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Original article

A field test of the gender-sensitive core set of leading health indicators in Manitoba, Canada

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Summary

As part of the development of a women's health profile for the province of Manitoba in Canada, Prairie Women's Health Centre of Excellence also conducted a field test of the WHO Kobe Centre gender-sensitive core set of leading health indicators.
The Manitoba department of health keeps comprehensive health care utilization data, which in combination with national survey data available through Statistics Canada, provided the data necessary for secondary gender-based analysis.
Of the Kobe indicators, 23 could be tested without modification, 1 could be tested with some modification to the definition provided, and 13 could not be tested at all.
Results show national or provincial level data do not adequately reflect health disparities among women and men; other factors and dis-aggregations provide additional important information. The authors provide recommendations for augmenting the core set where feasible.
All but one indicator would be valuable to monitor the need for policy change.

Keywords: Women's health indicators – Gender-sensitive health indicators – Pilot test – Manitoba Canada – Health disparities.

Prairie Women's Health Centre of Excellence (PWHCE) is supported by the Women's Health Contribution Program of Health Canada to improve the health of women and girls through policy advice, new research, information analysis, and communications. PWHCE's work with the WHO Kobe Centre and the Core Set of Gender Sensitive Leading Health Indicators is part of a larger project to develop a *Profile of the Health of Manitoba Women*[1]. The *Profile* will be a gender-based secondary analysis of existing data sets and reports for more than 100 indicators, providing a unique report on the status of women's health in the province. The *Profile* will also include recommendations for data collection, monitoring and policy change.
In March 2005, PWHCE contacted the Kobe Centre to offer to field test the gender-sensitive leading health indicators in the province of Manitoba in Canada and work began by the summer. The Kobe Centre provided technical assistance for the development of the pilot test. This paper provides information about the feasibility of using the WHO Core Set of 37 Gender-Sensitive Leading Health Indicators in a province of Canada. We begin with a brief description of the province, health services and administrative data, as they are pertinent to the results of the pilot test.

Manitoba and its residents

The province of Manitoba is in the east-west centre of Canada, with a southern border with the USA. It is a vast province (649 950 km^2), with a relatively sparse, unevenly distributed population (1.2 million). More than half the population lives in the capital city, Winnipeg (700 000), and most of the population lives south of 53°N. A great deal of the "land" in Manitoba is in fact freshwater rivers and lakes.
The original indigenous (Aboriginal) peoples of Manitoba were largely nomadic, traveling between and among established lakes and hunting grounds, as well as sheltered areas for wintering and trap lines. During European settlement and colonization, the indigenous peoples were moved off their traditional lands by force or by law and many were required

[1] For background information on the history preceding the *Profile* and the original set of indicators, please see Donner, L. 2004. The *Profile* is being done with collaboration and support from Manitoba Healthy Living and Health Canada and will be completed in 2007.

to live in Reserves under Canadian law. The history of the settlement and colonization of Manitoba, and the distribution of the arable and non-arable land, has led to considerable disparities in economic development and stability. Systematic and systemic oppression have created large inequities for Aboriginal residents in particular. For instance, under current law some Aboriginal people are entitled to some additional funded health services while others are not (MORN 2005, Bent, in prep). Other rural residents in Manitoba are largely dependent on single resource-based incomes that can be unstable, subject to the vagaries of weather, market demands and international trade agreements.

For the purposes of this project, issues of jurisdiction and entitlement for Aboriginal[2] residents are further complicated in the data. Manitoba Health collects utilization data about all residents, and data can be retrieved about those persons who voluntarily declare their First Nations status to Manitoba Health. In this system, all others are considered to be "non First Nations". On the other hand, Manitoba Vital Statistics, which is responsible for data about births and deaths in the province, includes in the death registry as "First Nations" all those, and only those, whose place of residence at the time of their death was a First Nations Reserve. This excludes all Aboriginal Manitobans who live off Reserve and includes non First Nations Manitobans living on Reserve. Statistics Canada uses several methods for determining Aboriginal ancestry, most often using the broadest definitions, allowing survey and census respondents to self-identify as Aboriginal. However, some First Nations Reserves refused to take part in recent Censuses, and in other cases widely used surveys (such as the Canadian Community Health Survey) did not include residents of the northern territories (most of whom are Aboriginal), or any First Nations Reserves, thus excluding many Aboriginal people from the survey population (Statistics Canada 2001).

