the health status of women as described in the Report. The Priorities for Action (pages 175 to 189) do not contain any reference to the particular health needs of women that would lead to healthier public policy.

G. Health Services System Issues

Issue	Extensive	Some	Few	None
Recognition that women are more likely to be informal caregivers than men		✓		
Recognition that women tend to be the guardians of the health of family members (children, elders, men)				✓
Recognition that women predominate as community health service volunteers			✓	

ANone@ no reference
 AFew@ one to two references
 ASome@ more than two references
 AExtensive@ more than two references plus at least one analysis of the issue from a gender perspective

Discussion

Toward a Healthy Future recognizes the importance of the unpaid, informal care provided by women to children, seniors, those who are recovering from illness and injury, and to the community as a whole through their volunteer work. It contains one reference to the impact of this work on the health of women:

While most women who cared for others did not claim that this was a burden, some 27% said that their caregiving affected their own health and two-thirds of working women aged 25 to 44 reported job repercussions as a result of their caregiving activities. Further research on these issues is required. (page 138)

While calling for further research, the Report does not use the existing research literature on women's experiences of providing such care, from which some useful conclusions might have been drawn.⁷ Since the release of *Toward a Healthy Future*, more work has been done in this field. Its inclusion would certainly strengthen future reports on the health of Canadians.

⁷ See for example, the summary of the literature in Janzen, B. L., *Women, Gender and Health: A Review of the Recent Literature*, pages 10 and 11 and Campbell, J et al, *Caregivers=Support Needs: Insights from the Experiences of Women Providing Care in Rural Nova Scotia*, 1998

H. Evidence-based Decision-making and Evaluation

Issue	Extensive	Some	Few	None
Acknowledge the need for appropriate data about men and women for analytical and decision making purposes.		✓		
Inclusion of indicators specific to Women's health			✓	
Inclusion of indicators specific to Gender equity		✓		

Discussion

It is noteworthy that the Report included references to both the United Nations Gender-Related Development Index and the Gender Empowerment Measure and discusses Canada's ranking in each (see pages 29 to 31). The Report states that Canada's ranking as seventh in the world in the Gender Empowerment Measure, compared to its ranking as first in the Gender-Related Development Index, suggests that:

Canada needs to provide more opportunities for women to participate in decision-making positions in the political, business and professional communities and to decrease the wage gap between women and men. (page 31)

3. Summary of the External Data Sources Cited and Not Cited in *Toward a Healthy Future* - Main Report and Statistical Summary

One of the major barriers frequently cited to using gender based analysis in health is the limited data available. Therefore, in addition to using the revised *Invisible Women* framework to analyze *Toward a Healthy Future*, we considered the data available to the authors of *Toward a Healthy Future* at the time of the preparation of the Report.

The summary below describes both the available sources of data cited in *Toward a Healthy Future*, and those not cited. This information is presented using the chapter headings contained in *Toward a Healthy Future*. A more detailed list appears in Appendix 2.

3.1 Data Sources Cited

Chapter 1. The Health Status of Canadians

The external (non-NPHS) sources cited in the main report are mainly from federal government sources B mostly Health Canada and Statistics Canada. Occasionally non-governmental agencies or academic journal articles were cited. Health status topics covered by the external citations in the main report were psychological well-being, HIV/AIDS, cardiovascular and cancer deaths, projected deaths from smoking, suicide, homicide, life expectancy and potential years of life lost, and various human development indices. There were some citations that addressed health status of cultural groups. Data on chronic health conditions in Aboriginal populations were drawn from the *First Nations and Inuit Regional Health Survey*, and Statistics Canada publications were cited regarding the life expectancy of immigrant groups and the relationship among gender, socioeconomic status and disability among immigrants.

The Statistical Report provided additional incidence or prevalence data on some of the same topics as the main report. The focus was mostly on HIV/AIDS, cancer and heart disease. There was also mention of communicable diseases, mental health conditions, suicide, alcohol and motor vehicle accidents, hospitalization, life expectancy and potential years of life lost. Most sources were various divisions of Health Canada, but there were occasional references to published research or non-governmental organizations. For the most part, the main differences between the main and statistical reports was that the latter provided more detail by age groups and provinces/territories.

The information presented from external sources was primarily sex-disaggregated statistics. There was no discussion of why these sex differences occur. Though statistical reports from various divisions would not contain such analysis, the published research literature would. For instance, one journal article cited discusses gender differences in patterns and reasons for suicide. Presenting some of the issues raised in the article in the main report would have

added some context to the suicide statistics from Health Canada.

Since the publication of *Toward a Healthy Future*, more work from the Health Canada-funded Centres of Excellence in Women's Health has been published, which will be available to the authors of future reports on the health status of Canadians. This material would be useful not only in helping to understand the ways in which the health status of women and men are different and the same, but also in helping to design the indicators used to measure women's and men's health status.

Chapter 2 The Socioeconomic Environment

The majority of external (non-NPHS) sources cited in the main report are from Statistics Canada. Occasionally journal articles or reports from research institutes are cited. Topics addressed are income trends for various types of families, people living below the LICO, income inequality, employment, labour force participation, occupations, work-family balance, unpaid work, care for children and seniors, literacy, educational attainment, workplace injuries, violence in the home (against women and children), women in shelters, violent crime outside the home, volunteer involvement. There was some discussion of age differences in various social indicators - income, employment and education - among Aboriginal people.

As with the main report, the Statistical Report cited primarily Statistics Canada sources. It describes the Canadian population (e.g., marital status, family composition, fertility and birth rates). Other than this population description, the statistical report covered many of the same issues as the main report B literacy, family income and low income in particular, unpaid household activities, physical and sexual assaults inside and outside the home, women in shelters.

In some cases the Statistical Report presented data on issues not covered in that chapter in the main report. For instance, in discussing education, the main report focuses on sex differences in high school dropout and university education. The statistical report presents additional data on school readiness among children. The main difference between the main and statistical reports was that the latter provided more detail by age groups and provinces/territories.

Again, most of the external sources were referring to sex-disaggregated data B not surprising as Statistics Canada was the most commonly cited source. However, when discussing some of the in-depth research articles or reports (Lee, Duxbury & Higgins, 1994; Messing, 1994), *Toward a Healthy Future* does briefly address reasons for job insecurity (child care responsibilities) and dissatisfaction (lack of control over work), as role overload from balancing work and family. However, none of these issues was discussed in depth. There were other areas of discussion where additional information could have provided at least

some degree of gender analysis. For instance, the section social environment and health deals with violence. Power imbalances in relationships (which most often favour men) were not addressed, even though other contributing factors such as witnessing abuse in childhood were addressed. Documents from the Health Canada-funded Centres on Violence Against Women and Children would have been useful here.

Chapter 3 Healthy Child Development

This section reported mostly research articles and synthesis reports (some of the latter were from non-government organizations as well as special reports prepared for Health Canada such as those of the National Forum on Health). There were only three references to Statistics Canada. Main topics covered by these sources and cited in the main report B and that addressed sex differences or female-specific issues B were: relationship of maternal education and smoking during pregnancy with low birthweight, teen pregnancy, school readiness, injuries, psychological well-being, emotional and behavioural competence (and relationship to maternal education, neighbourhood safety and family income), child poverty, violence (particularly in families) and bullying.

The statistical report contained additional data on low birthweights (sex differences for low birthweight babies, age of mothers and birth weight), additional trend information on teen pregnancies, and stillbirths and abortions. As with the other chapters, the statistical reports provided age and provincial breakdowns of these statistics (mostly from Statistics Canada).

There was a bit more discussion of reasons for sex differences in this chapter than in most of the others, as more in-depth research reports were mentioned. For example, risk taking among boys and male socialization were mentioned in relation to injury rates. The report also recognized the challenge for women in particular to balance work and family B and the need for child care.

However, there were other areas where additional information could have enhanced understanding of the issues discussed. For example, Health Canada's Tobacco Demand Reduction Strategy (TDRS) released many reports on women and tobacco (including pre and post-natal smoking). Many of these were written from a women-centred perspective. *Toward a Healthy Future's* discussion on smoking does not go beyond demographics (e.g., relationship between smoking and maternal education). As in the previous chapter, violence was discussed without any mention of economic and social inequalities between women and men.

Chapter 4 Physical Environment

The majority of external (non-NPHS) sources cited in the main report are from Statistics Canada. Occasionally journal articles or reports from research institutes or arms-length government-funded agencies are cited. Topics mentioned are sun exposure, skin cancer, environmental tobacco smoke (including workplaces), transportation to work, housing affordability, homelessness (including attitudes toward homelessness and homelessness among Aboriginal people), and purchasing environmentally friendly products.

The statistical report provides a few more references on smoking in the home and smoking by pregnant women, the purchase of organic foods and environmentally friendly products, as well as purifying household drinking water. There was additional information on provincial differences and in a few cases, age and education. As well, smoking in the home was mentioned in the main report, but it did not present sex differences in either smoking in the home oneself or being exposed to others' smoke. Data sources for the statistical report were varied and included Statistics Canada, a survey firm and research articles.

There was not a lot of gender analysis beyond presenting the sex-disaggregated data. An exception was a discussion of the links between homelessness and violence against women. The work of the National Network on Environments and Women's Health may have added some additional insights to this section of *Toward a Healthy Future*.

Chapter 5 Personal Health Practices

There were few external data sources that referred to sex differences, as the NPHS has an extensive focus on personal health practices and disaggregates data by sex. Additional data sources B from Health Canada, Province of Nova Scotia, and research agencies B discussed with regard to sex differences pertained to tobacco use in two provinces (prevalence rates), AIDS attributable to injection drug use, risky sexual behaviour and HIV testing, age of smoking initiation and implications for quitting. The statistical report also did not cite much external data pertaining to sex differences B the exceptions being illicit drug use and riding a bicycle or walking to work (from Health Canada and Statistics Canada).

There was no gender analysis of the above issues beyond the first step of presenting sex-disaggregated data. For smoking in particular, there are numerous Health Canada documents from the Women and Tobacco Reduction Program of the TDRS (most prepared between 1995 and 1997) available to assist with such analysis.

Chapter 6 Health Services

The main report chapter on health services did not discuss any data on sex differences or female-specific issues from external sources B though they did discuss some sex differences from NPHS survey data and also recognized that women are more likely to be both users of health care and informal caregivers. The statistical report addressed recommendations for cervical and breast cancer screening, physician visits, HIV testing and condom use. Sources were Health Canada, the Canadian Institute for Health Information (arms-length government-funded agency), and research articles. A separate statistical report section on personal resources and coping addressed home care and caregiving B including who receives care, suggested incentives to informal caregivers, impact of caregiving on other areas of life and attitudes toward caregiving. Sources are Statistics Canada and Health Canada (including research articles in journals published by these departments).

