

WOMEN'S HEALTH, WELLNESS, AND EQUITY IN VANCOUVER AND THE DOWNTOWN EASTSIDE

AN ENVIRONMENTAL SCAN FOR DECISION-MAKERS
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LAND ACKNOWLEDGEMENT

A report on women's health in the Downtown Eastside cannot be researched or written without considering the health inequities that Indigenous women face in Canada. The release of this report is situated in the wake of the 2015 Truth and Reconciliation Commission of Canada findings on the Residential School System for Indigenous children and the declaration of Vancouver as a City of Reconciliation in 2014. We acknowledge that the work done during this project took place on the ancestral land of Coast Salish peoples and as such we conducted our research using a social-justice, feminist, decolonizing theoretical framework. We are firm in our belief for Indigenous self-determination, and trauma and violence informed supports for Indigenous women living in Vancouver. We also believe that it is important to situate our work in the rich history of the women's movement in the Downtown Eastside that have sustained events such as the Valentine's Day Memorial March for Murdered and Missing Indigenous Women.

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MESSAGE FROM THE EXECUTIVE DIRECTOR

It is with great pleasure that I've seen this project come to fruition. It has been the perfect example of a the intersection of timing and opportunity: I was fortunate to be selected by the Canadian Women's Foundation (CWF) for their 2015-2016 Leadership Institute, a 1-year program offered through the Coady International Institute. As part of our curriculum, each participant had to submit an Organisational Capacity project and received a small grant from CWF to implement it. At VWHC, we were in the early stages of developing a new strategic plan - so what could better increase our capacity as an organisation than to position ourselves within our community and our network of partners?

My goal through the organizational capacity project was to get a clearer picture of where our organisation fits within the Vancouver Downtown Eastside (DTES)/women's services landscape, identify strategic trends or opportunities for VWHC, and of course, share the findings with our community partners and stakeholders. My heartfelt thanks to all who provided input and generously shared their knowledge and expertise. A special thank you goes to Taq Bhandal for taking the lead on this project, with the support of Lisa Cao and Nicole Lemire.

France-Emmanuelle Joly
Executive Director, Vancouver Women's Health Collective

1. INTRODUCTION TO THE REPORT

The Vancouver Women's Health Collective (VWHC) is a volunteer driven non-profit organization located in the Downtown Eastside of Vancouver, BC. The VWHC was started in 1971 by a group of women wanting to take back agency in their own health, and unsatisfied with the male-dominated, biomedical model of health care.¹ Though it began as a small support system, the VWHC has turned into a women's health resource centre where women can access a variety of wellness programs including yoga, hula hooping, and counselling and receive information on additional resources related to housing, food security, employment, and legal aid in a supportive environment.² In addition, the VWHC hosts a Nurse Practitioner's Community Clinic in partnership with BC Women's Hospital (an agency of the Provincial Health Services Authority) to improve access to health care for women. Over the years, the VWHC has been active in a variety of ways based on women's needs, the political climate, our volunteer power/expertise, and funding. In the last 5 years the VWHC has shifted from being a space that serves women who were assigned female at birth to a space that welcomes all self-identified women. As we move into a period of growth and roll out our new three-year strategic plan at our Annual General Meeting in September 2016, we want to continue to play an important role in advancing women's health in our neighbourhood and city. We want to continue to contribute to the collective work of feminist non-profit organizations, funding bodies, health authorities, and other collaborators servicing the Downtown Eastside and Vancouver more broadly.

This report documents the findings of a research project approved by the St. Francis Xavier University Ethics Board and funded by the Canadian Women's Foundation through the Women's Leadership Institute. Using qualitative methods, the purpose of the project was to gain an understanding of where our organization fits within the constellation of social and health care services available to self-identified women in the Downtown Eastside (DTES) and Vancouver. Moreover, to document the experiences, perspectives, and opinions other community organizations and VWHC stakeholders who are working to achieve health, wellness, and equity for women in our city. The findings in this report highlight some of the challenges for health care providers, women working in feminist non-profit organizations and funding bodies, women accessing the health care system, and policy-makers. Situating the role of the Vancouver Women's Health Collective and contributing partners involves contextualizing the project's findings within the history of the DTES, contemporary research, and policy frameworks. We hope to provide important information for decision-makers and make a contribution to discourses/debate about this neighbourhood³ in the wake of Vancouver's housing crisis and upcoming provincial election.

2. METHODS, QUESTIONS, AND OUR PROJECT PARTNERS

Contributors to this project included stakeholders in the VWHC and other community partners in Vancouver. In addition to feedback from the VWHC Board of Directors, we conducted two focus groups and three interviews with key informants from 15 different women's health and women's equity organizations servicing women across Vancouver, including the Downtown Eastside. The focus group and interview questions focused on identifying: (1) priorities and

challenges currently facing the advancement of women’s health equity in Vancouver and specifically in the Downtown Eastside; (2) innovations which are emerging to address these challenges, and (3) the role of the VWHC in advancing women’s health equity in Vancouver. The focus groups and interviews aimed to balance differences in race, ethnicity, gender, sexual orientation, and age among participants. All data was tape recorded and transcribed verbatim by one of the co-investigators. Organization, moderation, and analyzing of data used inductive methods described by Hesse-Biber (2013) and Ezzy (2002).⁴

The participants in this project varied greatly in the range of positions they had within their respective organizations, the years they had been working in their respective organization, and their participation in women’s movements from the 1970s until now. It should be noted that the mandates of our partners cover a wide range of perspectives, programming, and service. Some serve the DTES, some all of Vancouver and the Lower Mainland, and some serve all of BC, in addition to all different genders, ethnicities, orientations, and ages.

