Résumé

Les contraintes auxquelles sont soumis les partenariats intersectoriels dans le domaine de la santé des femmes : leçons découlant de l'expérience canadienne

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Le présent article aborde, à la lumière des leçons tirées dans trois différentes études, les enjeux qui limitent la capacité des organisations féminines à établir des partenariats visant, par l'élaboration et la mise en œuvre de politiques, à promouvoir la santé des femmes. Les principales questions concernent les valeurs sous-tendant le partenariat et la participation, la communication intersectorielle, les différentes visions du monde et les ressources limitées des organismes féministes. En surmontant ces contraintes et en tirant profit des réussites et des échecs, ces derniers devraient être en mesure de promouvoir la santé des femmes grâce au partenariat intersectoriel. Le secteur de la santé et les professionnels doivent s'ajuster à ces contraintes pour pouvoir bénéficier de l'expertise résidant au sein des organisations féminines.

Mots-clés : partenariat, participation, santé des femmes, politiques, intersectoriel

Constraints on Women's Intersectoral Health Partnerships: Lessons from Canada

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Issues that constrain women's organizations from developing partnerships that promote women's health through health policy development and implementation are discussed in terms of lessons drawn from 3 studies. Key issues are the values underlying notions of partnership and participation, communication across sectors, different worldviews, and the resource limitations of feminist organizations. By attending to constraints and learning from successes and failures, women's organizations will be able to promote women's health through intersectoral partnering. The health sector and health professionals need to respond to the constraints in order to benefit from the expertise that resides within women's organizations.

Keywords: partnership, participation, women's health, gender, policy, intersectoral

Introduction

The purpose of this paper is to explore issues that may constrain women's organizations from developing partnerships that are successful in promoting the health of women through health policy development and implementation. We include both development and implementation of health policy to emphasize the fact that participation through partnerships can extend to monitoring the implementation processes, as well as assessing outcomes, suggesting modifications, and returning full circle to implementation. Development and implementation, therefore, may include research such as evaluation.

Partnerships are one strategy for increasing the participation of women in health policy development and implementation. Using a framework for partnership development (Scott & Thurston, 1997), we analyzed data from two projects that examined the roles of women's organizations in health policy development (Horne, Donner, & Thurston, 1999; Thurston, Crow, & Scott, 1998) and a third that examined the impact of health policies on women (Scott, Horne, & Thurston, 2000). In the first project (Thurston et al., 1998), focus groups were held with representatives of 64 women's organizations and coalitions in the

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province of Alberta, Canada. The purpose of that study was to clarify the roles of women's groups in research and in policy development and implementation. In the second project (Horne et al., 1999), interviews were held with representatives of eight regional health bodies in the provinces of Manitoba and Saskatchewan, and the needs assessment and health plan documents of 28 regional health bodies were analyzed. The purpose of that study was to assess the integration of gender analysis into health policy development and implementation. The third project involved a policy analysis and literature review concerning the impact of privatization on women in Alberta.

We begin by discussing participation in health policy development and implementation and the notion of partnerships. We then discuss 12 lessons we have drawn concerning constraints on partnership development and implementation.

Participation in Health Policy Development and Implementation

Participation is a tenet of health promotion as encapsulated in the World Health Organization's (1986) Ottawa Charter definition. Fostering public participation is one of three strategies for health promotion encouraged in early policy documents issued by the Canadian government (Epp, 1986). Participatory action–research (Smith, Pyrch, & Lizardi, 1993), participatory research (Plaut, Landis, & Trevor, 1992), and participatory development (Kelly & Vlaenderen, 1995) are just some of the forms of participation thought to facilitate the process of health promotion.

The concept of public involvement in health system management preceded release of the major documents on health promotion cited above. In the 1950s, in fact, community development was synonymous with participation, according to Abbott (1995), and was central to the concept of primary health care introduced in the 1970s (Fournier & Potvin, 1995). In the 1970s Quebec reformed its health and social service system "under the banner of citizen participation" by creating the Centre Local de Services Communautaires (CLSCs) network (Godbout, 1981). More recently, one regional health authority in Alberta developed a Public Participation Framework that allows for a range of participation modes, from information exchange to delegation of authority to health programs (Maloff, Bilan, & Thurston, 2000).

In a variety of sectors, including health, partnerships have become a popular mechanism for, among other things, ensuring participatory policy development and implementation. The recognition that sectors other than health influence population health has increased the demand

for intersectoral partnerships (Draper, 1995). Much hope is placed in partnering for the purpose of, for instance, planning, mounting, and sustaining programs over the long term (Heart Health Nova Scotia, 1999; Ontario Health Promotion, 2000). Partnerships between organizations have been proposed as a solution to many of the problems faced by women in achieving optimum health (Feldberg & Carlsson, 1999; Giachello, 1995; Jadad, 1999; Zaini, 1988).