While these definitions and points of jurisdiction are important, the main issue should not be overlooked: Aboriginal people, especially Aboriginal women, have greater morbidity and mortality when compared to other Canadians, illustrating the need to do more than dis-aggregate data by sex. It is not possible to identify other sub-groups, except by age and geographic location, in the data sets.

Health systems in Manitoba

The health care system in Manitoba is multi-layered. Under the federal system of government, health is a matter of provincial jurisdiction; provinces are responsible for health budgets, monies, and the provision of health care. Provinces must comply with the provisions of the federal *Canada Health Act*, which since 1984 has ensured universal free access to physician and hospital care for all residents (medicare).

In 1998 Manitoba *de-centralized* the direct provision of health care to Regional Health Authorities (RHAs). Except for physician care in their offices, the actual delivery of health service is almost exclusively the domain of the RHAs. RHAs are responsible for public health, hospital administration, and community health clinics. The province maintains responsibility for ultimate oversight of health care expenditures, sets certain policy, and provides direction. Although the regionalized system was developed to allow for more local control of the community over health care provision, it has led, in some ways, to *centralization*: community hospital boards were dissolved and some smaller hospitals were closed or reduced their hours and range of service.

Manitobans are free to seek care from the physician of their choice. Access is an issue, however, since there are shortages of both family physicians and specialists, particularly outside of Winnipeg, where there are very few specialists in practice. Rural and northern Manitobans are often referred to Winnipeg for specialist care, and under some circumstances, their travel costs are also covered by the medicare system.

Because fee-for-service physicians bill Manitoba Health directly for all medical services and because hospitals report patient information directly to Manitoba Health, the department keeps two comprehensive data bases about population health care utilization. We have drawn upon published data from these in testing these Gender-Sensitive Leading Health Indicators.

Methods

For each of the proposed gender-sensitive leading health indicators we:

- obtained data if available for Canada and/or Manitoba, giving preference to using provincial data for Manitoba. Where small sample sizes prohibited age and sex disaggregation of the Manitoba data, we used Canadian data, available from national surveys held by Statistics Canada;
- determined if the draft indicator should be modified in any way given local circumstances (for example, we expanded the low birthweight indicator to include a separate analysis of high birthweight and we expanded the suicide indicator to include hospitalizations for self-inflicted injuries);
- analyzed the sex-disaggregated data, and other relevant literature, to provide a gender-based analysis of the implications for women's and men's health for each indicator;

[2] The term Aboriginal in Canada is commonly used to mean those persons who are First Nations (also called Indian), Métis and Inuit. These terms are confounded when they are used interchangeably in some policy and research discourse.

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– suggested policy implications from our findings;
– assessed the usefulness and applicability of the indicator.

We were limited to secondary analysis of existing data sets and thus we were unable to provide information about some indicators that would have required new, qualitative research: 2-005 *Women's Decision Making on Own Income* and 3-006 *Respectful Medical Care*. The final report was submitted to WHO Kobe Centre in spring 2006.

Results of the Field-Test

In November 2003, the Expert Group Meeting (WHO 2004a) set criteria for the Gender-Sensitive Leading Health Indicators. They specified that each indicator should:
– act as an early alert for emerging health issues and have a predictive capacity;
– highlight current and significant health issues that require and will respond to priority action;
– cover issues that underlie a range of health problems and would be further elucidated by gender-based analysis;
– be useful for monitoring performance and for evaluation of interventions – it should be feasible to measure the indicator;
– be valid and reliable for the general population and for diverse population groups.

In general we found that the indicators selected meet these criteria, and, taken together and individually, provide useful information about the health status of women and men.