The statistical report actually contained more analysis of the informal caregiving issue than the main report. For example, the research they cite shows that caregiving affects a number of areas of the caregiver's life (particularly for women), but both women and men see positives in caregiving as well (strengthening relationships, "giving back"). It is not clear why these issues were not explored in more depth in the main report. Also, all the Centres of Excellence in Women's Health have done extensive work on informal caregiving, home care and/or social support, as has Status of Women Canada. These sources may have provided additional context for this section.

Chapter 7 Biology and Genetic Endowment

External sources cited in this chapter referred not only to sex differences, but also to women in the context of reproductive issues. Most of the references cited were journal articles or in-depth reports, along with a few Health Canada reports. Topics covered included birth defects (including those related to alcohol), ethics of new reproductive technologies, susceptibility of young women to sexually transmitted diseases, informal care and social support, social isolation (including cultural groups), reasons for hospital admissions, use of publicly-funded home care, and resiliency (including discussion of prenatal care, maternal depression and support for families facing adverse circumstances such as poverty and abuse). There was no statistical report coinciding with this chapter.

There was more gender analysis in this chapter than the others, and in some cases these external data sources were used. For example, the discussion of fetal alcohol syndrome and birth defects noted the social context of drinking during pregnancy (poverty, malnutrition, depression, abuse, lack of access to prenatal care and drinking patterns of family and friends). The section on new reproductive and genetic technologies discusses how women's economic status makes them more susceptible to commercialization of new technologies, and that resources may go into these technologies at the expense of STD prevention. There was also explicit recognition that women are more likely to provide informal care, and that support to parents needs to consider larger social issues like poverty and abuse.

Chapter 8 Improving Health

This is the concluding chapter of the report. There were few external references that addressed sex differences or female-specific issues. This is not surprising, as the emphasis of this section was more on the implications of the previous chapters. There was bit more gender analysis in this section, but it was inconsistently applied. For example, in a discussion of outreach to pregnant women, social support, access to food, and poverty were recognized as important factors to consider (along with information). However, there was less emphasis on addressing these issues for women who are not pregnant B which could suggest that women are valued more for producing healthy babies than for themselves. There was also mention of the importance of the need to consider factors such as child care, neighbourhood safety and taxation policies B as well as parenting resources B when supporting parents to both work and spend time with their children. Teen pregnancy was recognized in the larger context of its relationship to educational attainment and employment. Discussion of women's employment made reference to pay equity.

3.2 Data Sources Not Cited in *Toward a Healthy Future*

In preparing *Toward a Healthy Future*, the authors did not include two key sources of data about the health of Canadian women. These are:

1. Health Canada's *Women's Health Strategy*
2. *Women in Canada: Statistical Report 1995*

The inclusion of each of these documents could have contributed to *Toward a Healthy Future* as follows:

Health Canada's Women's Health Strategy

The *Women's Health Strategy* of Health Canada reviews some of the ways in which the health system has failed to respond adequately to women's health needs and concerns. It highlights issues surrounding causes of death among women, their illnesses and life conditions, quality of life and the social and economic issues that influence their health. Finally, it outlines a broad range of areas where Departmental actions can address these issues. (p. 2)

The *Strategy* states that Health Canada will “integrate gender into all its programs and policies by conducting gender-based analysis.” (p. 2) This document also explicitly presents gender as a determinant of health, which is separate from but interactive with the other determinants of health.

The *Strategy* also recognizes culture as a determinant, and emphasizes the importance of diversity.

Most of the document refers to policies and programs. However, some aspects of it have implications for population-level research such as the NPHS and resulting documents such as *Toward a Healthy Future*. The second objective to “increase knowledge and understanding of women's health and women's health needs” is especially relevant.

The *Strategy* discusses some of the social and economic circumstances that influence women's health status and behaviour. Some of these issues such as work-family role strain and informal caregiving and unpaid work were also mentioned in *Toward a Healthy Future*. The *Strategy* has additional examples such as how assumptions about gender roles influence contraceptive and STD protective behaviour (women are seen as responsible for preventing pregnancy but at the same time may have difficulty negotiating safer sex with a male partner). Some of these examples of context - with some further elaboration about gender inequality - might have enhanced the discussions of gender in *Toward a Healthy Future* by providing some additional gender-based analysis.

The *Strategy* also mentions some statistical information that is not often seen elsewhere. For example, cancer deaths among those aged 20 to 44 are higher for women. Findings such as this would have been helpful in the statistical report that accompanied *Toward a Healthy Future*.

The *Strategy* was released in March 1999, approximately six months before the release of *Toward a Healthy Future*. However, the *Strategy* is not cited at all in *Toward a Healthy Future* in any of the discussions of sex differences, female-specific health issues or gender. While the *Strategy* cites the 1996 first *Report on the Health of Canadians*, the ACPH makes no reference to the *Women's Health Strategy*, in *Toward a Healthy Future*.

Women in Canada: Statistical Report 1995

Women in Canada contains much valuable information about sex differences as well as statistics specific to women. It draws mainly from Statistics Canada data, and also includes data from a number of other government departments (including Health Canada and Status of Women Canada).

We would not expect a report such as *Toward a Healthy Future* to duplicate all the information in *Women in Canada*. However, it might have been useful to readers to be able to refer to the report as a source of additional information. For instance, *Toward a Healthy Future* mentions high school and university completion, as well as relationship of education to earnings, in the chapter ASocioeconomic Environment⁶. *Women in Canada* goes into more depth in it's section on education -- distinguishing between undergraduate and graduate education. The latter report notes that women are more likely to be in undergraduate programs but less likely to be in graduate programs (especially doctoral). That report also notes that the earnings of women are lower than earnings of men who have the same level of education. Similarly, the section on crime and violence gets into more detail on wife assault B e.g., types of violence, number of times assaulted, risk of assault at separation. The section on disabilities presents information on transportation issues not covered by *Toward a Healthy Future*, as well as going into more depth on income, education, employment and household living arrangement.

The section on health covers many of the same topics as *Toward a Healthy Future* and/or the accompanying statistical report, but presents additional statistics on some of them. For example it differentiates between daily, experimental and never smokers; it presents more in-depth presentation of statistics on lung and breast cancer trends and includes a discussion of licit - including over-the-counter - as well as illicit drug use. There are also numerous tables containing age-sex breakdowns for various health conditions and behaviours.

Women in Canada provides more in-depth information on a number of additional areas including family status, housing, labour force participation and employment, income and earnings, crime and violence, immigrant women, visible minority women, and Aboriginal women. The latter three sections address mostly demographics (e.g., family status) and social indicators pertaining to education, occupation, and income. There was little health status information for those particular groups. Some of what was presented is also in *Toward a Healthy Future* (e.g., Aboriginal life expectancy), though there was some additional information in *Women in Canada* on fertility and birth rates.

Women in Canada is intended to be a statistical report, so there is very little narrative beyond describing differences and trends. There was no additional gender analysis in that report that would have been helpful to the authors of *Toward a Healthy Future*, so the main contribution of *Women in Canada* would have been as a source of a few additional statistical breakdowns and a reference for those particularly interested in women's health and its determinants.

In June 2000, after the publication of *Toward a Healthy Future*, Statistics Canada published a revised and updated version of *Women in Canada*. The data which it contains would be useful in helping to develop population health indicators which are relevant to the health status of women.

4. Conclusions: Strengths and Weaknesses in the Consideration of Gender in *Toward a Healthy Future* and Suggestions for the Future

***Toward a Healthy Future* marks an important step forward in the way in which women's health in general, and gender in particular, are considered in the Canadian population health literature. It contains much more information about the health situation and needs of women than did the first *Report on the Health of Canadians*.**

However, there are several ways in which stronger gender analysis could be presented. We recommend the following for consideration in the preparation of future reports on the health of Canadians.

- 1. Include gender as a determinant of health.** Including gender as a determinant of health would lead to a more consistent consideration of gender issues in future reports on the health of Canadians. Some chapters of *Toward a Healthy Future* include serious consideration of gender (notably the chapter on Biology and Genetic Endowment). Others present sex disaggregated data but little analysis of gender (for example, the chapters on Social Environment and Personal Health Practices). Still other chapters need both the presentation of more sex disaggregated data and an analysis of the meaning of the data (for example, the chapter on Socioeconomic Environment).
- 2. Include culture as a determinant of health and present data which include a recognition of diversity among women.** This includes: Aboriginal women, ethnic and visible minority women, women with disabilities, older and younger women, lesbian women, women living in rural and remote regions, new immigrant and refugee women. Data for all of these groups is not always obtainable, but where it is available it should be presented and then analyzed. These analyses should be based on an understanding of the systemic discrimination which these groups of women face, and the racism faced by Aboriginal and visible minority women.
- 3. Include an analysis of gender discrimination and its many impacts on women and men, boys and girls, and on the health of Canadian society as a whole.** While the Report does include a presentation of data, it needs to take the next steps of asking, and answering, the question "Why does this happen?" and "What does this mean for health?"@.

4. **Use the data already being collected to assist in the work of recommendations two and three above.** Both in Canada, and internationally, there is a growing body of literature on women's health status, their health needs, their experiences of the health care system, and service delivery models which better address women's health needs. The publications of the five federally funded Centres of Excellence for Women's Health provide a good starting point. Publications from the Women's Health Bureau, including the *Women's Health Strategy*, could be used to inform future work on the health of Canadians. Other important sources for future work would include: the research publications of Status of Women Canada (none of which were cited in *Toward a Healthy Future*); Statistics Canada's *Women in Canada* (2000); the Report of Health Canada's Advisory Committee on Women's Health Surveillance (1999); and the work of Vivienne Walters and Peggy McDonough of McMaster University, in undertaking gender analyses of data from the National Population Health Survey.

5. **Future reports would be stronger if they included more gender analysis of health policies and programs.** The Centres of Excellence for Women's Health have been working to raise awareness of this issue among policy makers. For example, in 1998-99 the Prairie Women's Health Centre did a gender analysis of the planning documents from health authorities/districts in Manitoba and Saskatchewan (*Invisible Women*, cited above). A second phase is now in progress to support interested health regions/districts to apply gender analysis more systematically to their policies. The framework is also now being adopted in a project funded by Status of Women Canada through the Centre d'Excellence pour la santé des femmes in Montreal. In B. C., the Vancouver-Richmond Health Board has developed a model for gender-sensitive health services.

VI. Analyses of Documents from the Canadian Institute of Health Information

Each of the three documents is discussed separately below. The revised *Invisible Women* framework is presented only in the analysis of the first of the documents - the *National Consensus Conference on Population Health Indicators*. The analyses of *Roadmap Initiative...Launching the Process* and *Health Care in Canada 2000: A First Annual Report* follow. The content of these two documents did not make the use of the framework appropriate. The conclusions drawn from the analyses of all three documents are presented together.