TABLE 1. LIST OF PROJECT PARTNERS

- | | |
|---|--|
| ▪ Women Against Violence Against Women | ▪ Central City Foundation |
| ▪ BC Women’s Hospital - Nurse Practitioners | ▪ Network of Inner City Community Services Society |
| ▪ Providing Alternatives Counselling and Education (PACE) Society | ▪ Every Woman’s Health Centre |
| ▪ Elizabeth Bagshaw Women’s Clinic | ▪ Options for Sexual Health |
| ▪ BC Centre of Excellence for Women’s Health | ▪ Vancouver Aboriginal Friendship Centre |
| ▪ Atira Women’s Resource Society | ▪ Vancouver Status of Women |
| ▪ WISH Drop-In Centre Society | ▪ Oak Tree Clinic |
| ▪ DTES Community Pharmacist | |

3. THEORETICAL FRAMEWORK

Advocates and scholars globally have worked to expand the definition of what is commonly understood as health; moving beyond a focus on women’s actual, potential, and non-maternity to the social determinants of health and the ways in which social inequities affect health.⁵ Leslie Doyal states, “any artificial and sustained constraint on an individual’s ability to relate to people [...] will constitute serious and objective harm”.⁶ Illness is not just a physical state, but also a social phenomenon; illness disrupts both the physiology of the body and our social lives.⁷ For women, constructions of their sex and gender, and the interactions between the two, often dictate their everyday experiences of health. From an *intersectionality* framework, any attention given in this manner to women’s health should consider how race, gender, colonialism, Indigeneity, culture, income, education, sexuality, age, migrant status, geography, etc. dictate women’s position within specific locations, times, spaces, and relations. Coined by black feminist and other racialized women scholars, the ultimate goal of intersectionality research is to reveal how hierarchies of power, structural oppression, and social identity are mutually constructed and construct women’s lived experiences.⁸ It is important to consider the statistics presented below within the context of globalization, transnational capitalism, trade

agreements, exploitation in health human resource circuits, and other political and economic trends related to neoliberalism.

In Canada, inequities based on sex/gender and other axes of exclusion continue to exist in health and health care. Indeed, leading health researchers show that despite women's greater use of the health care, they experience poorer treatment in the system, are underrepresented in health research and policy making, are more likely to be exposed to gender-based violence and discrimination.⁹ Notably, a newly published study from researchers at UBC surveying over 12,000 people shows that gender inequalities continue to exist among adults living in British Columbia.¹⁰ Moreover, despite representing the majority of the health care labour force, women are more likely to be under-paid, and under-valued in their health care work.¹¹

Public health researchers and psychologists describe how health and its determinants can contribute to a cycle that extends to effect women's everyday lives and the lives of those around her. For example, low socio-economic status (SES) is shown to be strong predictor of poor physical and psychological health, when measuring cognition, brain development, mental health, and even gastrointestinal health.¹² SES also has important implications for interpersonal, psychological, and physical health of women and their families. For example, when women experience inequities in SES it affects the care of children, parents and other elders, responsibilities of the household, her possible job and career, and the ability to overcome adversity become more difficult.

The Vancouver Women's Health Collective aims to empower all women in Vancouver in the context of these inequities to take charge of their own health. As the very first women's health organization to take up feminist self-help strategies, our focus is specifically on underserved and under-represented women.¹³ Our understanding of underserved extends beyond differences based on income-level and we aim to serve all self-identified women who feel that their health and health care needs are not being met. We recognize that all women can experience barriers to achieving their self-determined wellness goals regardless of socio-economic status, sexual orientation, varying gender identities, race/ethnicity, or ability. At the same time we are located on West Hastings Street in the Downtown Eastside. As such, we do serve a fair number of women who experience a disproportionate amount of social, political, economic barriers such as lack of access to nutritious food, lack of access to safe and affordable health care, inadequate housing, poverty, trauma, addictions, etc.¹⁴ It should be noted that approximately 40 percent of the Downtown Eastside residents are female.¹⁵ Similarly, roughly 10-40 percent of the population are Indigenous.¹⁶ As such, in this report and in our approach we draw on the theoretical framework of intersectionality. Overall, the design of this study aligns with the values embedded in this framework. The women that we, and our partners, serve and work alongside have varying experiences, identities, and perspectives.

4. A NOTE ON “STUDYING” THIS NEIGHBOURHOOD

While this study does aim to present women's health concerns across Vancouver, the DTES is where our center is located and often where the most vulnerable women live. There is no dearth in literature on Vancouver's “downtown eastside”. A quick search of UBC's repository of

theses, dissertations, and other UBC community reports yields a result of 3332 hits. Indeed, a variety of disciplinary approaches have been taken to ‘study’ this important area with implications for feminist, non-profit organizations and their funders, public health administrators, other policy makers, and social justice scholars and advocates. Not to mention what a search of newspaper clippings, peer-reviewed articles, hashtags, and just general talk around the block would reveal. While trying to unravel some of these meanings, it is important to remember that the “downtown eastside” as a phrase is very much linked to the everyday lives of the women that have lived and/or worked there for at least the past fifty plus years.

5. CAPACITY, WOMEN’S WORK AND FEMINIST, NON-PROFIT ORGANIZATIONS

“I think the thing is that a lot of the work that we do it is not tangible. You can’t measure it. A lot of it is relationship based, I think it needs to be acknowledged that to do this work, it’s more than a job, it’s like a commitment, it’s a philosophy, it’s a way of being”

Self-identified women make up the vast majority of employees in feminist, non-profit organizations working in Vancouver, though the representation of women is different across health authorities and funding bodies. Nationally, women make up 80 percent of those working in the field of “health”.¹⁷ There is literature across Canada and internationally on the gendered aspects of women as care workers that this report will not go into, however it is important to note that feminist non-profit organizations perform a form of carework, and often face the brunt of cuts to public spending.¹⁸ Many of our partners are champions in offering low-barrier forms of employment for women from many different socio-economic and gendered experiences. Additionally, women working within issue-specific organizations are experiential in some capacity with that issue, whether it be sex work, mental health work, addictions work, violence against women prevention and support work, and so on.

In the qualitative data, the theme of supporting women as employees and the strategies to do this came up in several ways. Due to the nature of the work (as put beautifully by one of our participants and recounted above), social justice oriented non-profit organizations in Downtown Eastside operate not just as a particular service but rather as community building spaces. As one participant put it, we are “supporting the people who come through the front doors in their self-defined goals.” Our partners describe their work as being based on building relationships and trust, not only between them and their clients, but also within their own teams. Open communication among staff and volunteers and collective decision-making were described as important values, in addition to treating colleagues and clients with respect.