General findings

The results of our field-test are summarized in Table 1 (see printed at the end of this text). Most of the indicators could be tested through provincial health utilization data or national survey data or both. Our general findings were:

1. National or provincial data do demonstrate differences between women and men. However, women and men are not homogeneous groups, and national or provincial level data do not adequately reflect health disparities among women and men. Other factors must also be considered in understanding the health of the population. In Manitoba, the most important of these (that can be measured) are:
   – income
   – aboriginal ancestry
   – age
   – geographic location

   Note that we cannot analyze health disparities among other sub-populations by ancestry from the data.
2. Indicators which measure mortality should be expanded, where possible, to include some measure of morbidity as well, such as hospital readmission (for 1-001 *Maternal Mortality* and 1-003 *Infant Mortality*) and Health Adjusted Life Expectancy (for 1-005 *Life Expectancy at Age 65*).
3. Where possible, both survey data and health utilization data should be used. Despite well-recognized issues of reliability in using survey data to measure social behaviours (e. g. 2-007 *Heavy Drinking*, 2-008 *Illicit Drug Use*, 2-009 *Overweight and Obesity* and 2-010 *Condom Use*), we found that survey data and utilization data can describe different, but equally important measures of health status. For example, we expanded our analysis of 1-006 *Self-Rated Depression* to include Treatment for Depression, using work published by Martens et al. (2004), based on all Manitobans treated for depression through the public health system. The Canadian Community Health Survey (CCHS*)* methodology is based on the same diagnostic questions as those recommended for physician use. While women were more likely to be considered depressed than men in both data sets, in other ways there were strikingly different results. CCHS found the highest rate of depression among young women aged 15 to 19 (12 % in one year), yet those most likely to receive treatment for depression were women aged 40 to 50 (28 % over 5 years, compared to 15 % of their male counterparts) (Statistics Canada, CANSIM Table 105-0005 2004; Martens et al. 2004). Martens et al. (2004) also found that of the 409 Manitobans who were found through the survey to be at probable risk of depression, only 150 (37 %) were actually treated for depression; the remainder received no treatment. Of the 581 who were treated for depression, 431 (74 %) were classified as not at "probable risk of depression". This raises many questions that cannot be answered from these data alone.
4. It is important to consider how the indicators in the Core Set, plus other factors, combine to influence the health of women and men, and how those influences are similar and different. For example, women's greater risk of poverty contributes to disparities in health both between women and men, and among sub-populations of women (Donner 2000).
5. Neither survey data nor health utilization data alone tell the complete stories of the ways in which gender influences health. Often the data point to questions that could best be answered through in-depth interviews and other qualitative research methods beyond the scope of this field test.

Detailed results

Of the 37 indicators, 23 could be tested without modification. We have recommended enhancements to 10 of these. One more could be tested with some modification to the definition provided. We found 13 of the indicators could not be tested

in Manitoba, nor in Canada, and that of the 37, one was not relevant in our situation.

Indicators tested without modification:
1-008 Domestic Violence
1-009 Sexual Violence
1-011 HIV Prevalence
2-003 Literacy Rates
2-004 Proportion of Population Living Below National Poverty Line
2-006 Percentage of Regular Smokers
2-007 Heavy Drinking
2-008 Prevalence of Illicit Drug Use
2-010 Percentage Of Young People Aged 15–24 Reporting Using Condom At Last High Risk Sex
2-012 Access to Safe Abortion
3-002 Rate of Cataract Procedures
3-003 Medication for Cardio-vascular Disease
3-007 Wait Times for Coronary Interventions

Indictors tested without modification, and with proposed enhancements:

1-001 Maternal Mortality. In countries where data are available, this indicator should be expanded to include maternal morbidity. We suggest including:
1. Hospital Readmission for Any Cause Within 3 Months of Birth as a measure of severe maternal morbidity only. "Readmission" will, however, exclude those women who give birth outside of hospital.
2. Severe Maternal Morbidity During Birth and the Immediate Postpartum Period, although it does not capture those complications arising after discharge from hospital following childbirth.

1-002 Low Birthweight. Low birthweight remains an important indicator of both maternal ***and*** infant health in an industrialized country such as Canada. High birthweight also creates risks for both mothers and infants (Health Canada 2003), and we recommend that, in countries where the data are available, this indicator be expanded to include live born infants with birthweight greater than 4000 g.