CIHI describes itself as follows:

*Mandated by Canada's health ministers, the Institute is a national, not-for-profit organization responsible for developing and maintaining the country's comprehensive health information system. The Institute delivers the knowledge and develops the tools to advance Canada's health policies, improve the health of the population, strengthen the health system and assist leaders in the health sector make informed decisions.*⁸

Given that CIHI plans to “deliver the knowledge” and “develop the tools” to improve the health care system and the health of the Canadian population, as well as assisting leaders in the health sector to make informed decisions, it is important to examine the understanding of gender present in these documents.

⁸ Canadian Institutes for Health Information, *What We Do*, available at: <http://www.cihi.ca/wedo/do.htm>

1. National Consensus Conference on Population Health Indicators

The Report describes its purpose as follows:

The purpose of the project is to identify what measures should be used to report on the health of Canadians and the health system and then to compile and make this information widely available. These indicators are primarily intended to support regional health authorities in monitoring progress in improving and maintaining the health of the population and the functioning of the health system for which they are responsible.
(page i)

CIHI, in co-operation with the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Services (the group which produced *Toward a Healthy Future*) and Statistics Canada, jointly convened the “National Consensus Conference” in May, 1999.

1.1. Applying the Revised *Invisible Women* Framework to the *Report of the National Consensus Conference on Population Health Indicators*

A. Recognition of the Connections Between Gender and Each of the Other Determinants of Health (i.e. sex-disaggregated data plus discussion of how these may operate differently for women and men)

Determinants	Extensive	Some	Few	None
Income and social status				✓
Social support networks				✓
Education				✓
Employment and working conditions				✓
Social Environments				✓
Physical environments				✓
Biology and genetic endowment				✓
Personal health practices and coping skills				✓
Healthy child development				✓
Health services		✓		
Culture				✓

ANone@ no reference to the connection between gender and the determinant in question; no sex disaggregated data presented

AFew@ one to two references to the connection between gender and the determinant in question or instances of sex disaggregated data

ASome@ more than two references to the connection between gender and the determinant in question or instances of sex disaggregated data

AExtensive@ either more than two references to the connection between gender and the determinant in question or more than two instances of sex disaggregated data plus at least one analysis of the issue from a gender perspective

Discussion

It is noteworthy that in this document CIHI has not considered gender to be a determinant of health. The non-medical determinants of health listed are: health behaviours, living and working conditions, personal resources and environmental factors. **Culture was also excluded from consideration in this document.**

B. Recognition of Barriers to Healthy Behaviour or Access to Services

Barriers	Yes	No
Lack of child care		✓
Lack of local services		✓
Lack of transportation		✓
Lack of flexibility of services (including health, social services, recreational opportunities, etc.)		✓
Cost of services		✓
Safety concerns (e.g., risk of violence)		✓
Language		✓
Preferred type of provider or service not available (e.g., midwife, smoking cessation program)		✓

Discussion

The Health Indicators Framework contained in the *National Consensus Conference on Population Health Indicators* (page 3) includes “accessibility” as a measure of the performance of the health system. Accessibility is defined as “The ability of clients/patients to obtain care/service at the right place and the right time, based on respective needs” (page 3). This broad definition could include all of the barriers contained in the list from the framework above, however, the detailed listing of proposed measures of the accessibility of the health care system include none of the above. Those measures included by CIHI are: influenza immunization among seniors (not disaggregated by sex), screening mammography among women aged 50 to 69, Pap smears among women aged 18 to 69 and childhood immunizations. **This limited definition of accessibility to health services will not allow**

for the measurement, or analysis, or reduction of the major barriers which women face in attempting to gain access to the health care.

C. Disaggregation of Data by Sex for the Following

Data type	Extensive	Few	None
Morbidity	✓		
Mortality	✓		
Service utilization	✓		

ANone@ no sex disaggregated data presented

AFew@ one to two instances of sex disaggregated data

AExtensive@ more than two instances of sex disaggregated data

Discussion

This document includes description of 76 indicators which would apply to both males and females. Of those, the presentation of data by sex is proposed for only 13 of those (pages B-1 to B-15). They are: life expectancy, circulatory deaths, cancer deaths, respiratory deaths, suicide, unintentional injury deaths, AIDS deaths, potential years of life lost, pneumonia and influenza hospitalizations, ambulatory care sensitive conditions, hip fractures, population count and hospital days per capita.

The table below shows all of the proposed population health indicators, categorized by whether or not CIHI proposes to present data disaggregated by sex. Some indicators are proposed for females only. The proposed female-only indicators are: breastfeeding, screening mammography, Pap smears, vaginal birth after Cesarean section, breast conserving surgery, Cesarean sections, teen pregnancies/teen births and hysterectomy rates. No male-only indicators are proposed.

The CIHI Proposed Population Health Indicators

Indicators	Sex Disaggregated or female only*	Not Sex Disaggregated
1.0 Health Status		
1.1 Deaths	life expectancy, circulatory deaths, cancer deaths, respiratory deaths, suicide, unintentional injury deaths, AIDS deaths, potential years of life lost	infant mortality, perinatal deaths, pertussis deaths, inequalities in life expectancy (defined as differences in average health status between the top and bottom thirds of the population)
1.2 Health Conditions		overweight, arthritis, diabetes, asthma, chronic pain, depression and injury hospitalizations, food and waterborne diseases
1.3 Activity Limitation		functional health, disability days, activity limitations and health expectancy
1.4 Well-being		self-rated health, self-esteem and mastery

Indicators	Sex Disaggregated or female only*	Not Sex Disaggregated
2.0 Non-Medical Determinants of Health		
2.1 Health Behaviours	breastfeeding	smoking rate, smoking initiation, regular heavy drinking, and physical activity
2.2 Living and Working Conditions		high school graduation, post- secondary graduation, unemployment rate, long term unemployment, youth unemployment, low income rate, children in low income families, income inequality, housing affordability, crime rate, youth crime rate and decision latitude at work
2.3 Personal Resources		school readiness, social support, life stress
2.4 Environmental Factors		
Indicators to measure environmental factors are under development		
3.0 Health System Performance		
3.1 Acceptability		
None listed		
3.2 Accessibility	screening mammography, Pap smears	childhood immunizations
3.3 Appropriateness	vaginal birth after Cesarean, breast conserving surgery, Cesarean sections	

Indicators	Sex Disaggregated or female only*	Not Sex Disaggregated
3.4 Competence		
None listed		
3.5 Continuity		
None listed		
3.6 Effectiveness	pneumonia and influenza hospitalization, ambulatory care sensitive conditions	quitting smoking, low birthweight, pertusis, measles, tuberculosis, HIV infection, chlamydia infection and deaths due to medically treatable diseases
3.7 Efficiency		surgical day case rates, may not require hospitalization, percentage alternate care level days, expected compared to actual stay
3.8 Safety	hip fractures	
4.0 Community and Health Services Characteristics	population count, teen pregnancy/teen births, hospital days per capita, hysterectomy rates	expenditures per capita, doctors and nurses per capita, coronary artery bypass graft surgery rates, hip and knee replacement rates, myringotomy rates (ear tube insertion)

* There were no Indicators proposed which apply only to males.

Discussion

A number of issues arise from the Indicators as proposed:

1. **Many important determinants of the health of women are not included** (see #4 –my mistake I left this in, mjh-b) Articulating Women’s Health Issues below). While recognizing that this list of indicators cannot be exhaustive, **a useful set of indicators was recommended in the 1999 Report of Health Canada’s Advisory Committee on Women’s Health Surveillance.**⁹

CIHI described the participants at the National Consensus Conference on Population Health Indicators as “eighty-one experts from regions (23% of participants), national associations (15%), academics/researchers (16%) and other groups, including consumers (12%)” (page 2). It is noteworthy that none of the members of the Women’s Health Surveillance Advisory Committee, (which was meeting and working at the time that the National Consensus Conference on Population Health Indicators was held), were among those invited by CIHI to attend their National Consensus Conference on Population Health Indicators.

2. **In many cases, where CIHI proposes to present non-sex disaggregated data, it is already routinely collected and presented separately for women and men** (for example, HIV rates, low income rates, unemployment, etc.). All data in the National Population Health Survey is collected separately by sex, so for example the proposed data on overweight, arthritis, diabetes, asthma, chronic pain and depression, could be disaggregated for presentation in these Indicators.
3. In all cases where CIHI plans to produce sex disaggregated data it is not clear that this will include a presentation or an analysis of the differences between women and men. Rather, data will be Age/sex standardized. That is, rather than analyzing the differences between women and men, boys and girls, data may be Acontrolled for sex. This is an approach which will not serve to develop inclusive population health indicators.
4. The inclusion of data on teen births perpetuates gender bias by presenting data only about teen mothers. The fathers of these children are totally absent.

⁹

Health Canada, *Women’s Health Surveillance: A Plan of Action for Health Canada*, 1999, pages 7 to 9 and available at: <http://www.hc-sc.gc.ca/hpb/lcdc/publicat/whs-ssf/index.html>

5. The lack of sex disaggregated data planned for inclusion in these Indicators probably reflects a narrow definition of what constitutes “women’s health”. For example, CIHI proposes to present data about teen pregnancy and birth rates, hysterectomy rates, Cesarean sections, vaginal births after Cesarean section, Pap smears, screening mammography and breast conserving surgery for women having surgery for breast cancer. They have not chosen to disaggregate by sex any of the non-medical issues important to the health of women. (See D below.)

D. Articulating Women’s Health Issues

Types of Women’s Health Issues	Extensive	Some	Few	None
Conditions related to reproductive system and associated services		✓		
Conditions more prevalent in women (e.g., breast cancer, osteoporosis) and related services		✓		
Family and child health issues (e.g., parent-child issues)				✓
Woman-specific needs for diseases common among both women and men (e.g., heart disease)				✓
Women’s health needs across the lifespan				✓
Woman-specific “healthy lifestyle” promotion concerns (e.g., tobacco reduction, healthy eating, physical activity)				✓
Holistic approach that goes beyond physical health (i.e., include mental, emotional and/or spiritual health)			✓	
Women’s life situations (e.g., violence, poverty, child care responsibilities, housing, transportation, discrimination)				✓

ANone@ no reference

AFew@ one to two references

ASome@ more than two references

AExtensive@ either more than two references or two references plus at least one analysis of the issue from a gender perspective

Discussion

The narrow definition of “women’s health” described above is reflected in this table as well. The non-medical issues listed above, which are understood in the women’s health literature as critical to women’s health, will not be included in these Indicators.