Partnerships

The term *partnership,* like the broader term *participation*, is used to describe many different relationships and understandings. For instance, "Ontario community heart health partnerships are known by many names — coalitions, networks, co-ordinating committees and work groups to name a few. They are referred to here, generically, as partnerships, and imply a group working towards a set of shared outcomes" (Ontario Health Promotion, 2000). The relationships captured in the term partnership may differ in structure, degree of formality, mandate, and role. Organizations or individuals may be consulted on a topic or be involved in decision-making in a formal partnership. If women's health is to benefit from partnerships between organizations, its advocates will have to agree on how to define and then assess a partnership.

We recommend that the term partnership be reserved for a formal long-term relationship defined by a collective strategy that includes:

> a shared vision of a need and…the development of agreements to address a problem and bring the vision into reality. Collective strategies involve the establishment of a referent organization, which functions to regulate relationships and activities, appreciate emergent trends and issues, and provide infrastructure support. (Scott & Thurston, 1997, p. 416)

The referent organization (Trist, 1983) for a partnership may be as simple as a joint management committee in which collaboration takes the form of shared decision-making; therefore, someone who is labelled a partner should not be asked to serve in an advisory capacity only. Some common characteristics of partnerships include shared authority; responsibility and management; joint investment of resources (time, work, funding, material, expertise, information) and reputation; the development of a new structure; comprehensive planning; detailed communication strategies; the distribution of power — it may be unequal; and shared liability, risk, accountability, and rewards (Health Canada, 1996; Scott & Thurston, 1997; Winer & Ray, 1997).

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Constraints on Intersectoral Partnership Development

The partnership framework (Scott & Thurston, 1997) that we use to identify constraints for women's organizations consists of six categories: external factors, domain, partnership characteristics, partner characteristics, communication, and operations. We will first briefly describe each of these categories and then discuss the lesson we draw from our analysis. *External factors*, such as the political and economic system, influence the partnership at the administrative level or at the service provision level; they are the socio-political context in which the partnership functions. The *domain* is the sphere of interest of the partnership. The *partnership characteristics* reflect the way in which the partnership is established, including the groundwork necessary to initiate it. Each partner will have distinctive *partner characteristics*, such as the organizational structure of the partner agency; the resources that the partner and its representative bring to the partnership; representation of the target group in the partner agency; and the reputation of the partner, its personnel, and the group(s) it serves. *Communication*, which affects all of the other categories, can be either formal or informal. *Operations*, which, like communication, affect all of the other categories, are the administrative and service provision activities carried out on behalf of the partnership; the types of operations carried out by the partnership interact with the external environment, the domain, partnership and partner characteristics, and communication; operations are limited by time frame, available resources, and expertise.

External Factors

Lesson 1. The impact of *external factors* has intensified the role of local, provincial, and national networks. The shifting of administrative and financial responsibilities from the province to local health authorities has exponentially increased the number of targets of health policy lobbying. It is now next to impossible for women to organize, as they once did, to have a program instituted provincially. In addition, globalization and the impact of policies such as the North American Free Trade Agreement have broadened the range of concerns that activists must analyze when preparing a local response. Local partners may need to draw on the expertise of national organizations in order to respond. The Canadian Women's Health Network plays an important role in dealing with constraints on access to and synthesis of information; the Centres of Excellence in Women's Health Research do as well, but their long-term future is currently in doubt.

    Lesson 2. A formal partnership agreement can soften the impact of change in terms of partner representatives and commitment. Because of the speed and persistence of change within the health and voluntary

sectors, health personnel with whom organizations have built up a working relationship are frequently transferred or discharged. The transfer of responsibility will be easier if the partnership is formally documented. The loss of a champion, however, can threaten the success of a partnership and can make it difficult for champions in women's organizations to continue their work.

Women's organizations have been constrained in their ability to advocate for women's health because they are now trying to provide more services with the same or fewer resources, while staff and volunteers are also expected to do more. Cutbacks in health and social services have resulted in more women, and more women with complex problems, turning to not-for-profit women's services for help, thus putting more demands on those services at a time when their funding is also being cut (Thurston et al., 1998). Health "reform" has increased the burden of responsibility on women for the provision of care in the home, in the name of community-based care. For women's organizations, this has meant that their meagre underpaid staff and many volunteers often experience personal crises of care — sick children, parents, partners, or friends to attend to outside of their advocacy work. Given the constraints faced by women's organizations, formal partnership agreements should be regularly revisited and resource commitments renegotiated to reflect organizational capacities. In some cases, the strategic decision will be to seek new partners or to dissolve the partnership, leaving current partners with good working relationships.