“I think that this is the sense, that the charity model still persists in that way. And it also I think feeds into our sense of what we deserve quote unquote, which we often get stuck around that”

Social justice non-profit organizations in Canada have a history stemming from a model of charity and philanthropy.¹⁹ However, since the feminist movements in the 1970s and onwards, organizations with a focus on women have taken progressive approaches to their operations and governance. Through public education, we have been instrumental to the project of women’s equity. If you look at the history of our organizations, there are a few that have been around for 50 years and longer, but the majority of them were founded in the last 30 years.

Over this time period, feminist non-profits have pushed for access to reproductive and sexual health services for all women, health services and public education for HIV/AIDS, increased government supports for women as mothers and workers, supervised injection sites, etc. Problematically, since the late-nineties, funding pools for feminist, non-profit organizations in Vancouver have decreased in concert with the slow dismantling of public supports. Moreover, in the current housing market these groups are competing against big buyers for prime downtown real estate. This is a particularly troubling trend, given the stated importance of safe, affordable housing for women living in the Downtown Eastside.

In this time of tight budgets, our organizations are thinking about new ways to mitigate the undervaluation of this work. One strategy has been to be reflexive in the hiring, training, and supporting process of new employees and volunteers. To give an example, different organizations have approached the risk of employee burn out by:

- Adding the question “do you have a wellness plan” onto their interview guides
- Extensive, several week long volunteer training
- Very strong commitment to addressing compassion fatigue
- Making connections with other non-profit organizations to ensure follow up with clients and make positive changes

At the same time, our participants stated that having the financial resources to fully support staff and have enough staff members is an increasing challenge. Some organizations have started social enterprises or put extensive resources into fundraising, but overall non-profit organizations require more core funding, particularly for hiring, training, and maintaining their staff capacity. This is an important consideration for governments, given data that continues to show negative impact of dissolving state-funded programs on women’s equity. As many of our organizations are access points for more than just health care, ensuring that the work of feminist non-profit organizations is supported financially would mean supporting groups who service the social determinants of health in addition to access to health care. Both mainstream health promotion and progressive feminist, decolonial literature continues to demonstrate the importance of considering women’s social locations across different axes such as sex, gender, race, ethnicity, ability, sexual orientation, migrant status, and so on.

For example, a number of our partners working in sexual and reproductive health services have found that there is a growing disjuncture between the capacity for STI testing and the demand for it. One of our partners based in BC is the largest non-profit provider of sexual health services. At the moment, the waiting list at their lower mainland clinics for STI testing is 3-6 weeks. Others who focus on contraception and abortion have found that they are turning women away who need STI testing done. This is partially related to the ability to recruit health care professionals to work in a public health unit, who would make more money working in a hospital setting. Matching salaries for nurses, physicians, pharmacists, and others working in the public health sector is important for providing necessary prevention, education, and testing services.

In another example, one of our partners keeps a listing of low-barrier lawyers accessible to women in need of legal support, however because of a lack of funding the staff are not able to prioritize keeping that list updated. Research from Westcoast LEAF demonstrates that affordable or pro bono civil and criminal legal aid across Canada is in decline.²⁰ In British

Columbia, government funding for legal aid has been cut by almost 50 percent, with the most affected services being family and poverty law.²¹ Additionally, the eligibility criteria allowing legal aid has become significantly more restrictive, including a lowered monthly income cut-off and a necessity that violence or the fear for one's safety must be present in order to access family law legal aid. As a result, women, whose need for legal services primarily lies in family and poverty law, are increasingly being denied legal assistance; BC remains the least successful province in terms of per-capita legal aid.²² The organization gave BC a D for 'women and access to justice' in their 2016 report card rating the province's progress in the areas enshrined in the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).

Within our organizations, we are continuing the important discuss of what it means to serve 'women'. Indeed, since the 1970s feminist, non-profit organizations have been consciously reevaluating their gender policies and the construction of gender in general. As more and more literature, advocacy, and experience is emerging related to the experiences of people identifying as transgender, lesbian, queer, gender variant, gender non-binary, two-spirit, and other sexual orientations and genders the notion of 'women's only spaces' is a becoming an increasingly inclusive but also contested topic. Another important ongoing conversation that we continue to have is about our relationships and connections with each other. Interestingly our findings show that the Vancouver Women's Health Collective in the last 5 years has had a low level of visibility within the environment of feminist non-profit organizations in the DTES. This could be in part due to the 2010 activist struggle for trans-women's representation in Lu's Pharmacy – a previous social enterprise of the VWHC. At this time, Lu's Pharmacy operated under a women born women only policy. The VWHC gender policy remains an ongoing discussion with our Board of Directors. We maintain that we are a space for all self-identified women, while also recognizing the paradoxes of having feminine-centric space with blurry edges.

6. PRESSING WOMEN'S HEALTH CONCERNS

"I think a huge part of it is just that women- there's a fatigue of trying to explain yourself to a healthcare care professional over and over again, and even myself, having to navigate all the loopholes, or all the different types of specialists. It's something that you have to find strength and power within yourself to keep moving forward with your health concerns..."

We define health as comprising the mental, physical, emotional, and spiritual wellness of women. When asked the question about the major concerns to women's health that our partners are hearing from their clients or seeing in their work, a number of key issues came up. The following descriptions of these concerns are by no means comprehensive. There are a number of studies, reports, and books that can be read to fully comprehend the scope of these concerns and the different contexts in which they exist in the Downtown Eastside, Vancouver, British Columbia and beyond. For the purposes of this report, we briefly highlight some of the main themes and immediate needs described by our Partners. It should also be noted that despite the barriers that women in the Downtown Eastside and Vancouver are up against, the VWHC and our partners continue to see the agency that women exert over their own health. Many of our partners shared narratives that demonstrate the resiliency of women.