1-003 Infant Mortality. Infant mortality is the single most comprehensive measure of population health (Health Canada 2003). To be useful as a gender-sensitive indicator, we recommend that where possible, the data be disaggregated by neonatal and post neonatal mortality. Neonatal mortality is strongly related to maternal care during pregnancy and childbirth (Manitoba Health 2000), whereas post neonatal mortality (excluding deaths associated with congenital abnormalities) is more strongly related to infant care and living conditions. In countries where data are available, this indicator could also be expanded to include neonatal and post neonatal hospital readmissions as a measure of infant morbidity.

1-004 Mortality Rate for Children Ages One to Four Years. In Canada, when all deaths among children aged one to four years of age were reviewed, there were no significant differences between boys and girls. Since childhood deaths are relatively rare in Canada, we recommend that data be presented for more than one year at a time. This will allow for the analysis of sex-disaggregated data at the provincial and more local levels. Furthermore, we recommend that where data permit, additional information about causes of death be included.

1-005 Life Expectancy at Age 65. Where data are available, life expectancy data should be supplemented with a measure of the quality of life, such as Health Adjusted Life Expectancy.

1-006 Self-Rated Depression. As described above, we recommend expanding this indicator to include treatment for depression where these data are available.

1-007 Self-Rated Health. The indicator as proposed includes only an analysis of "fair" and "poor" self-rated health. We recommended that this be expanded to include the other categories of "excellent" and "very good".

1-010 Suicide. In Manitoba and in Canada suicide is an excellent gender-sensitive indicator of the health of men and clearly points to the need for gender-sensitive suicide prevention programs. However, examining suicide alone underestimates the importance of self-inflicted injuries among women. Hospitalizations for self-inflicted injuries for Manitoba women exceeded those for men by at least 7-fold. We recommend that, where data are available, this indicator be expanded to include information about self-inflicted injuries. Adding an indicator that includes all injuries could also be considered.

2-009 Overweight and Obesity. We suggest this indicator be renamed "healthy body weights" and that all four weight groups (underweight, normal weight, overweight and obese) be included. The limitations of Body Mass Index as a means of measuring healthy body weights should be explained. It would be valuable to make the connections among the issues of gender, body image, healthy body weights and physical activity.

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3-004 Births Attended by Skilled Health Professionals. Nearly all births in Manitoba are attended by a physician or midwife. It is important, however, to continue to record and monitor the women's access to maternity care, including choices in providers, and information about the distances women must travel to give birth.

Indicator tested with some modification:
2-011 Contraceptive Prevalence. Despite the importance of contraception in the lives of Canadian women and men, comprehensive contraceptive prevalence data are not available. This indicator was modified to make use of the data available about women's contraceptive use. There are no publicly available data about Canadian men's contraception use.

Indicators which could not be field tested in Manitoba:
There were few indicators that we could not test at all. Most often, this was the result of short-comings of data collection, rather than the value of the indicator.

2-001a Access to Potable Water and 2-001b Adequate Sanitation could not be tested as required by the WHO criteria. Most residences are supplied by public or semi-public water and sanitation systems, according to provincial and national guidelines. However, boil-water advisories are issued regularly for some communities, and sometimes for long periods of time. A means of consistently measuring access to water, and the subsequent health of the population would be valuable.

2-002 Use of Biomass Fuel. There is no way to measure this indicator in Manitoba. The extreme fluctuations in annual temperatures require all residents to have heat, most of which is generated via public utilities. This indicator is not relevant for Manitoba.

2-005 Decision Making on Own Income. National survey data about income are conducted by household, rather than by individual, and men's and women's ability and freedom to have control over their personal income is therefore not collected separately. This is an important indicator and worth investigating in jurisdictions with the appropriate capability.

2-013 Regular Health Exams. Physician standards for periodic or regular health exams vary with age, sex and other factors. Complete physicals and ambulatory visits are both recorded, but not in accordance with the WHO definition.

2-014 Prevalence of Anemia. Iron-deficiency anemia is rarely the primary reason for physician visits in Manitoba. Data sets for blood composition are held separately by private laboratories in Manitoba, under arrangements with Manitoba Health, and cannot be extracted for these purposes. While this will be an important indicator in some jurisdictions, it does not apply to Manitoba. We recommend that the indicator be modified to include some other measure of adequate nutrition for children and adults.