Lesson 3. The partnership agreement must take into consideration the values and differences that drive the various partners. Fournier and Potvin (1995) point out that the literature on participation is fraught with inconsistencies, not the least of which is the failure to clarify the assumptions that underlie values. They identify three views of participation that have different underlying values: maximizing the outcomes of a program (a utilitarian view), helping people to take control of their lives (conscientization), and acting as a democratic tool to extend and protect the power of marginalized peoples (democratization). The last might be called the civil society viewpoint. Fournier and Potvin argue that these three views of participation are not mutually exclusive; however, we have found that the utilitarian view, coupled with a market discourse, often sidelines democratization goals in the health sector and in other sectors. The market discourse around price, efficiency, the consumer, and responsibility is not insignificant. In fact, it reflects a growing reluctance on the part of governments to continue to provide the welfare services that have been built up over the last 50 years (Lloyd & Gichrist, 1994). "The concepts of welfare for all and of the collective responsibility of the state for all its citizens are under increasing attack" in Europe (Van Rees, 1991,

p. 97) and also in Canada (Scott et al., 2000). Therefore, the collective orientation of feminist analyses to "the personal is the political" is discordant with the individualistic public sector discourse. Since a successful partnership depends upon agreement on goals, this discordance poses a threat.

Contrasting worldviews is a significant factor when program goals are being articulated within a partnership; for example, advocates of women's health may wish to question medicine's authoritative role in diagnosis and intervention by having others (e.g., nurses, peer practitioners, program participants) determine a program's admission criteria. Feminists will often have deconstructed medical explanations for women's health problems, such as "excess weight," and highlight the goal of minimizing the dominance of medicine. As Findlay and Miller (1994) put it, "faced with the prospect of having our fitness and bodyweight monitored and graded from the womb to the workplace, and perhaps into old age, we begin to grasp the far-reaching authority we have granted, as a society, to the medical profession" (p. 127). Thus a partnership around heart health, diabetes, or any one of a number of other health issues may be marked by fundamental differences, which, if revealed late in the partnership, could cause a fracture after significant resources have already been committed. Groundwork and communication are the best ways to prevent this from happening.

Domain

Lesson 4. The domain of women's health is often given either rhetorical attention or none at all. At best, it is the focus of small sections in a given health system. The Canadian government has expressed a commitment to women's health several times and has initiated exemplary health promotion projects for women (Thurston & O'Connor, 1996); however, significant national policy documents reveal that the commitment has not served to mainstream gender analysis. Scott, Thurston, and Crow (2002) assessed the treatment of gender and women's health in the 1990 report of the Federal Provincial Territorial Working Group on Women's Health, the 1994 report of the Federal Provincial Territorial Advisory Committee on Population Health, and the 1997 reports of the National Forum on Health. They conclude that gendered analysis has been generally inconsistent and weak unless the document addresses women's health specifically. Most importantly, they report that the implications of the analysis are rarely reflected in the policy recommendations. The establishment of a national Gender and Health Institute was announced in August 2000 as a result of concerted lobbying by women's health advocates to have women's health specified in the proposed Canadian Institutes for Health Research. The absence of a separate women's health institute had been

viewed by some as minimizing the importance of the domain in favour of children's and men's health. Given the fact that health professionals have great difficulty understanding the concept of gender, and continue to construct women's health as pertaining to reproduction or reproductive organs (Horne et al., 1999), apparently there is still a need to promote the domain of women's health.

Projects carried out in three provinces reveal similar constraints around the domain of women's health, including a failure to mainstream gender analysis of health policy at both provincial and regional levels (Horne et al., 1999; Scott et al., 2000). In assessing the gendered analysis of health-needs assessments and health plans in Manitoba and Saskatchewan, Horne et al. (1999) found little evidence of gender analysis being a practice or even understood, despite the stated intention of one government to make women's health a priority. As with the federal documents, at the provincial and regional levels the best effort at attending to women's needs was presentation of epidemiological data, usually concerning breast cancer, breastfeeding rates, or some other unavoidably female issue. Much of the remaining data were not even disaggregated by sex. Furthermore, in interviews conducted with health policy-makers, the discourse on women's health was situated within concerns about women's reproductive role and their role as guardians of the health of children and husbands. There was little attention to diversity among women in terms of ethnicity, disability, sexual orientation, or other social characteristics. Few districts or health authorities had engaged women's organizations in either needs assessment or health planning.