E. Diversity

1. Recognition of Diversity as an Issue

	Yes	No
Acknowledgement of the diversity among women		✓
Examples or acknowledgement ways in which diversity interacts with gender and the other determinants of health		✓

2. Discussions of Diversity

Discussion of findings for women in any of the following groups	Extensive	Some	Few	None
Aboriginal women				✓
Francophone women				✓
Women from cultural groups from outside North America or Western Europe				✓
Rural women				✓
Single mothers				✓
Adolescents girls and young women			✓	
Senior women			✓	
Women who have experienced abusive relationships				✓
Women with disabilities				✓
Women living on low incomes				✓
Women with low literacy skills				✓

ANone@ no reference

AFew@ one to two references

ASome@ more than two references

AExtensive@ more than two references plus at least one analysis of the issue from a gender perspective

Note: These categories have been selected because they are consistent with data gathered for the National Population Health Survey.

Health Canada has recognized the importance of culture in determining the health of populations by including culture as a determinant of health. However this recognition is not reflected in the proposed National Population Health Indicators. While this data is more difficult to obtain than data disaggregated by sex, there is no reference at all to these issues in the proposed indicators, or to the data available in the National Population Health Survey. There is a need to make this data available to researchers and policy makers in order to deepen their understanding of how culture works, along with other determinants, including gender, to influence health.

Because some of the data to be included in the proposed Indicators will be standardized by age and sex, it may be possible to look specifically at the situations of young women and senior women, if sex and age specific rates are also included.

F. Inclusion of a Specific Focus on Women=s Needs or Concerns

Focus	Extensive	Some	Few	None
Focus on women=s physical health needs or concerns				✓
Focus on women=s mental health needs or concerns				✓
Focus on women=s social needs (e.g., social supports, financial issues)				✓

ANone@ no reference

AFew@ one to two references

ASome@ more than two references

AExtensive@ either more than two references plus at least one analysis of the issue from a gender perspective

Discussion

The lack of consideration given to gender as a determinant of health, and arising from that, to the presentation of data that would allow for the examination of the health needs and concerns of women and of men, is notable.

G. Health Services System Issues

Issue	Extensive	Some	Few	None
Recognition that women are more likely to be informal caregivers than men				✓
Recognition that women tend to be the guardians of the health of family members (children, elders, men)				✓
Recognition that women predominate as community health service volunteers.				✓

ANone@ no reference

AFew@ one to two references

ASome@ more than two references

AExtensive@ more than two references plus at least one analysis of the issue from a gender perspective

Discussion

There will not be data collected or presented about these issues, which are important to the health of women, in the Indicators, despite the fact that they are designed to measure both “health system performance” and “community and health system characteristics.” This contrasts with the work already done in *Toward a Healthy Future*, and may result in less gender sensitivity in future reports.

H. Evidence-based Decision-making and Evaluation

Issue	Extensive	Some	Few	None
Acknowledge the need for appropriate data about men and women for analytical and decision making purposes.				✓
Inclusion of indicators specific to Women's health		✓		
Inclusion of indicators specific to Gender equity				✓

ANone@ no reference

AFew@ one to two references

ASome@ more than two references

AExtensive@ more than two references plus at least one analysis of the issue from a gender perspective

Discussion

Rather than acknowledging the need for appropriate data about men and women for analytical and decision making purposes, the Indicators as proposed exclude the presentation of existing sex disaggregated data. These Indicators included which are specific to women's health are limited to reproductive health issues (such as Cesarean section rates and teen pregnancy rates) and conditions more common to women (such as breast cancer).

2. *Health Care in Canada: A First Annual Report, 2000*

The Annual Report

draws on data confirmed at the National Consensus Conference on Population Health Indicators in May, 1999, supplemented with quality local, regional, provincial/territorial, national and international research and evidence. (page ix)

CIHI states that this and future reports in the series:

will reflect the emerging consensus around appropriate indicators for comparative reporting and take advantage of the most up-to-date health information that exists and is being developed. (page ix)

It therefore presents us with an opportunity to evaluate the extent to which gender as a determinant of health, and women's health in particular, are presented in the reports based on the *National Consensus Conference on Population Health Indicators*.

The document contains no references to gender as a determinant of health. **The word "gender" appears nowhere in this document.**

The report contains the following references to women:

- \$ percentage of women physicians increasing (pages ix, 26 and 37);
- \$ occupational stress among women nurses (page 25);
- \$ Pap smears to screen for cervical cancers, including information that women with lower incomes and education, as well as younger women, are less likely to have Pap smears (pages xii, 36 and 37);
- \$ screening mammography for breast cancer detection, including information that women with lower incomes or education, or women without a regular family doctor were less likely to have had screening mammography (xii and 37);
- \$ women as caregivers, including information that more women than men are informal caregivers and that women spend on average more time in informal caregiving than do men (page 60);
- \$ hysterectomy rates (page 43);

- \$ Cesarean section rates, including information on vaginal birth after Cesarean section (page 42);
- \$ use of complementary and alternative care, including information that women are twice as likely to use these measures as men (page 38).

The Report contained the following references to men:

- \$ caregiving, including information that men are less likely to provide informal caregiving, and to provide fewer hours of care than women (page 60)
- \$ complementary and alternative medicine, including information that men are less likely to use these than women (page 38).

It is alarming to note that in comparison to the considerable gender consideration in *Toward a Healthy Future*, gender considerations were virtually absent in this later work.

Women's health, when it is considered, is defined very narrowly as conditions unique to women, or more common in women (such as breast cancer).

Without actively considering gender, and the ways in which the health needs and health status of women and men are different, and the ways in which they are the same, *Health Care in Canada: The Annual Report(s)* will not provide the necessary data or information required by various stakeholders including service providers, health researchers and policy makers at the regional, provincial/territorial and federal levels to improve the health of Canadians and to manage our health care system in a way which meets the needs of the population.

3. Roadmap Initiative...Launching the Process

The revised edition of this document, published jointly by CIHI and Statistics Canada, was produced in March, 2000. The approach is consistent with the other two CIHI documents reviewed above.

The introduction to the Report states that:

the Roadmap Initiative is designed to enable us to provide clear, confident answers to two basic questions:

- \$ *How healthy is Canada's health care system?*
- \$ *How healthy are Canadians?* (page 1)

The Report states that those involved in the Roadmap Initiative **must**:

- \$ *Support or facilitate the generation of information which serves to improve the health of Canadians or the quality, cost-effectiveness and accessibility of health care;*
- \$ *Provide a foundation for measuring performance and outcomes linked to health care and a better understanding of the non-medical determinants of Canadians' health;*
- \$ *Enable the creation, analysis and dissemination of the best possible 'evidence' from across Canada and around the world as a basis for informed decisions by patients, citizens, informal caregivers, health professionals, providers, managers, and policy makers; and*
- \$ *Assist individuals and communities to make informed choices about their own health, the health of others and the future of Canada's health system. (Preamble, unnumbered)*

As Health Canada has recognized in both its *Women's Health Strategy* and its *Gender Based Analysis Policy*, none of these things are possible without a thorough consideration of gender.

The Roadmap Initiative has missed this opportunity. Gender is mentioned once, on page 2 of the document, as a determinant of health. Unfortunately, that is the only reference in this document, which includes a listing of 41 data collection and reporting projects, grouped into five areas: A) Reports and Indicators Projects; B) Integrated Health Services Projects; C) Health Resource Management Projects; D) Infostructure and Technical Standards Projects and E) Population Health Projects.

The *Roadmap Initiative* contains one reference to women, in a description of the proposed enhancement to the Therapeutic Abortions Database (page 6). The only reference to sex disaggregation of data is in a description of the proposed enhancements to the Physician Resource Databases (page 13).

The objectives of the *Roadmap Initiative* will not be realized without adopting a gender and diversity framework for the health of Canadians, and applying that framework in considering all of the determinants of health, including the social and economic determinants of the health of women and men.

Health Canada's *Gender Based Analysis Policy* states:

- \$ *GBA is essential to understanding and applying health determinants theory because it explores the relationship between gender and the other determinants of health and how this relationship mediates health and health services.*
- \$ *GBA makes for good science and sound evidence by ensuring that biological and social differences between women and men are brought into the foreground.*
- \$ *Good science makes for good policy. Together they lead to better health for all Canadians.*
- \$ *Good policy safeguards human rights and Canada's commitments to ensuring that Canadians are served by the best possible health policies, programs and services. Good policy is particularly critical in a period of health system renewal. (Page 6)*

Yet, consistent with the approach taken in the two other CIHI documents reviewed for this project, gender is given virtually no consideration at all in *Roadmap Initiative*.

4. Conclusions: The Consideration of Gender in the CIHI Reports Reviewed

As noted above, none of the three CIHI documents reviewed give issues of gender in general, or women's health in particular, serious consideration. This seems unusual, given Health Canada's stated policies, and the expertise of the authors involved.

For an explanation, we turned to work by Patricia Kaufert, PhD, of the Faculty of Community Health Sciences at the University of Manitoba. In a recently published review of gender and population health, she described the authors of the major texts in population health as follows:

*A singularly well-informed group, its members will have known about gender differences in mortality and morbidity rates, women's differential use of health care services, and their relatively more difficult access to the determinants of health, such as employment and other forms of economic and social capital. Their decision to ignore women cannot be explained as a matter of chance or academic absent-mindedness. At some level, conscious or unconscious, the decision was made to ignore these differences, to treat them as taken for granted, no longer questioned, examined or viewed as problematic.*¹⁰ (page 123)

She described her experience in reviewing one of the founding works in population health, *Why are Some People Healthy and Others Not? The Determinants of Health of Populations* edited by R. Evans, M. L. Barer and R. Murrin (1994). In describing her review of Evans' book, she states:

Looking for the women, I had the odd experience of sensing their presence, while being unable to see them. For it was obvious that some of the deaths, as well as some of the poverty and wealth, on which these statistics are based involved women, but how many women, or where, or when, was impossible to tell. For epidemiologists and statisticians, the aggregation of data, or their adjustment for age or sex, are simply routine procedures. This approach is so commonplace I did not question it myself until deliberately hunting for the women and finding they were missing or hidden within an aggregated data set. In their own way, these analytic techniques are as effective as is the chador in concealing the female presence. Everyone knows she is there, but by being veiled she becomes invisible; people act as if she had no presence or voice or relevance. (pages 124 to 125)

¹⁰ Kaufert, Patricia, The vanishing woman: gender and population health, in Pollard, T and Hyatt, S, *Sex, Gender and Health*

There are several problems with CIHI's decision to exclude gender in their development of population health indicators for Canadians. These are:

1. Ignoring gender in the development of population health indicators and reports negatively affects the quality of research. As Kaufert noted in her discussion of the exclusion of women from the Whitehall 1 study of coronary heart disease among British civil servants:

The consequence for women was a dearth of scientific knowledge on the signs, symptoms, and best methods of diagnosing and managing heart disease in women. Physicians, trained to associate heart disease with men, tended to misdiagnose or ignore symptoms of heart disease in women. Being ignored was dangerous for women's health and bad medical science. Similarly, being invisible within the determinants of health model may prove deleterious for women and limit our understanding of the ways in which the determinants of health may function differently for women. (page 130)

There are many excellent research sources available for use by CIHI, including the work of the Centres of Excellence in Women's Health; the ongoing work of Vivienne Walters and Peggy McDonough, of McMaster University, conducting gender analyses of data from the National Population Health Survey, one of the major data sources referred to in the *National Consensus Conference on Population Health Indicators*; and the work of other Canadian and international scholars, including the English researchers Sara Arber, Ellen Annandale, Kate Hunt, Leslie Doyal and Sally Macintyre.