3-001 Ambulance Transport. Emergency medical transportation is not an insured benefit under Manitoba's medicare system. Manitobans may get ambulance transport through private insurance, often provided as an employee benefit. Some First Nations Manitobans can get transportation to and from home communities as part of federal entitlements, but not in all circumstances. There is no way to measure this indicator in Manitoba.

3-005 Facilities Offering Gender-Sensitive Care. A means to monitor the availability of gender-specific, gender-sensitive and women-centred health care services and delivery is valuable where available. The definitions of these terms (gender-specific, gender-sensitive, and women-centred) should be made clearer.

3-006 Respectful Care, and 3-008 Access to Provider of Choice. There are national survey data on patient satisfaction that could be used in lieu of these, but there are no data available which match the WHO definition.

3-009 Proportion of Population Covered by Insurance, 3-010 Not Seeking or Deferring Care and 3-011 Out-of-Pocket Health Expenditures. As all physician and hospital care is insured through the medicare system, Manitobans do not defer medical or hospital care due to personal costs *per se*. However, women report that the expenses of travel and accommodation, lost income, childcare and other items contribute to their decision about whether or not they will seek health care (Sutherns et al. 2004). The costs of uninsured health services (such as prescription drugs, dental care, physiotherapy, optometry and "alternative health services") are prohibitive for some Manitobans. However, data about both expenditures on these items and costs as a barrier to seeking health services, are currently only available at the household level, preventing any gender-based analysis. These indicators are important to monitor, even within countries that provide universal health care, to establish base-line sex-disaggregated data of out-of-pocket expenses, and to monitor changes, particularly for women, who are more likely to have limited incomes.

We recommend the addition of three indicators to the *Core Set*.

a) **Proportion of Women and Men Living in Suitable Housing** – While we acknowledge that this would be difficult to measure, stable, secure housing is a critical issue for the health of women and men and should be included in the *Core Set*.

b) **Proportion of Women and Men Using Prescription Drugs** – One of the indicators in the *Core Set* looks at prescription drug use (*3-003 Utilization of Medication for Cardiovascular Disease*), however there is no indicator for overall prescription drug use among women and men. Manitoba research has shown that women were both more likely than men to have had prescriptions dispensed in the previous year and on average, had more prescriptions dispensed than their male counterparts (Fransoo et al. 2005). In other circumstances, women's lower incomes may prevent them from filling prescriptions. We suggest two potential indicators:
   – proportion of women and men being dispensed at least one prescription per year, by age
   – average number of prescriptions dispensed for men and women, by age, per year period

c) **Proportion of Women and Men with Cardiovascular Disease** – Cardiovascular disease (cvd) is the leading cause of death among both Manitoba women and men (Statistics Canada 2006). In Canada, cvd is also the leading cause of hospital admissions among males, and among females is second only to hospitalizations for pregnancy and childbirth (Grace et al. 2003). We suggest that some or all of the following be considered for inclusion:
   – cardiovascular disease prevalence
   – treatments for cvd
   – mortality from cvd
   – risk factors for cvd (some of these including smoking, overweight/obesity and poverty are already included in these Indicators)
   – cardiac rehabilitation
   – hospitalizations for cvd (Tudiver & Kammermayer 2005).

Policy implications

Part of the task of the field test was to consider the policy implications for each indicator. We found that the relevant policy level for the indicators varied considerably. In some cases the field test pointed to the need to change or address the data collection guidelines to measure the indicator at all. In other cases, the indicator illustrates a need for change in principles, presumptions and systemic health care. Thirdly, there were indicators for which we could address specific policy at some responsible level, either requiring change or further gender considerations.

Conclusions

Manitoba, a province of a developed country (Canada), served as a good field test site for the core set of gender-sensitive leading health indicators. With access to comprehensive health utilization data from within the province and national survey data from Statistics Canada, it was possible to test most of the indicators. Of the few that could not be tested, only one (biomass fuel) was completely irrelevant for the population. Others, as identified above and in Table 1, would be valuable to collect and monitor over time, though they may require modification.

The Manitoba field test demonstrates that indicator analysis should include sub-populations and regional or socio-economic disparities. Fransoo et al. (2005) illustrate differences in the health status of Manitobans by sex, region and income level for certain health conditions. Our additional analyses confirm that Manitoba's population health is not homogeneous. Gender-based analysis, with information drawn from other sources and consideration of women's and men's roles, responsibilities and relative social power, serves to explain why these differences may exist.