Women's health advocates are also constrained by differences in philosophy and strategy. Feminists have come to the conclusion that there are many types of feminism and many strategies, and that the community must provide a space for debate and criticism (Crow & Gotell, 2000). Representatives of women's organizations, however, often feel that analytical differences cannot be debated publicly because anything less than a united front is grounds for minimizing all of their concerns. Zadek (1999), in discussing responses to globalized trade practices, describes the constraints against presenting a united front:

> The concerns underpinning this work [developing ethical trade practices] include the rapidly escalating inter-relatedness and complexity of civil society issues; the profusion of initiatives, networks and alliances; radically different interpretations of relative strengths and weaknesses of different initiatives and approaches; and shortfalls in strategic thinking in this area, or at least institutional fragmentation of strategic perspectives. (p. 1)

Partnership Characteristics

Lesson 5. The ongoing work of relationship building, both among women's health advocacy organizations and among sectors, is important for communication and for the ability to respond quickly to opportunities to form strategic partnerships. One partnership characteristic that affects the ability of a partnership to achieve success is the groundwork that is laid before it is launched. The formal and informal relationships established through work, social activities, cultural events, and shared connections do much to ease an organization's transition into a partnership situation. When we speak of a women's community, we mean the shared understanding and networks that serve to build a climate of trust. The study conducted in Alberta, however, revealed that policies increasingly erected barriers to networking (e.g., by failing to support a provincial women's advisory council, reducing program funding) (Scott et al., 2000). The weaker the network, the more time (a precious resource for women, both volunteers and employees) it takes to identify appropriate partners and make connections. While women in smaller communities have the advantage of knowing each other, they face other constraints such as loss of privacy or difficulty making the transition from social acquaintance to partner. On the other hand, shifting identities is difficult in all settings; for instance, professionals revealed a reluctance to give up the power associated with expertise and to trust the ability of others to analyze their community's problems and offer solutions. Similar issues have been identified in other studies (Freyens, Mbakuliyerno, & Martin, 1993).

Partner Characteristics

Lesson 6. An ongoing problem for women's health organizations is dealing internally with the issue of representation. The importance of formal representation of the target group in the partner agency is one of the *partner characteristics* discussed by all the informants in an earlier study (Scott & Thurston, 1997). In the present study, such characteristics varied from partnership to partnership; for example, some agencies involved the target group at the board/management committee level while others sought feedback through questionnaires or informal meetings. Representatives of women's organizations discussed the constraints of involving women from many different backgrounds. Women in rural areas discussed the constraint of distance, while other women mentioned racism and different cultural norms among communities. While there are no simple solutions to the issue of increasing representation, several actions are possible. These include paying extraordinary costs, providing opportunities for skill building, and attending to process issues in meet-

ings in order to minimize inequities (Wiebe, MacKean, & Thurston, 1998).

Lesson **7.** An unexpected outcome of partnership development is increased competition among women's organizations. While perhaps not intentional, the outcome of a partnership may be the strengthening of one partner's "comparative position within a wider context of clientilism and patronage" (Whaites, 1996, p. 241). In other words, competition for the position of sole organization to understand and speak for a certain group of people, and, ultimately, control financial and practical support, is a reward that is difficult to turn one's back on once it becomes a possibility. Health organizations may favour certain agencies because they are "easier to work with," which can mean anything from having a similar philosophy to being large and therefore more likely to have staff available to attend meetings at the health organization's convenience. Maintaining local networks with open lines of communication is one way to offset this constraint, although the stress on women's organizations and cutbacks in the funding of coalitions have made such networking more difficult. Local groups that do network can reach agreements on the boundaries for competition: for instance, violence-prevention services may agree that they will not apply for funding that would normally go to women's shelters.

Lesson **8.** Increased "professionalization" and delegated authority can change the nature of or reduce an organization's advocacy role. Professionalization refers to a situation in which professional status is more highly valued than life experience or ability (Crow, 2000). For example, organizations may agree to use professionals in place of experienced practitioners. If these professionals require higher salaries than other agency staff, internal tension can result. Some respondents stated that professionalization weakens the organization's focus on social criticism; Whaites (1996) contends that this threatens the organization's role in the civil society. The term most commonly used in this context was *co-optation*. Thus a partnership that results in delegated authority can change the relationships among women's health advocates. Being aware of this possibility and creating mechanisms such as opportunities to discuss strategic decisions in relation to underlying philosophies may serve to offset any long–term negative consequences.