FIGURE 1. PRESSING WOMEN'S HEALTH CONCERNS

1. Racialized, gendered, and classed discrimination
2. Not enough safe places for women
3. Holistic approaches to primary health care and health promotion
4. Stress management and coping with trauma
5. Over prescription of drugs
6. Educating women about health and accessing the system

6.1 RACIALIZED, GENDERED, AND CLASSED DISCRIMINATION

“Absolutely, and just, and even, that moment of watching a practitioner go through your file, and wondering what they think of you, and the choices you’ve made as a person, and yeah... a lot of things kind of put you on display. And it just gives women that sense of insecurity and it shouldn’t be that way because healthcare should be a safe place where women can, you know, feel free to express whatever they need and whatever’s bothering them in order to achieve that sense of well-being again, you know?”

Discrimination and judgment were noted as significant health concerns for women, particularly for women who are sex workers, trans-women, women of colour, and Indigenous women. When it comes to parenting, if women are HIV positive, sex-workers, and/or using substances, their roles as mothers are largely erased. Our partners described the tense relationship between the Ministry of Child and Family Development, Vancouver Aboriginal Child & Family Services Society, the disproportionate removal of Indigenous children from their homes, and women’s mistrust of the child welfare system. One of our partners states, “for some reason they don’t seem to think that women in this community have the ability or the capacity to parent. And so the scrutiny becomes, it breaks down the confidence of the moms and then they start questioning their own abilities.”

Women from the Downtown Eastside also face discrimination in the health care system. Given the complex nature of their health needs that do not conform to the dominant structures of health care delivery, these women are often considered flakey, dis-organizing, and generally as ‘not having it together’. For example, participants state that many women from the DTES face judgment from physician specialists. One partner described, “we’re trying to write letters back to specialists who are saying you know this is the population, these are the barriers, we don’t think it’s fair that you charged them 150 dollars when they don’t show up for their appointment.” Many of our partners describe that these women’s lives (and really any women’s lives) are often contradictory to the ways in which appointment scheduling, long wait lists, health care hours, and the medicalization of health currently exist.

In their narratives about Indigenous women and youth in particular, our partners suggest that Indigenous community members continue to face ongoing disenfranchisement as a result of colonialism. Indigenous researchers and community members continue to show deeply-rooted health inequities associated with intergenerational trauma and oppression of Indigenous peoples in Canada.²³ Coupled with the medicalization of mental health, the ways these processes play out in material ways in the Downtown Eastside is troubling. For example,

power relations are reproduced as corporations such as Goldcorp mining (funder of the Woodward's development) (not so) slowly settle in 'develop' the low-income and disproportionately Indigenous neighbourhood. According to a 2011 report titled *Upscale: the Downside of Gentrification*, which surveyed the numbers of single-room occupancy converted hotels, the rent in these buildings has in some cases gone to upwards of \$1,000 a month, making it virtually impossible for residents who depend on various forms of government sponsored social assistance. Notions of property, possession, renewal, and resources circulate through the debates and discourses, re-centralizing colonialism as an ongoing process. In fact, John O'Neil, a white man, long-time researcher of Aboriginal health, and Dean of Health Sciences at SFU has been quoted on the topic of the DTES stating, "in some people's minds, it's the largest reserve in Canada".²⁴

Discrimination is also a relevant health concern for other racialized women, who are often lumped into the category of "immigrant" whether they were born in Canada or have recently arrived. Much like the Indigenous case, the experience of discrimination faced by women of colour in Canada must be viewed within the history of immigration in Canada. Although overtly racist policies excluding and exploiting immigrants from Asia and Africa have been replaced with more multiculturalist ones, women of colour continue to face discrimination in various spheres of their lives. This is a particularly important consideration given the high concentration of newcomers to Vancouver, including refugees.

6.2 NOT ENOUGH SAFE PLACES FOR WOMEN

"There was no safe place for women, and even today... Not enough at all, and there's absolutely nowhere for them to go. I mean, bit more if you have children... So, it's concerning to me, that there aren't, there isn't more inclusivity I guess of women and women's services for women. I mean, understanding that women do need their own space, especially because you know women in mixed groups- women really need that time to find out who they are... Because often you see them, women become so isolated, and so secretive, and they're full of shame, and they take all that on, and you just watch it sort of fall away, and through things like support groups, friends, and just, you know, some of the linking up and you know, partnering with other community people and helping help them get housing, and helping them, just kind of getting them that safe place and it's massive..."

On top of the need for better integration of a holistic health model, our findings reflect that having spaces and community produce an "x-factor" effect. There is a very powerful sense of healing that occurs when all women have safe places to go 24/7 to access social supports and some stability. It is this x-factor that was describe by our partners as one of the keys to a successful recovery from health crises, whatever they may be. There are not nearly enough safe places open all day for women to go in the Downtown Eastside. Moreover, that there could be more women-centered, equity-oriented health care spaces like the Vancouver Women's Health Collective.

For example, we need only to remind ourselves about the numbers of murdered and missing women and their stories, some of which are shared in the 2004 influential report by Amnesty International and the Native Women's Association of Canada titled *Stolen Sisters: A Human Rights Response to Discrimination and Violence against Indigenous Women in Canada*.²⁵ Violence against Indigenous women has been a major focus of the Indigenous women's movement and campaigns such as Idle No More. In another example, it is important for

women who are coming out of hospital to have a safe and healthy place to recover. One of our partners describes that some seniors and elders in Vancouver who have gone for surgeries come back with little supports to help them graduate back to their permanent or in some cases non-permanent homes such as shelters. It is also important for women and their families to have affordable access to safe, clean apartments and houses for permanent and/or long-term stay. For women who experience homelessness, the picture is quite dampening. Though there are plenty of men's shelters that are open 24 hours across city, this is not the case for women. For example, at the moment, the Downtown Eastside Women's Centre (DEWC) Shelter is not able to stay open 24 hours because they share the space with Portland Hotel Society drop-in group space for drug users funded by Vancouver Coastal Health. However, as of April 7th, 2016, VCH will no longer be funding that particular program and instead consolidating it with another provided by Lookout Emergency Aid Society. As a result the DEWC is advocating for the expansion of the women's only emergency-shelter at the 412 East Cordova location.²⁶