In particular, by not using Health Canada's 1999 Report, *Women's Health Surveillance: A Plan of Action for Health Canada*, CIHI has neglected an opportunity to build on the expertise and recommendations of the Advisory Committee on Women's Health Surveillance. It is timely to include this work since CIHI's initiative is a work in progress.

2. Ignoring gender is contrary to Canada's stated commitments to gender equality. Health Canada's *Gender Based Analysis Policy* states that:

The Government of Canada is committed to gender equality. Women and men, boys and girls, should benefit equally from the same rights and social status. 'To benefit equally' means that gender equality is rooted in results, not merely in providing the opportunities for achieving results. Canada's position on gender equality is enshrined in the Canadian Charter of Rights and Freedoms and in international and domestic documents. (page 3)

Health Canada's *Women's Health Strategy* states:

In keeping with the commitment in the Federal Plan for Gender Equality, Health Canada will, as a matter of standard practice, apply gender-based analysis to programs and policies in the areas of health system modernization, population health, risk management, direct services and research. (page 21)

Yet the reports reviewed, funded in large measure by Health Canada, unevenly reflect this commitment.

3. The Canadian Institutes of Health Research (CIHR) will require gender based analyses of data in order to determine research priorities. Without the collection of the data by CIHI, research proposals will be reviewed without the data necessary to determine research priorities for women and men, boys and girls. The efficient use of resources requires that the data gathering systems now being created include consideration of gender in order to inform future decision making. It will be much more expensive to try to add this in after the fact.
4. The lack of attention to gender has resulted in the total exclusion of the informal caregiving sector from CIHI's proposed population health indicators. Without an understanding of the work of informal, unpaid caregiving, their analysis of the health of Canadians, and especially that of women, who are both the major providers and the major recipients of informal care, is incomplete.

VII. Analysis of Health Canada's *Taking Action on Population Health*

This document gives direction to Health Canada's Population and Public Health Branch (formerly the Health Promotion and Programs Branch) staff about the implementation of a population health approach. It includes gender as a determinant of health (page 1) and notes that as our knowledge grows, the list of health determinants will likely evolve.

The document provides staff with eight Guiding Principles in the implementation of a population health approach (pages 6 - 11). These are:

1. Health is a capacity, a resource for everyday living.
2. The determinants of health are addressed recognizing that they are complex and inter-related.
3. The focus is upstream.
4. Health is everyone's business.
5. Decisions are based on evidence.
6. Accountability for health outcomes is increased
7. Management of health issues is horizontal
8. Multiple strategies, in multiple settings, in multiple systems and sectors are used.

It stresses the complex and interrelated nature of the determinants and the need to focus on root causes (pages 8-9) and the need for good research to support these decisions (pages 9- 10).

Ideally, the present health status of a population is analyzed and future health scenarios are developed as the basis of setting goals or targets to improve healthy outcomes for the entire population. Indicators of health status, as opposed to disease status, are needed for all the determinants of health. Changes in the rates or proportions in the population with improved health status can be measured and correlations made between these improvements and changes in the determinants of health for the defined populations.

The key is to identify what strategies or interventions will have the greatest 'upstream' impacts. To do this requires the foresight to know what is likely to determine health in the future, over both the short and long-term, and to invest now in ways that will reduce either the probability that a given health problem will occur, or that it will be further aggravated... (page 9)

The document supports the use of new measures of health, based on the analyses of both quantitative and qualitative data (page 11).

It then states that the first of four major challenges facing Health Canada in implementing a population health approach is *improving the information base for health and its determinants, and facilitating access to health information*. (page 21).

The current state of work on population health indicators will fall short in providing the data and information needed to achieve the objectives of *Taking Action on Population Health*.

Appendix 1

Revised Framework for Gender Analysis of Health Planning Documents

Revised Framework for Gender Analysis of Health Planning Documents

The original *Invisible Women* framework was revised for this project to include the following components:

- A. Recognition of the connections between gender and each of the other determinants of health
- B. Recognition of barriers to healthy behaviour or access to services
- C. Disaggregation of data by sex
- D. Articulating women=s health issues
- E. Diversity
 - 1. Acknowledging diversity
 - 2. Discussion of findings for women in specific groups
- F. Inclusion of a specific focus on women=s needs or concerns
- G. Health services system issues
- H. Evidence-based decision-making and evaluation

All the charts were applied to *Toward a Healthy Future* as they appear on the following pages.

A. Recognition of the Connections Between Gender and Each of the Other Determinants of Health (i.e., sex-disaggregated data plus discussion of how these may operate differently for women and men)

Determinants	Extensive	Some	Few	None
Income and social status				
Social support networks				
Education				
Employment and working conditions				
Social Environments				
Physical environments				
Biology and genetic endowment				
Personal health practices and coping skills				
Healthy child development				
Health services				
Culture				

- ANone@ no reference to the connection between gender and the determinant in question; no sex disaggregated data presented
- AFew@ one to two references to the connection between gender and the determinant in question or instances of sex disaggregated data
- ASome@ more than two references to the connection between gender and the determinant in question or instances of sex disaggregated data
- AExtensive@ either more than two references to the connection between gender and the determinant in question or more than two instances of sex disaggregated data plus at least one analysis of the issue from a gender perspective

B. Recognition of Barriers to Healthy Behaviour or Access to Services

Barriers	Yes	No
Lack of child care		
Lack of local services		
Lack of transportation		
Lack of flexibility of services (including health, social services, recreational opportunities, etc.)		
Cost of services		
Safety concerns (e.g., risk of violence)		
Language		
Preferred type of provider or service not available (e.g., midwife, smoking cessation program)		

C. Disaggregation of Data by Sex for the Following

Data type	Extensive	Few	None
Morbidity			
Mortality			
Service utilization			
Other - none reported			

ANone@ no sex disaggregated data presented
 AFew@ one to two instances of sex disaggregated data
 AExtensive@ more than two instances of sex disaggregated data

D. Articulating Women's Health Issues

Types of Women's Health Issues	Extensive	Some	Few	None
Conditions related to reproductive system and associated services				
Conditions more prevalent in women (e.g., breast cancer, osteoporosis) and related services				
Family and child health issues (e.g., parent-child issues)				
Woman-specific needs for diseases common among both women and men (e.g., heart disease)				
Women's health needs across the lifespan				
Woman-specific "healthy lifestyle" promotion concerns (e.g., tobacco reduction, healthy eating, physical activity)				
Holistic approach that goes beyond physical health (i.e., include mental, emotional and/or Spiritual health)				
Women's life situations (e.g., violence, poverty, child care responsibilities, housing, transportation, discrimination)				

ANone@ no reference
 AFew@ one to two references
 ASome@ more than two references
 AExtensive@ either more than two references plus at least one analysis of the issue from a gender perspective

E. Diversity

1. Recognition of Diversity as an Issue

	Yes	No
Acknowledgement of the diversity among women		
Examples or acknowledgement ways in which diversity interacts with gender and the other determinants of health		

2. Discussions of Diversity

Discussion of findings for women in any of the following groups	Extensive	Some	Few	None
Aboriginal women				
Francophone women				
Women from cultural groups from outside North America or Western Europe				
Rural women				
Single mothers				
Adolescents girls and young women				
Senior women				
Women who have experienced abusive relationships				
Women with disabilities				
Women living on low incomes				
Women with low literacy skills				
Others: (specify)				

ANone@

no reference

AFew@

one to two references

ASome@

more than two references

AExtensive@

more than two references plus at least one analysis of the issue from a gender perspective

F. Inclusion of a Specific Focus on Women's Needs or Concerns

Focus	Extensive	Some	Few	None
Focus on women's physical health needs or concerns				
Focus on women's mental health needs or concerns				
Focus on women's social needs (e.g., social supports, financial issues)				

ANone@ no reference
 AFew@ one to two references
 ASome@ more than two references
 AExtensive@ more than two references plus at least one analysis of the issue from a gender perspective

G. Health Services System Issues

Issue	Extensive	Some	Few	None
Recognition that women are more likely to be informal caregivers than men				
Recognition that women tend to be the guardians of the health of family members (children, elders, men)				
Recognition that women predominate as community health service volunteers.				

ANone@ no reference
 AFew@ one to two references
 ASome@ more than two references
 AExtensive@ more than two references plus at least one analysis of the issue from a gender perspective

H. Evidence-based Decision-making and Evaluation

Issue	Extensive	Some	Few	None
Acknowledge the need for appropriate data about men and women for analytical and decision making purposes.				
Inclusion of indicators specific to women's health				
Inclusion of indicators specific to Gender equity				

ANone@ no reference
 AFew@ one to two references
 ASome@ more than two references
 AExtensive@ more than two references plus at least one analysis of the issue from a gender perspective

Appendix 2

Data Selection in *Toward a Healthy Future*

Data Selection in *Toward a Healthy Future*

Overall, the main report -- *Toward a Healthy Future* -- draws information on sex differences from many other sources. These are listed for each chapter of the main report plus the statistical background documents. Organizations are included to show the diversity of sources of information. The reader is referred to the references for each chapter in *Toward a Healthy Future* for full citations. Sources are listed here in the order in which they are cited in the documents.

At the end of each subsection below, we also note references made to non-NPHS data sources in the statistical reports that supplement the main report.

We will not discuss information that comes from special tabulations of either the 1994-95 or 1996-97 NPHS data sets, or from the 1994-95 NPHS report. Though these sources are cited, we do not consider them to be external data sources for the purpose of this section.

For most of the statistics that come from the various sources reports listed below, the differences between women and men are presented at the descriptive level. There is little interpretation of why these differences occur. Sex-disaggregated data is the first step in conducting a gender analysis, but is not in itself sufficient.

Chapter 1. The Health Status of Canadians

Several additional sources of information about sex differences were cited in this chapter of the main report.