Communication

Lesson **9.** Technology offers considerable communication and networking opportunities. Technological means of *communication* include the telephone, the fax machine, e-mail, Web sites, and video conferences, the result of which is "better networking" (Giachello, 1995, p. 12). Many of the women's organizations examined in the studies, however, were strug-

gling to maintain a basic office and telephone service. If they had a computer, they may have lacked high-speed Internet access or, more importantly, the personnel and time necessary to sort through the plethora of Web sites and listservs that are available (Thurston et al., 1998). Opportunities are increasing, however, and as new electronic media become available women's organizations are developing mechanisms to transform them into effective tools. National women's organizations in Canada are particularly adept at identifying credible and useful Web sites and distributing this information through listservs.

Lesson 10. Communication is a key facet of successful partnerships and an area where power is revealed and should be negotiated. Participation is one concept upon which potential partners should agree. Citizen participation and consumer participation are frequently assumed to be synonymous with public participation but may represent divergent worldviews. Although citizen participation and public participation are similar concepts, we prefer the term public participation because it avoids the issue of geopolitical status (such as immigrant status). Consumer participation is linked to the application of the market model to health care, in our opinion, and does not reflect the reality of women's experience. Women cannot "shop" for health care in the way they shop for consumer goods. Some women, in fact, cannot afford to shop at all. The views of some women in the studies are reflected in a statement by Mintzberg (1996): "I am not a mere customer of my government, thank you. I expect something more than arm's length trading and something less than the encouragement to consume" (p. 77).

Attempts to reach agreement on the meaning of participation often reveal power imbalances surrounding professional expertise and language. The use of medical and technical jargon may be the easiest hurdle to overcome — a glossary, for instance, would be a simple solution. The larger issue, however, is one of legitimating speech when power differentials exist. Women with disabilities, little education, or menial jobs report feeling silenced by health professionals. Kelly and Vlaenderen (1995) identify the difficulties of engaging in dialogue in the face of power differentials: "Dialogical dynamics of marginalization continued to operate even in a situation which was explicitly designed to overcome marginalization" (p. 372). A commitment by professionals to monitor their use of jargon and formal structures within the referent organization, such as rules of engagement at meetings, can help in maintaining equity.

Operations

Lesson 11. The *operations* or activities undertaken by a partnership can make considerable demands on the partners. Women's organizations reported finding it increasingly difficult to spend many hours consulting

on the programs and activities of health authorities. In one case, an esti-mated 3881.5 hours were contributed to a regional coalition (Heart Health Nova Scotia, 1999); at the modest rate of $15 an hour, this amounts to $58,222. Care must be taken to ensure that the type of activ-ities that are carried out and the manner in which they are carried out will advance the vision of the partnership without harming one of the partners. This leads to the most significant question for any potential partner: Is a partnership necessary to achieve the desired goal? A partner-ship may appear to be a more economical or efficient way of getting the job done because one of the partners is absorbing costs disproportionate to its resources. However, our work on gender analysis indicates that partnerships among women's health organizations may be the only way to ensure that a program is woman-centred. As long as women's organi-zations are under-funded, the health system may have to value the women-centred approach and community partnerships by supporting the partners financially.

Conclusion

We have identified a number of constraints faced by women's organiza-tions in developing intersectoral partnerships, several lessons to be drawn concerning such partnerships, and some strategies for overcoming the constraints. All of the categories of factors for analyzing partnerships are interconnected. The many constraints could leave one feeling quite pes-simistic about the potential for achieving social change through inter-sectoral partnerships. However, we have also found that intersectoral part-nerships can advance women's health and that feminist health groups are a key source of knowledge for the planning and development of pro-grams in the health sector. Advocates of women's health possess a great deal of expertise in overcoming inequities, and this expertise needs to be shared widely. Women's organizations, researchers, activists, and theorists can use the lessons we have identified in conjunction with the strengths inherent in the women's movement to overcome the constraints.

In all three provinces in which the studies were conducted, the status of women has improved both legally and materially in the last decade, not because policy-makers have suddenly acted in a spirit of beneficence but because of women's organizing. While women are adapting to the differential impact of health reforms on their lives, history tells us that such policies cannot drive women back into the home nor reverse the gains they have made. As gains in the status of women become threat-ened by policy changes, more women may be willing to support activist organizations. At the same time, we hope we have added to the oppor-tunities for women's organizations to learn from partnerships and share

strategies in order to counteract the restrictions placed on them by funding cutbacks, increased workloads, and other social pressures. Learning from other countries and from other sectors such as international development is one such opportunity in this complex, interconnected world.

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