Overwhelming evidence points to the importance of safe and affordable housing for overall health and wellbeing. The Housing First (HF) approach has been identified as an important policy and practice solution to this dialogue about safe spaces. A 4-year national research project (2009-2013) funded by the Mental Health Commission of Canada, the At Home/Chez Soi project²⁷ assessed different approaches for people experiencing homelessness and mental health issues in an attempt to achieve stable housing and life situations across 5 cities; Vancouver, Winnipeg, Toronto, Montreal, and Moncton. The Housing First approach, which provided immediate access to subsidized housing, along with either Intensive Case Management (ICM) or Assertive Community Treatment (ACT), was compared with Treatment as Usual (TAU), the current services established in each respective city. Results of the Vancouver study demonstrated that HF was more effective in achieving stable housing whether the participant dealt with addiction or not, a reduction in the total average annual visits to emergency departments per person, and higher usage of outpatient services and lower use of acute services. There were also observable improvements to the participants' community functioning and quality of life, decreases in interactions with police and courts, fewer stays in shelters and social service use. After a 2 year follow up, it was also shown that for every \$10 invested, there was an average of \$8.55 saved for every participant described as 'high need' (as opposed to moderate need, which had +\$1.67 for every \$10). By providing a 24/7hr safe space, women's centres can help achieve the Housing First strategy when permanent, long-term housing may not always be an option.

6.3 HOLISTIC APPROACHES TO PRIMARY HEALTH CARE AND HEALTH PROMOTION

Both our experience at the VWHC and the experiences of our partners demonstrate that a major health concern facing women is the need for a more holistic approach to health care and health promotion. This would involve re-imagining our social systems, health policy, research, and health care services through an intersectional, equity-oriented lens. For example, much like the philosophy of the VWHC, one of our partners suggested the creation of more centralized women's centres in welcoming spaces that would provide all women with necessary well-women care such as access to contraception, STI testing, pap smears, pregnancy and parenting supports, and low-barrier wellness and mindfulness programs. Health promotion needs to be a central feature in women's health, tailored for the full range of

settings where women's health is addressed, and to the needs of diverse women. For example, supported by 6 years of research and consultation funded by the Canadian Institute for Health Research (CIHR), researchers at the BC Centre of Excellence for Women's Health advocate going beyond gender specific approaches in health promotion to be gender transformative in our approach: that is, to address gender based health inequities and transform harmful gender roles, norms and relations, even as we are working on health improvement.²⁸

In her Nursing Practice doctoral dissertation project conducted at VWHC in Spring 2016, Prodan-Bhalla tested for the indicators of equity-oriented primary health care using a quantitative tool developed by the Critical Research in Health and Healthcare Inequities (CRiHHI) Research Unit at UBC.²⁹ Though a small sample size, the findings are nevertheless important given that the VWHC is the only full-time, drop-in and appointment based, self-identified women's only, feminist community health clinic and resource centre in the Downtown Eastside and Vancouver. From our clients' perspective, there is a strong correlation between their quality of life and their level of trust with BC Women's Hospital Nurse Practitioners and the resource centre volunteers. Non-discriminatory posture of the primary health care provider and trust were also found to be correlated and important to our clients. The findings point to compelling models of primary health care delivery such as the BCWH/VWHC partnership and other community health centres identified by CRiHHI in their Research to Equip Primary Healthcare for Equity project (EQUIP).

6.4 STRESS MANAGEMENT AND COPING WITH TRAUMA

Though the need for a holistic approach to health has always been at the center of the women's movement, it is particularly salient at a time when more and more evidence points to the over-medicalization of health and health in our society. One of our participants describes that alongside the usual areas of chronic illness that affect all women in the Downtown Eastside (such as diabetes and fibromyalgia), women in our neighbourhoods also experience "a somatising of trauma in various ways". In the context presented above coping with trauma remains an important health consideration in the day-to-day lives of many women. Experiences such as emotional abuse, sexualized violence, child removals, residential schools, war and civil strife, refugee camps, and the often destabilizing immigration process as a whole are just some of the traumatic events that women cope with in Vancouver. Trauma is shown to manifest in mental health issues, such as severe anxiety, depression, personality disorders, post-traumatic stress, and a predisposition towards addiction.³⁰ As such, a trauma and violence informed approach to health and health care is an important component of addressing women's pressing health concerns.

6.5 OVER PRESCRIPTION OF DRUGS

The over prescription of drugs to women is closely tied to the inequities rooted in our current political economic system. Editors of the book *The Push to Prescribe: Women and Canadian Drug Policy* suggest that over prescription has become an even stronger determinant since the advent of neoliberalism and the erosion of the strong social safety nets and policies based on collective rights as the leading global ideology. In regards to pharmaceutical consumption, a neoliberal ideology individualizes and 'depoliticizes' health, and suggests "women can, and

should, minimize their risk of disease by [...] choosing to take a pill”.³¹ Although we believe that there is a time and place for biochemical intervention, researchers also find that a profit making ideology premised on consumer choice is an inappropriate and disempowering approach to health and health care. Intervening at the molecular level for conditions that can often be solved through social supports and programs is problematic. A palpable example of this problem is the over-prescription of anti-anxiety and pain medication to all women, but older women in particular. Evidence demonstrates that almost one in three women over the age of 65 is exposed to potentially inappropriate prescriptions.³² For example, our partners describe that clients “are getting prescriptions for things and they don’t even know what it is” and that they wish that “there were more traditional type healing facilities or place that they can go that didn’t just rely on prescribing pharmaceuticals.” Overall, we need more options in the DTES and Vancouver to support women to achieve health and wellbeing through multiple resources that best align with their self-defined choices.

6.6. EDUCATING WOMEN ABOUT THEIR HEALTH AND ACCESSING THE SYSTEM

“And to be patient, another big thing would be that you do have to take the ministeps to get to the- someone might not know- like an example I had with someone who didn’t know what a refill was, he just never was in the system to know that “yes, you have refills” and so you need to guide them to say “don’t panic!” because they come into the clinic panicking going “Oh my god I’m out of meds!” and I’m like “no, no, you’re fine”. But like it’s just guiding and kind of, you know, don’t lose patience with them, you know there’s reasons why- they’ve had certain challenges. A refill to us is literally nothing but for them, they have to learn from someone else...”