These include:

1. Health Canada, Mental Health Unit (1998), *Population Mental Health in Canada* regarding measures of psychological well-being
2. First Nations and Inuit Regional Health Survey National Steering Committee (1999), *First Nations and Inuit Regional Health Survey* (1997) on chronic health conditions in the Aboriginal population
3. Health Canada, Laboratory Centre for Disease Control (1998), *HIV and AIDS in Canada Surveillance Report 1997* about number of reported HIV/AIDS cases and deaths
4. Health Canada, Laboratory Centre for Disease Control (1998), *Epi Update: Estimates of HIV Prevalence and Incidence in Canada* on changing demographic of groups being infected (e.g., more women and Aboriginal people)

5. Canadian Institute for Health Information (1998), *National Trauma Registry Report: Hospital Injury Admissions* (1995-96) on hospital rates for injuries
6. Statistics Canada (year of publication not stated), *The Health of Canada's Immigrants* (1994-95) regarding relationships among gender, socioeconomic status and disability among immigrants
7. Statistics Canada, Health Statistics Division (1996) Unpublished Vital Statistics on deaths from cardiovascular disease
8. National Cancer Institute of Canada (1998), *Canadian Cancer Statistics*, on cancer deaths
9. Statistics Canada, Health Statistics Division (1997), *Health Indicators* regarding suicide rates
10. Health Canada (1994), *Suicide in Canada, Update of the Report on the Task Force on Suicide in Canada*, on attempted and completed suicides, including discussion of gays and lesbians and people who have experienced childhood sexual abuse.
11. Canetto and Sakinofsky (1998). The gender paradox in suicide. Research article in the journal *Suicide and Life-Threatening Behavior*, on fatal and non-fatal intentions
12. United Nations Children's Fund (1996), *Progress of Nations*, on international comparisons suicide rates
13. Fedorowycz (1998). Homicide in Canada, 1997. Research article in *Juristat* on homicide victims and accused persons
14. Ellison, May and Gibbons (1995). Projected smoking-attributable mortality rates in Canada 1991-2000. Research paper in *Chronic Diseases in Canada* (from Laboratory Centres for Disease Control) on smoking-related mortality
15. Statistics Canada (1998). *Compendium of Vital Statistics, 1996* on life expectancy
16. Chen, Wilkins & Eng (1996). Health expectancy by immigrant status, 1986 and 1991. Research paper in *Health Reports* (from Statistics Canada) on life expectancies of immigrant groups
17. Robine & Ritchie (1991). Healthy life expectancy: Evaluation of global indicators of change in population health. Research article in *British Medical Journal* that included discussion of disability-free years

18. Statistics Canada, Health Statistics Division (1999). *Health indicators* B potential years of life lost
19. United Nations Development Program (1998). *Human Development Report 1998*, on Canada's performance on various measures of human development B Human Development Index, Gender-Related Development Index, Human Poverty Index and Gender Empowerment Index

Most references cited in the statistical report sections "well-being", "general health and function" and "injuries" that mentioned sex differences were special tabulations of NPHS data. Reference "a" below is from the injury section. The remaining references cited that are external to NPHS or other previous health promotion survey data from Health Canada are taken from the sections entitled "conditions and diseases" and "death":

- a. Canadian Institute for Health Information (1998), *National Trauma Registry Report: Hospital Injury Admissions* (1995-96) on hospital rates for injuries by age group as well as sex
- b. Health Canada, Laboratory Centre for Disease Control, Bureau of HIV/AIDS, STD and TB, Division of STD Prevention and Control (no date) B special tabulations regarding trends over time in rates for syphilis, gonorrhea and chlamydia (sex differences are further disaggregated by age); trends in female AIDS cases over time
- c. Health Canada, Laboratory Centre for Disease Control, Bureau of HIV/AIDS, STD and TB (1998). *HIV and AIDS in Canada, Surveillance report to December, 1997* B trends over time in who is diagnosed with HIV infection B including more women
- d. Health Canada, Laboratory Centre for Disease Control, Bureau of HIV/AIDS, STD and TB (1998). Epi updates: HIV/AIDS epidemiology among Aboriginal people in Canada, May 1998 B regarding differences in AIDS cases attributed to injection drug use between Aboriginal and non-Aboriginal women and men
- e. Health Canada (1998). Notifiable diseases annual summary, 1996. In *Canada Communicable Diseases Report* B concerning rates of giardia, hepatitis A, *Salmonella* campylobacter, *E. coli* and shigella
- f. National Cancer Institute of Canada (1998), *Canadian Cancer Statistics*, on cancer deaths, on trends for incidence of and mortality from various types of cancer (breast, lung, prostate) over time, including age and provincial/territorial breakdowns
- g. Statistics Canada, Health Statistics Division (no date). Special tabulations B on cancer incidence and mortality rates for males and females age 60 and older; suicide rates; life expectancy at birth, trends over time, and relationship between life expectancy and age
- h. Heart and Stroke Foundation of Canada (1997). *Heart Disease and Stroke in Canada* B regarding provincial/territorial differences in cardiovascular disease mortality in females and males
- i. Statistics Canada, Health Statistics Division. Unpublished vital statistics standard tables for 1996. Special tabulations on deaths due to cardiovascular disease

- j. Johansen, Nargundkar, Nair & al. (1998). At risk of first or recurring heart disease. Article in *Health Reports* B concerning numbers of women and men hospitalized for acute myocardial infarction
- k. World Health Organization (1995). *World Health Statistics Annual* B regarding comparison of Canada's cardiovascular disease mortality rates with those of other countries
- l. Canadian Institute for Health Information (no date). *Mental Health Database 1995-96* B on hospitalization for various mental health conditions (neuroses, depression, affective psychoses, adjustment reaction, schizophrenia, alcohol/drug dependence
- m. Canadian Institute for Health Information (no date). *Hospital morbidity database, 1994-95 and 1995-96* B concerning rates of hospitalization for all causes (including pregnancy, as well as respiratory, circulatory, digestive, genitourinary and musculo-skeletal diseases, cancer, mental disorders, injuries or poisoning
- n. Statistics Canada (1998). *Compendium of Vital Statistics, 1996* B on infant, perinatal and early neonatal mortality
- o. Ellison, Morrison, deGroh et al. (1998). *Health Consequences of Smoking among Canadian Smokers: an Update* B projected future deaths from smoking
- p.. Traffic Injury Research Foundation (1997). Alcohol use among drivers and pedestrians fatally injured in motor vehicle accidents, Canada, 1995 B regarding legal alcohol impairment among drivers fatally injured in motor vehicle collisions
- q. Health Canada (1994). *Suicide in Canada: Update of the Task Force on Suicide in Canada* B concerning comparison of Canadian suicide rates with those of other countries, suicide rates by sexual orientation
- r. Statistics Canada, Health Statistics Division (1999). *Health Indicators* B regarding suicide rates and trends over time (including youth aged 15-24); all-cause mortality rates (standardized by age), includes sex-disaggregation of rates for provinces and territories; potential years of life lost
- s. United Nations Children's Fund (1996). *Progress of Nations 1996* B on comparisons between suicide rates of Canada and other countries
- t. Organisation for Economic Co-operation and Development (no date). *OECD Health Data 1998* B on comparisons of potential years of life lost and life expectancy at birth between Canada and other countries
- u. Statistics Canada (1998). Deaths 1996. Article in *The Daily* B regarding trends in life expectancy over time

Socioeconomic Environment

Sources external to the NPHS that were used to develop this chapter and that were discussed in terms of sex differences included:

1. Statistics Canada (1998), 1996 Census: Sources of income earnings and total and family income. Published in *The Daily*. Numbers and percentages of individuals and various family types living below Low Income Cut-off (LICO), income deficiency relative to LICO (depth of poverty)
2. Statistics Canada (year of publication not specified). *Low Income Persons, 1980 to 1996*, on income inequality between women and men over time, as well as between different age groups of women, as well as women's concentration in lowest paying occupations
3. Statistics Canada and the Organization for Economic Co-operation and Development (1994), *Literacy, economy and society: Results of the first international adult literacy survey*, regarding prose, document and quantitative literacy
4. Statistics Canada (1998). *The value of words: Literacy and economic security in Canada*, on the relationship between literacy and income
5. Statistics Canada (date not specified). *Labour force update: An overview of the labour market*, on part-time employment
6. Statistics Canada (1998). 1996 Census: Labour force activity, occupation and industry, place of work, mode of transportation to work, unpaid work. Article in *The Daily*. The present report cites statistics on employment (including self-employment) and unpaid household work, child care and care to seniors.
7. Statistics Canada (1998). 1996 Census: Sources of income, earnings and total income, and family income. Article in *The Daily*. Present report cites employment income.
8. Statistics Canada (1998). *Historical Labour Force Statistics, 1997*, on unemployment rates
9. Betcherman & Leckie (1997). *Youth Employment and Education Trends in the 1980s and 1990s*. Paper for Canadian Policy Research Networks. Present report cites youth unemployment and part-time work statistics.
10. Statistics Canada, Health Statistics Division (1996). Special tabulations from the Association of Workers Compensation Boards of Canada and Labour Force Survey, 1996, on workplace injuries

11. Statistics Canada, Centre for Justice Statistics (1997). *Assaults Against Children and Youth in the Family, 1996* on assaults on children reported to police
12. Statistics Canada (1993). *Violence against Women Survey*, on violence against women by intimate partners
13. Statistics Canada, Centre for Justice Statistics (1997). *Uniform Crime Reporting Survey, 1996* on spousal assaults reported to police
14. Statistics Canada, Centre for Justice Statistics (1997). *Family Violence in Canada: A statistical profile*. The present report cites their data on use of women-s shelters and predictors of wife assault.
15. Statistics Canada, Centre for Justice Statistics (1998). *Canadian Crime Statistics, 1997*, on spousal homicide
16. Statistics Canada (1998). *Crime Statistics*, on young men and women as perpetrators of violent crime
17. Hall, Knighton, Read et al (1998). *Caring Canadians,Involved Canadians: Highlights from the 1997 National Survey of Giving, Volunteering and Participating B* on volunteering for not-for-profit organizations, involvement in community organizations (such as school, church, recreation) and charitable donations
18. Messing (1994). Women-s occupational health: A critical review and discussion of the issues. Research article in *Women and Health*, on inequalities in earning, job security, satisfaction and control over work
19. Lee, Duxbury, & Higgins (1994). *Employed mothers: Balancing work and family life*. Paper for Canadian Centre for Management Development. The present report cites their statistics on stresses of balancing work and family.
20. Human Resources Development Canada (1998). *High school may not be enough: An analysis of the school leavers follow-up survey, 1995 B* the present report cites their statistics on high school drop out

The statistical report section on social and economic environment contains the following non-NPHS references that mention sex differences or female-specific issues. In cases where the statistical report refers to a document that is also cited in the main report, the number from the above list of main report references is noted.