“I think, to put it bluntly, I don’t think, like, women can just realize that something’s wrong or that this didn’t go well- and even if they did I don’t, I think it takes more than just a realization to go ahead and like, overcome a barrier or, file a complaint towards somebody. I think it would takes something like one of your workshops on patient’s rights for them to really, to really propel them forward and take that step. I’m just kind of saying more from personal experience; it’s really hard to say “Ok, that was wrong” and I’m going to file a complaint. And to actually go through with that because, you’re talking about having to look up where to file that complaint, and who to speak to, and the right forms to fill out, and then playing the waiting game and a lot of that might be, not accessible for a lot of women.”

Another important health concern for women in Vancouver is a dearth of low-barrier access to information about the health care system. We, at the VWHC and our partners, have found that women need better access to education about their rights in health care. For example, we find that there is more funding needed for sex-positive sexual and reproductive health education, and health literacy skill-building programs. Though this should also be incorporated into the public school curriculum, feminist non-profit organizations also believe this is an important consideration for the health care sector.

At the moment the Vancouver Women’s Health Collective offers a workshop provided by VWHC volunteers on the Rights of Women in the Health Care System: BC & Vancouver. This workshop asks women to share their own meanings of health and then helps to translate these definitions to accessing health care and other resources in Vancouver. In addition to these topics, our partners describe that similar resources are needed to promote women’s rights to contraception, to not have sex with their partner, to not be treated violently or disrespectfully. This is necessary in combination with similar education for self-identified boys and men and an increase in the availability of affordable contraception. Movement to increase the health

literacy of all women and girls in BC would also mean that women are more confident that they are receiving the most accurate information from their health care providers.

It is important to note that this very gendered need is also inflected by racialization. For example, immigrant women of colour such as refugees arriving to Vancouver in increasing numbers may be coming from countries that do not have robust public health care system. In addition to the differences in their experience of patriarchy, language barriers, and the immigration process, these women are more likely to face barriers to accessing the health care system in part due to a lack of education about how the system works. Add into this the power dynamics between all marginalized women whether racialized or not, and a gap is made obvious.

7. HEALTH CARE POLICY, NON-HEALTH CARE POLICY, AND FUNDING

The following sections of the report provide, in point form, some of the policies and practice that are currently barriers to the goal of achieving health, wellness, and equity for all self-identified women in the DTES, Vancouver, and BC. The information is divided according to the three main emergent themes identified both in discussions with our partners, our own review of health and health systems literature, and our experience at the VWHC.

HEALTH CARE POLICY

“Trying to give a routine response to populations that are anything but routine. And it creates more and more barriers to access in the system repeatedly. And not resolving any of the deeper issues”

- Health care centers need to have more flexible hours. Indeed, health care scheduling from 9-5 Monday to Friday does not consider the complexity of women’s lives, nor the vast majority of unpaid care work that women do
- Need for more interpretation services, especially for immigrant and refugee women
- Alternative forms of pain management such as chiropractors, massage therapists, naturopathic doctors are unaffordable for some women, notably single mothers with low-incomes
- Location of BC Women’s Hospital is not accessible to all
- Need for an increase in the number of health professionals trained in Indigenous Cultural Safety, Trauma and Violence Informed, and Harm Reduction perspectives
- Structure of funding pools and few lines of communication between health authorities create negative competition that feeds down into client-level care (The following health authorities currently operate in Metro Vancouver: Vancouver Coastal Health Authority, Provincial Health Services Authority which includes BC Women’s Hospital, Fraser Health Authority, and Providence Health Care a Catholic affiliate to VCH and PHSA).

“Everyone is always saying that community groups need to spend more time collaborating. So do funders. And within our health care system, the inherent built-in really negative competition among health authorities for funding is what trickles down in really poorly funded programs.”

- Gatekeeping for patients who are seniors and/or patients who are admitted as psychiatric
- Lack of more innovative, feminist mental health support models that don't rely only on the traditional model of counseling and psychology, but offers alternative ways of healing and approaches to mindfulness. This would also include many more supports to prevent mental health crises.

"We will respond to it when it's acute, and you have to go to emerg, and I have to you know involuntarily admit you. But 6 months ago when you came begging for counselling because you knew you went down this hole before, I've got nothing to give you"

- The anonymization of testing, particularly for HIV/AIDS (though online testing by the BC CDC is thought to be a breakthrough for women who don't want to be documented)
- The medicalization of women's health and the fee-for-service model
- Situating the place of BC Women's Hospital in the VCH Downtown Eastside Second Generation Strategy

NON-HEALTH CARE POLICY

Aside from the health care system, there are a number of other policy areas that dictate the conditions in which feminist, non-profit organizations work to meet their mandates. These include immigration policy, employment insurance and training, subsidized housing, laws on sex work, laws on substance use, regulations around abortion care, child welfare, childcare, and public transportation access among others. The example below demonstrates the contradictory nature of policies that pit women's health and safety against each other:

- The housing market in Vancouver is deeply affecting the ability of women to live healthy lives, and the ability of feminist, non-profit organizations to support women facing a health crisis. There is largely no other conversation to be had if women do not have a safe, affordable, and permanent place to take care of themselves and their families. This applies to women across class, race, and sex/gender lines.
- In 2006, the Conservative government shut down most of the Status of Women Canada offices, stating that we do not need to 'separate' the men from the women in this country despite the vast amount of evidence that points to the needs for gender-based research, policy, and funding.
- For women of colour who have been in Canada for a long time, who are not newcomers but who are lumped into the category of "immigrant", there are not many supports for employment training, language training, and funding proposals. When looking at the new five-year strategy for the Canadian Institute for Health Research (CIHR), the largest state-run funding body of health research, "visible minorities" (read: people of colour) have been largely erased from the research agenda.
- Largely due to criminalization, organizations representing sex worker rights are finding it difficult to engage with members that they serve, and to work with undocumented or under-age sex workers and people who are engaged in trading sex under age. They find that on a structural level, societal stigma and laws such as C-36 The Protection of Community and

Exploited Persons Act are huge barriers. Though the Vancouver Policy Department has a non-enforcement policy, our partners state that there are plenty of ways to criminalize sex workers, without relying on sex work laws.

- The Jane Doe Legal Advocates group finds that women are very reluctant to report violence for fear that their children will be taken away from them. One of our partners described, “there is this overwhelming terror that their child will be automatically taken away.” Other organizations working in the field of housing and supporting women who have experienced any form of violence echoed this comment. Another partner stated, “once you have [the experience of violence] on your [MCFD] file you can never get out, really because it is seen as a strike against you as a parent even though you might have been the survivor of violence as opposed to the perpetrator.”

FUNDING

“You know, wanting to be able to help women be able to fully participate in society but not have all the resources necessary to do so is a huge challenge”

It is clear from an insider’s point of view that the entire women’s sector lacks the much-needed core funding to adequately support the women in the DTES, Vancouver, and BC. Many of our non-profit organizations, specifically women’s centres, are completely volunteer-driven, many only able to sustain a small number of paid positions depending on the size of the organization itself. Despite the deep benefits of volunteer-driven organizations, they are also susceptible to high turnover, instability, and limited capacity, making it very difficult to sustain long-term programming as well as high output and productivity.

Continuous cuts to provincial and federal funding streams are felt, especially to the women’s and youth programs in the DTES, less and less money is given out each passing year and organizations are forced to make do with their new budgets. Moreover, the annual funding cycle means that it is difficult to engage in long-term planning. The shift toward time-limited project funding and calls for proposals based on trending community issues also makes it much more difficult to propose and implement innovative health initiatives on the individual level and create healthy collaboration between organizations. Often times, organizations needing grant money will orientate their services and initiatives to the same issue, such as housing or food resources. Many short-term solutions then become implemented by different organizations all working towards fixing the same thing, creating redundancy in the system. And again, because all determinants of health bleed into each other (i.e. poor health in one dimension eventually affects other dimensions), all of these efforts become negated, such that sustainable well-being is never reached. This lack of core and long-term funding has lasting effects on the progress that we see towards holistic and effective health care strategies in the DTES.

- Proposal driven programs and a lack of core funding foster competition and non-sustainable program planning
- More funding needed for innovative approaches to health promotion
- The entire women’s sector is very underfunded

- Cuts to national funding streams cripple operations of important non-profit organizations (e.g. Cultural Connections for Aboriginal Youth program)

The mental health sector is shown to be under funded in BC. There is a high need for services, but due to limited capacity clients are left on waitlists spanning as long as 1-2 years for something as simple as group therapy. This under funding also interfaces with the momentum and commitment required from women dealing with erratic lifestyles and addiction, with the window of opportunity to capitalize on this motivation being extremely small in some cases. Costs for private therapy can range from \$100 - \$280 just for a single session; for nearly all the patients with severe manifestations of mental illnesses this becomes an unreachable service. Even after answering the question of therapist fit and style, it can take years of treatment just to begin seeing positive changes to the patient's mental health. Mental health funding would benefit from focusing on proactive actions as opposed to reactive needs.

8. POSSIBLE SOLUTIONS AND WAYS FORWARD

When asked about solutions, our partners proposed a number of short-term and long-term equity-orientated approaches to women's health and equity in the Downtown Eastside, Vancouver, and BC more broadly. These are highlighted below and represent expert information from leading women in the field. For these proposals to be successful, feminist non-profit organizations, health authorities, funders, and policy-makers would have to work together in mutually respectful partnerships.

- The VWHC takes a lead in coordinating a collaborative network of women's organizations that operate under feminist, intersectional, sex-positive, gender inclusive, orientation inclusive, age inclusive mandates. The overarching theme connecting these groups would be women's health and equity in Vancouver. Though the VWHC is located in the Downtown Eastside, we service women from all across the lower mainland who feel that they are underserved in the healthcare system.
- Draw on evidence from leading researchers on how to incorporate harm reduction, trauma- and violence informed care, Indigenous cultural safety, contextually-tailored care, gender transformative health promotion, and other equity-oriented approaches to health care³³.
- Collaborating with licensing bodies for the health professions such as the College of Registered Nurses of British Columbia and the College of Physicians and Surgeons of British Columbia, in addition to health professions education institutes such as the UBC School of Nursing and the UBC Faculty of Medicine to train new and established health professionals using critical pedagogical perspectives.
- Creation of more peer health navigator programs for both primary and other forms of health care that bridge allopathic and non-allopathic forms of prevention, healing, and recovery.
- Initiating steps towards the decriminalization of sex work and HIV non-disclosure, with evidence taken from the feminist non-profits and health researchers working in these areas.

- Continued communication between different women’s health and equity organizations in the Downtown Eastside for the purposes of referrals, client follow-up, and partnership building
- Open dialogue and meaningful inclusion of feminist, non-profits in health care, non-health care, and funding related decision-making by health authorities and other governmental bodies such as BC housing and the Ministry of Child and Family Development.
- Increase the number of positions and match the salaries of health professionals working in community health settings such as nurses, pharmacists, and physicians.
- Increase the number of Nurse Practitioner positions and clinics available, given evidence that demonstrates that a mixed model of drop-in appointments and scheduled appointments aligns with an equity-oriented primary health care model.
- Increase in the number of portable housing subsidies and the allocation of designated social justice real estate, to broaden the scope of housing options to which women have access.
- Using a model of program delivery that gives women a lot of choice points, not just one. For example, breaking a twelve-week program into three or four different stages to allow for different commitment levels.
- Model successful programs in other provinces, such as the Ontario framework for laboring and birthing centers or the Winnipeg model of having post-sexual assault care, STI testing, abortions, and other reproductive and sexual health services all in one place. It should be noted that some of our partners put forth a recommendation at a recent Women Transforming Cities meeting to turn the Vancouver Art Gallery space into such a place for women in Vancouver.