- a. Statistics Canada (no date). 1996 Census: Postcensal population estimates. In *The Nation Series B* includes population of women and men in Canada
- b. Statistics Canada (no date). 1996 Census: Marital status, common-law unions and family composition. In *The Nation Series B* on family composition for older women
- c. Statistics Canada (1997). 1996 Census: Marital status, common-law unions and families. In *The Daily B* on family composition, including female and male lone parents
- d. Statistics Canada (1998). Births 1996. Reported in *The Daily B* on fertility rates (average number of children born live to women age 15-49)
- e. Health Canada, Health Statistics Division (1999). *Health indicators, 1999 B* on decline in birth rates (per 1,000 pop.) of at least past 25 years; changes in female and male labour force participation rates
- f. Dumas & Belanger (no date). *Report on the demographic situation in Canada, 1997: Current demographic analysis B* on fertility rates in Canada compared to women in other countries
- g. Statistics Canada (1999). *Compendium of vital statistics 1996 B* definitions of fertility rates and crude birth rates
- h. Statistics Canada (no date). 1996 Census: Education. In *The Nation Series B* on increase over time in women obtaining university degrees
- i. Ross, Scott & Kelly (1996). Overview: Children in Canada in the 1990s. In *Growing Up in Canada: National Longitudinal Survey of Children and Youth*. Prepared for HRDC and Statistics Canada B school readiness of boys and girls, mother and father characteristics associated with children's school readiness
- j. Willms (1997). *Literacy skills of Canadian Youth*. Prepared for International Adult Literacy Series B sex differences in scores on prose, document and quantitative literacy
- k. Statistics Canada (1998). 1996 Census: Sources of income. Article in *The Daily* – regarding female lone parents below the low income cut-off (LICO)
- l. Statistics Canada (no date). 1996 Census: Sources of income. In *The Nation Series B* on wage disparities between men and women
- n. Statistics Canada, Housing, Family and Social Status Statistics Division (no date). *Family expenditures survey, 1996 B* about average family income in various family types
- o. Statistics Canada (no date). *Historical Labour Force Statistics, 1970-1997 B* regarding trends in female and male labour force participation rates, including by age
- p. Statistics Canada (1998). 1996 Census: Unpaid work. In *The Daily B* on unpaid household activities of males and females
- q. Statistics Canada (no date). 1996 Census: Unpaid work. In *The Nation Series B* on unpaid household activities of males and females by employment status and presence of children

- r. Statistics Canada, Centre for Justice Statistics (1997). *Assaults against children and youth in the family, 1996*, on patterns of physical and sexual assault by sex of victim and relationship to perpetrator
- s. Statistics Canada, Centre for Justice Statistics (1998). *Canadian Crime Statistics, 1997* on spousal homicides
- t. Statistics Canada, Centre for Justice Statistics (1997). *Uniform Crime Reporting Survey, 1996*, on trends in family-related homicides over time
- u. Statistics Canada, Centre for Justice Statistics (1997). *Family violence in Canada: A statistical profile*, on circumstances of women living in shelters

Healthy Child Development

The following external sources were used to present (a) differences between groups of women on maternal-child issues or (b) differences between female and male children.

1. National Centre for Health Statistics (1998). *Health, United States, 1998 -- with socioeconomic status and health chartbook*, on the relationship between low birthweight and maternal education.
2. Connor & McIntyre (1998). How tobacco and alcohol affect newborn children. From a conference presentation at *Investing in children: A national research conference, 1998*. The present report cites statistics on age and marital status and relationship to birthweight, and the relationship income, education and age to smoking while pregnant
3. MacMillan, Walsh, Davidson et al (no date). Children's health chapter in *First Nations and Inuit Regional Health Survey*, regarding birthweight among Aboriginal people
4. Statistics Canada, Health Statistics Division (1999). *Health Indicators*, on teen pregnancy trends
5. Canadian Council on Social Development (1998). *The progress of Canada's children, 1998*, on teen pregnancy trends and funding for child care
6. Ketting & Visser (1994). Contraception in the Netherlands: The low abortion rate explained. Research article in *Patient Education and Counselling*, on effective strategies for preventing teen pregnancy
7. Kohen, Hertzman & Brook-Gunn (1998). Neighbourhood influences on children's school readiness. Prepared for Human Resources Development Canada, based on data from *1996-97 National Longitudinal Survey on Children and Youth*. Present report cites statistics on maternal education and neighbourhood safety as related to cognitive and behavioural competence when children begin school

8. King, Wold, Tudor-Smith et al. (1997). The health of youth: A cross-national survey, 1993-94. Prepared for *World Health Organization* report. Data cited in present report is on trends in unintentional injuries in school age children and psychological well-being in adolescence
9. Morrongiello (1998). Determinants of health: Children and youth, volume 1. Prepared for *National Forum on Health* report Canada health action: Building on the legacy, volume 1. Data cited in present report is on severity of injuries and possible reasons for sex differences
10. Offord & Lipman (1996). Emotional and behavioural problems. Prepared for report *Growing up in Canada: National Longitudinal Survey of Children and Youth*. Present report cites data on emotional and behavioural competence and relationship to family income
11. National Council of Welfare (1998). *Poverty Profile, 1996*, on child poverty in various family types
12. Statistics Canada, Canadian Centre for Social Justice Statistics (1997). *Assaults Against Children and Youth in the Family, 1996*, on physical and sexual assaults of children by family members
13. Statistics Canada (1993). *Violence Against Women Survey*, on how young women most likely to be sexually assaulted
14. Canadian Council on Social Development (1997). *The Progress of Canada's Children, 1997*, on teen perceptions of bullying

The section of the statistical report entitled "conditions and diseases" refers to the following sources external to the NPHS:

- a. Statistics Canada (1998). Births, 1996. In *The Daily B* on under weight newborns (includes by province or territory) and recent trends
- b. Statistics Canada, Health Statistics Division (no date). Special tabulations B on underweight babies (disaggregated by sex), trends in low birth weights among female and male babies over time, teen pregnancies (includes by age)
- c. Statistics Canada (no date). *Births and Deaths, 1995 B* on trends in low birth weight and teen pregnancies over time
- d. Organisation for Economic Co-operation and Development (no date). *OECD Health Data 1998 B* Canada's rate of low birth weight compared to other countries
- e. Statistics Canada, Health Statistics Division (1999). *Health Indicators*, on teen pregnancies and trends over time (includes breakdowns by age)

- f. Health Canada, Laboratory Centre for Disease Control, Canadian Congenital Anomaly Surveillance System (1997). *Birth Defect Prevalences in Canada, 1995* B regarding rates of stillbirths and types of birth anomalies per 10,000 births, including differences among provinces and territories
- g. Statistics Canada (no date). *Therapeutic Abortions, 1995* B concerning total and hospital specific abortion rates per 100 live births (including abortions among teens), provincial and territorial trends over time
- h. Statistics Canada (1997). "Therapeutic Abortions, 1995". In *The Daily* B regarding trends on abortion rates over time (also discusses changes in legal status for abortions and the availability of private clinics, age, previous delivery)
- i. Wadhera & Millar (1997). Marital status and abortion. Article in *Health Reports* B on abortion trends over time, by marital status

Physical Environment

The following sources reported sex differences in conditions related to the physical environment:

- 1. National Cancer Institute of Canada (1999). *Canadian Cancer Statistics, 1999* B concerning morbidity and mortality from melanoma
- 2. Statistics Canada (1996). *Sun Exposure Survey, 1996*, on self-reported sun exposure at work and leisure
- 3. U.S. Department of Health and Human Services (1994). *Preventing Tobacco Use among Young People: a Report of the Surgeon General* - on susceptibility of pregnant women, fetuses and young children to the harmful effects of environmental tobacco smoke
- 4. Health Canada (1994). *Survey on Smoking in Canada, Cycle 2* B on smoke-free workplaces and workplace smoking restrictions
- 5. Statistics Canada (1998). "1996 Census: Labour force activity, occupation and industry, place of work, mode of transportation to work, unpaid work". Reported in *The Daily*, regarding modes of transportation to work
- 6. Statistics Canada (1998). "1996 Census: Private households, housing costs, and social and economic costs of families". Reported in *The Daily*, regarding housing affordability (this citation does not refer to sex differences specifically, but does refer to lone parent families, who are most often female-headed)
- 7. Canadian Public Health Association (1997). *Position Paper on Homelessness* B refers to increasing number of women and children who are homeless

8. Beavis, Klos, & Carter (1997). *Literature Review: Aboriginal People and Homelessness*. Prepared for Canadian Mental Health Association B includes data on Aboriginal women
9. Environics (1998). *Survey of Canadians' Attitudes Toward Homelessness, June 1996, March 1997, and March 1998* B on public perceptions of homelessness trends and which groups are most likely homeless
10. Novac, Brown & Bourbonnais (no date). *No room of her own: A literature review on women and homelessness* B discusses relationship between homelessness and violence against women
11. Environics Research Group (1998). *The environmental monitor, 1998, Cycle 1*, regarding purchases of environmentally friendly products and use of energy saving strategies.

The statistical report section on the physical environment contains the following non-NPHS references that mention sex differences or female-specific issues.

- a. Statistics Canada, Housing, Family and Social Statistics Division (no date). *General Social Survey: Cycle 10 (1995)*, regarding smoking in the home and exposure of children to environmental tobacco smoke in the home, including relationship to parental education
- b. Clark (1998). "Exposure to secondhand smoke". *Canadian Social Trends*, concerning exposure of nonsmoking adults and teens to environmental tobacco smoke in the home
- c. Connor & McIntyre (1998). "How tobacco and alcohol affect newborn children" (conference presentation -- Investing in children: National research conference) on smoking prevalence among pregnant women

In addition, the statistical report section on lifestyle behaviour cited the following:

- a. Environics Research Group (1998). *The environmental monitor, 1998, Cycle 1*, B on buying environmentally friendly products, organic food and purifying household drinking water
- b. Environics Research Group (1998). *The environmental monitor, 1998, Cycle 4*, B on buying environmentally friendly products, organic food and purifying household drinking water

Personal Health Practices

The following sources reported sex differences in conditions related to the personal health practices:

1. Ontario Tobacco Research Unit (1997). *Monitoring the Ontario Tobacco Strategy: Youth and Tobacco in Ontario, 1997*, regarding trends in smoking rates over time among junior high and high school students
2. Province of Nova Scotia (1998). *Nova Scotia Student Drug Use, 1998*, regarding trends in smoking rates over time among junior high and high school students
3. Health Canada (1998). AIDS and HIV in Canada, from *HIV/AIDS Epi Update*, concerning AIDS cases attributed to injection drug use
4. Canadian Health Monitor, and Houston, Archibald & Sutherland (1997). Asexual risk behaviours are associated with HIV testing in the Canadian general population[®]. (Presentation at 7th Annual Conference on HIV/AIDS Research.) Data cited in present report is on percentage of women and men who engage in risky sexual behaviour and have never been tested
5. Chen & Miller (1998). Age of smoking initiation: Implications for quitting. Published in *Health Reports*, on effects of tobacco tax increases on youth smoking

NOTE: There were not a lot of external data sources regarding sex differences cited in this chapter. Most sex differences discussed were based on 1994-95 or 1996-97 NPHS data.