9. NEW AND SUCCESSFUL INITIATIVES

All of our partners are important contributors to the project of achieving health, wellness, and equity for all self-identified women in Vancouver. Each organization is essential to this project. We are all committed to meeting women where they are at and supporting them to meet their self-defined health and wellness needs. In this section, we highlight some of the many successful and innovative initiatives that our partners and our organization have developed and sustained:

- **Vancouver Women’s Health Collective:** comprehensive wellness and prevention programming that includes in house, no-cost yoga, hula hooping, acupuncture, counseling, and monthly health topic workshops. Outreach workshops including Women’s Rights in the Health Care System, Go Figure: A Body Image Workshop, and Single Mothers and Health in Vancouver (in partnership with Vancouver Status of Women).

- **The Single Mother's Resource Guide (SMRG):** has been published for the last 20 years, and Vancouver Status of Women is now on its 10th edition. Listings about housing rights, education, employment, how to navigate violence and abuse in a relationship, childcare, healthcare, etc.
- **Downtown Community Health Centre (DCHC) Women's Night:** Women's Night happens every Tuesday from 5:00-8:30pm at the DCHC and is open to all self-identified women. The evening provides free basic health care (including counseling, testing and education), a clothing drive, dinner, and time to socialize.
- **Skeena House operated by the Vancouver Aboriginal Friendship Centre Society:** Formerly a hotel, the Skeena House on East Hastings now provides temporary housing mainly to those who are currently living in shelters. The House also offers on-site support services as well as referrals to other health services.
- **Vancouver Aboriginal Friendship Centre Society Community Navigator Program:** This program is designed to meet the specific needs of Aboriginal peoples in the Vancouver region who are experiencing absolute, hidden, at risk, chronic, or episodic homelessness.
- **Raven Song Community Health Centre (Vancouver Coastal Health):** The Centre offers a range of health services to people of all ages. These include community health services, mental health and addiction services, speech therapy, nutrition counseling, etc.
- **Vancouver Aboriginal Friendship Centre Society Tenant-Landlord Community Relations Program:** The program focuses on the availability and affordability of housing for those who are homeless or are at risk of becoming homeless. The program helps build relationships between tenants and landlords.
- **PACE's Peer Navigator Program:** Through this program, Peer Health Navigators assist sex workers in accessing and engaging with health and social care services through direct systems navigation support and enhanced case coordination, including peer accompaniments to initial and follow-up appointments, hospital visitations, and client advocacy in health and social care settings.
- **WISH MAP Van:** The Mobile Access Project Van offers outreach services to women working on the street from 10:30pm to 6:00am, seven nights a week. Their purpose is to improve sex working women's health and safety by providing supplies (i.e. condoms and clean needles), referrals to shelters, health services, etc., as well as a break from their work. This project was born from a partnership between PACE Society and WISH Drop-in Centre Society in 2004.
- **BC Centre of Excellence for Women's Health Guidance for MCFD on working in trauma-informed way:** These guidelines infuse that idea of being informed about the extent and nature of trauma experienced by children and families, and the need to work in a relational way so that people are not re-traumatized in interactions with MCFD, and ways

are found to support safety, trustworthiness, choice, and empowerment in these interactions.

- **Providing culturally safe ways of healing for Indigenous women facing violence:** WAVAW fundraises to put on a big ceremony every year, such as the Tsilhqot'in Mass Dance Ceremony in 2013.
- **NICCSS Violence Prevention Fund:** The Fund can provide one-time, non-interest loans to help women who have experienced violence and are looking for a safe and stable home. The program also gives referrals for community services and assistance in navigating bureaucratic systems.
- **Options for Sexual Health's 1-800-SEX SENSE line:** Information and resource line and email service.
- **Central City Foundation Abbott Mansion and Cosmopolitan Hotel:** secure and low-costing housing in the Downtown Eastside, and building host of the Vancouver Women's Health Collective at the 29 West Hastings Site.
- **WAVAW Hospital Accompaniment Program (offered in partnership with the Sexual Assault Service through BC Women's Hospital):** The 24-hour service offers transportation to Vancouver General Hospital and support for women while they receive medical attention from the Sexual Assault Service team and during police interviews, if any.
- **Abortion services:** Not a "new" initiative, but definitely a necessary one, Every Women's Health Centre and Elizabeth Bagshaw Women's Clinic do the important work of offering abortion services in Metro Vancouver in non-judgmental, social justice oriented environments.
- **Nurse Practitioner Clinics:** Located at the Vancouver Women's Health Collective, WISH Drop-In Society, Aboriginal Mother's Centre. The clinics offer check-ups, diagnosis and prescriptions, pap tests, HIV testing, specialist referrals, birth control options, and more. Does not operate on a fee-for-service model.
- **Atira Sorella Housing for Women** opened April 2011, providing 108 units of long-term supportive housing for women, including 12 units for women with their young children.

In addition to their own innovative initiatives, our partners demonstrated the importance of partnership and collaborative effort in moving forward the agenda of women's health and equity. Some past and present examples include:

- **SHAWNA project, led by the Gender & Sexual Health Initiative in collaboration with Oak Tree Clinic, BC Women's Hospital, BCCDC, WISH, and Pivot Legal Society, among others:** The 5-year project began in 2014 and focuses on the social, legal, gender gaps in women's sexual health and HIV care in Metro Vancouver. The project promotes meaningful engagement and inclusion of women living with HIV.

- **The Downtown Eastside Vancouver Community-based Women’s Sexual Assault Program, a partnership between Battered Women Support Services and Atira Women’s Resource Society**, that began in 2012 but no longer operates. The program delivered a dedicated education and awareness outreach, mobile crisis response and follow-up to support women survivors of violence in Downtown Eastside.
- **Options for Sexual Health is partnering with the First Nations Health Authority** on getting contraceptives out to Indigenous women in rural communities.
- **BC Women’s Hospital operates the Fir Square Combined Care Unit, which is the first in Canada to care for women who use substances and their newborns. This hospital unit works in partnership with Sheway**, which is a pregnancy outreach program located in the Downtown Eastside and is governed by Vancouver Coastal Health, the Ministry for Child and Family Development, Vancouver Native Health Society, and YWCA of Vancouver.

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