The statistical report section most closely related to personal health practices was the one entitled “lifestyle behaviours”. There were few additional sources other than NPHS data or previous Health Canada health promotion surveys. However, the following external references that mention sex differences or female-specific issues were cited:

- a. Health Canada, Information Access and Co-ordination Division, Policy and Consultation Branch (no date). *Canada's Alcohol and Other Drugs Survey, 1994 B* special tabulations on illicit drug use (sex differences were also broken down by age)
- b. Statistics Canada (no date). “1996 Census: Mode of transportation.” In *The Nation Series B* on riding a bicycle or walking to work

Health Services

The chapter on health services did not include citations from any external sources regarding sex differences. The sex difference data reported came primarily from the 1996-97 NPHS. There were occasional statements (that were not referenced) -- e.g., how that the shift from more inpatient to more outpatient services would impact women most B both as clients and as informal caregivers, and how short maternity stays can create difficulties for new mothers who do not have support at home.

The statistical report section on health services contains the following non-NPHS references that mention sex differences or female-specific issues:

- a. Miller, Anderson, Brisson et al. (1991). "Report of a national workshop on screening for cancer of the cervix." Article in *Canadian Medical Association Journal* B includes recommendations for screening
- b. Workshop group (1989). "Reducing deaths from breast cancer in Canada." Article in *Canadian Medical Association Journal* B includes guidelines for screening
- c. Canadian Institute for Health Information (1994). *National Physician Database, 1993-94* B on number of physician visits for males and females
- d. Health Canada, Laboratory Centre for Disease Control, Division of HIV Epidemiology (1997). *Canada Health Monitor* survey B on testing and condom use
- e. Houston, Archibald & Sutherland (1998). "Sexual risk behaviours are associated with HIV testing in the Canadian general population". Presentation at Canadian Conference on HIV/AIDS research B on testing and condom use

The statistical report section entitled "personal resources and coping" dealt with caregiving and use of home care services, so we have included it here under health services. External references that addressed sex differences are as follows:

- a. Statistics Canada (1997). General Social Survey, Cycle 11, 1996. Article in *The Daily* B includes who receives care, suggested incentives to help people provide care (such as financial compensation)
- b. Statistics Canada, Housing, Family and Social Statistics Division (no date). General Social Survey, Cycle 11, 1996. (Special tabulations from public microdata file) - on who receives care, self-reported impact of providing care on social activities, expenses, holidays, relocation, own health, employment, and time for self; positive feelings about caregiving (e.g., strengthening relationships), self-rated degree of burden B sex differences were analyzed by several age categories, but the survey did not assess time spent providing informal care
- c. Statistics Canada (no date). 1996 Census: Unpaid work. In *The Nation Series* B on who provides care to children, seniors and people with long-term health problems (differences by age, province and family type did not look at these differences by sex, though differences by employment status were sex-disaggregated)

- d. Cranswick (1997). "Canada's caregivers". Article in *Canadian Social Trends* B covers perception of caregiver burden, by family and employment status
- e. Wilkins & Park (1998). "Home care in Canada". Article in *Health Reports* B on who uses home care, adjusted by age and health conditions

Biology and Genetic Endowment

External sources cited in this chapter referred not only to sex differences, but in some cases to women specifically in the context of reproductive issues.

1. Cohen (1987). Neural tube defects: Epidemiology, detection and prevention. *Journal of Obstetrical and Gynaecological Neonatal Nursing*, regarding the role of folic acid in reducing birth defects
2. Ashley (1994). Alcohol-related birth defects. In the report *Aboriginal Substance Use: Research Issues*. Data cited in the present report pertained to fetal alcohol syndrome and individual differences in women's susceptibility to effects of alcohol
3. McKenzie, D. (1997). Fetal alcohol syndrome. *1997 Canadian Profile: Alcohol, Tobacco and Other Drugs*. Prepared for Canadian Centre on Substance Abuse and Addiction Research Foundation of Ontario. Data cited in present report is on social influences (family, friends, adverse situations) on drinking during pregnancy.
4. MRC, NSERC & SSHRC (1998). *Tri-council Policy Statement: Ethical Conduct for Research Involving Humans*, regarding ethics of new reproductive technologies (including sex selection)
5. Health Canada (1996). *New Reproductive and Genetic Technologies: Setting Boundaries, Enhancing Health*, regarding how NRT's are especially a of concern for women because the technologies are performed on women's bodies as well as implications of commercialization related to women's socioeconomic status
6. Engel (1993). *The Complete Canadian Health Guide*, regarding susceptibility of adolescent women's immature genital tract to organisms that cause STD's
7. Chappel (1997). Maintaining and enhancing independence in old age. In National Forum on Health report *Determinants of Health: Adults and Seniors*, regarding women most often providing informal care, as well as protective effects of social support from negative effects of serious illness
8. Canadian Institute for Health Information (no date). *Hospital Morbidity Database, 1995-96*, regarding reasons for admission to hospital

9. Wilkins & Park (1998). Home care in Canada. In the journal *Health Reports* from Statistics Canada, on use of publicly-funded home care
10. Health Canada (in press). *Risk of Social Isolation*. Prepared by Statistics Canada, Family and Community Support Services Division, regarding widowhood as increasing risk of social isolation (along with disability, low education and being a new Canadian or having a cultural background other than French or British)
11. Health Canada (1996). *The Broader Determinants of Healthy Aging: a Discussion Paper*, regarding how older “ethnic” women who are widowed are at especially high risk for social isolation
12. Steinhauer (1998). Developing resiliency in children from disadvantaged populations. In National Forum on Health report *Determinants of Health: Children and Youth (Volume 1)* on importance of providing support to parents B including prenatal care and treatment for maternal depression, as well as support for families facing adverse circumstances such as poverty and abuse

Improving Health

The following sources were cited pertaining to sex differences or female-specific references as they apply to recommendations for improving health:

1. Steinhauer, P. (1998). Developing resiliency in children from disadvantaged populations. *Determinants of Health: Children and Youth, Volume 1*. Report for National Forum on Health. Discussion includes reference to supporting pregnant women and new mothersB including outreach to pregnant women regarding social support, information, food and protection to pregnant women who are isolated, impoverished or otherwise distressed.
2. McDaniel, S. (1998). Toward healthy families. *Determinants of Health: Settings and Issues, Volume 3*. Report for National Forum on Health. Discussion of this reference includes reference to supporting parents to both support their families and spend time with children B including positive parenting, access to high quality child care, neighbourhood safety and tax policies.
3. Anisef, P. (1998). Making the transition from school to employment. *Determinants of Health: Children and Youth, Volume 1*. Report for National Forum on Health. Discussion of this reference includes mention of preventing of teen pregnancy.
4. Sullivan, Uneke, Lavis et al. (1998). Labour adjustment policy and health: Considerations for a changing world. *Determinants of Health: Settings and Issues, Volume 3*. Report for National Forum on Health. Discussion of this reference includes mention of pay equity.

REFERENCES

- Berkman, L. F. & Kawachi, I. (Eds.) 2000. *Social epidemiology*, New York: Oxford University Press.
- Campbell, J. Bruhm. G. and Lilley, S. *Caregivers' Social Support Needs*, Maritime Centre of Excellence for Women's Health, 1998.
- Canadian Institute for Health Information, *National Consensus Conference on Population Health Indicators*, 1999
- Canadian Institute for Health Information, *Health Care in Canada, A First Annual Report, 2000* and available at <http://www.cihi.ca>
- Canadian Institute for Health Information, *Roadmap Initiative...Launching the Process*, Revised March 2000 and available at <http://www.cihi.ca>
- Evans, R. G., Barer, M. L. and Marmor, R., 1994. *Why are Some People Healthy and Others Not? The Determinants of Health of Populations*, New York: Aldine De Gruyter
- Federal, Provincial and Territorial Advisory Committee on Population Health *Toward a Healthy Future: Second Report on the Health of Canadians*. 1999
- Federal, Provincial and Territorial Advisory Committee on Population Health *Statistical Report on the Health of Canadians*, 1999
- First Nations and Inuit Regional Health Survey National Steering Committee, *First Nations and Inuit Regional Health Survey*, 1999
- Hawe, P. & Shiell, A. 2000. Social capital and health promotion: A review. *Social Science and Medicine*, 51, 1-15.
- Health Canada, *A Second Diagnostic on the Health of First Nations and Inuit People*, November, 1999 and available for downloading at: http://www.hc-sc.gc.ca/msb/fnihp/index_e.htm
- Health Canada, *Gender Based Analysis Policy*, 2000 and available at: <http://www.hc-sc.gc.ca/women/english/gba.pdf>
- Health Canada, *Women's Health Strategy*, 1999 and available at: <http://www.hc-sc.gc.ca/women/english/womenstrat.htm>

Health Canada, *Women's Health Surveillance: A Plan of Action for Health Canada*, Report from the Advisory Committee on Women's Health Surveillance and available at:

<http://www.hc-sc.gc.ca/hpb/lcdc/publicat/whs-ssf/index.html>

Janzen, B. L., *Women, Gender and Health: A Review of the Recent Literature*, Prairie Women's Health Centre of Excellence, 1998

Kaufert, P. The Vanishing woman: gender and population health, in *Sex, Gender and Health*, Cambridge University Press, 1999

Krieger, N., Discrimination and health, in L. F. Berkman & I. Kawachi (Eds.), *Social epidemiology* (pp. 36-75). New York: Oxford University Press, 2000

Lee, C., Duxbury, L., Higgins, C. *Employed Mothers: Balancing work and Family Life*. Ottawa: Canadian Centre for Management Development, 1994

Link, B. G. & Phelan, J., Social conditions as fundamental causes of disease, *Journal of Health and Social Behavior* (Extra issue), 1995, pp 80-94

Lorber, J, *Paradoxes of Gender*, 1996: New Haven, CT: University Press.

Macintyre, S., Maciver, S. & Sooman, A. Area, class and health: Should we be focusing on places or people? *International Social Policy*, 1993: 22, pages 213-234.

Messing, K., Women's Occupational Health: A Critical Review and Discussion of the Issues. *Women and Health* 25, 4 (1994): 39-69

Mustard, C., Kaufert, P., Kozyrskyj, A., and Mayer, T. Sex Differences in the Use of Health Care Services *New England Journal of Medicine* 338 (1998), pp 1678-1683.