Completion of the *Manitoba Women's Health Profile* in 2007 may uncover additional information that could be applied to the Core Set, but in the meantime, we have observed and recommended a few changes to the list, including our proposal that the Core Set include three new indicators. Wilson (2004) and Bent (2004) point to the need for indicators that are culturally appropriate for Aboriginal women and which incorporate spiritual and emotional dimensions, in keeping with Aboriginal holistic views of health and well-being.

Monitoring inequities in health is not sufficient however; we require action to improve the health of women, and to remove the gender-based barriers to good health.

Addendum

The *Core Set of Gender-Sensitive Leading Health Indicators* includes "rate of self-rated depression" as the sole indicator of mental health status. In Canada, until June, 2006, these data were available from Statistics Canada, based on survey responses to the Composite International Diagnostic Interview (CIDI) Short Form for Major Depression. Data were collected as part of two national surveys – the National Population Health Survey (1994, 1996 and 1998) and the Canadian Community Health Survey (2000-01 and 2003). Respondents were grouped into one of four categories – no risk of depression, possible risk of depression, probable risk of depression, or risk of depression not specified – based on their responses to a series of questions.

In July, 2006, Statistics Canada announced that they would no longer support the use of "probable risk of depression" as an indicator of population health, noting that the short form interview had never been fully validated by the CIDI research team. At the current time, Statistics Canada does not support its use as an indicator of the probability of depression or to calculate the population prevalence of depression. Instead, Statistics Canada recommends using the concept of Major Depressive Episode (previous 12 months or lifetime).

One notable difference between these two different measures of depression is that where Probable Risk of Depression consistently showed the highest rates among young women aged 15 to 19, Major Depressive Episode – Previous 12 Months, shows that women aged 35 to 44 are at highest risk. While the Short Form CIDI may not have reliably identified major depression, it did serve as an early alert to troubling trends in mental health, particularly among young women.

This change by Statistics Canada results in the following changes to our results. Of the 37 indicators, 22 (rather than 23) could be tested without modification and 2 (rather than 1) could be tested with a modified definition

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Table 1 Results of pilot field test of the WHO core set of gender-sensitive leading health indicators in Manitoba, Canada.

	Indicator	Definition	Data Collection & Reporting	Comments on Data Collection & Reporting	Applicability of the Indicator
1-001	Maternal Mortality	Deaths of women while pregnant or within 42 days of the termination of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from other causes, expressed as a rate per 100000 live births.	All deaths are recorded and reported to provincial Vital Statistics authorities. These are reported through the Canadian Perinatal Surveillance System and some provincial systems. In Manitoba, the College of Physicians and Surgeons investigates and reports on all maternal deaths.	Maternal mortality is a rare event in Canada. In order to measure perinatal morbidity and the quality of perinatal care, this indicator could be expanded, in countries where data are available, to include maternal hospital readmissions and/or severe maternal morbidity during birth and the immediate postpartum period.	This is a useful indicator, as maternal mortality is still an important indicator of women's health in an industrialized society such as Canada. It could be strengthened by including available data about regional and other disparities. Where data are available, this indicator could usefully be expanded to include maternal morbidity.
1-002	Low birthweight	"Number of liveborn babies per 1000 live births with birthweight less than 2500g as a percentage of the total number of liveborn babies weighed, with the measurement being taken preferably within the first hours of life, before significant postnatal weight loss has occurred"	Registration of births is compulsory and birthweights are collected as part of the provincial/ territorial Vital Statistics systems. These authorities forward this information to Statistics Canada, which publishes it annually.	1. Rather than low birthweight, the Canadian Perinatal Surveillance System (CPSS) reports on infants born "small for gestation age". 2. High birthweight (greater than 4000 g or 8.8 pounds) increases the risk of birth complications for both mothers and babies (Health Canada 2003). Data about high birthweight are published annually by Statistics Canada. The CPSS reports on babies born "large for gestational age" rather than on high birthweight. In Manitoba the ratio of high birthweight to low birthweight births is approximately 3:1.	1. Low birthweight is an important *gender sensitive* leading health indicator, because it is a reflection of the health of pregnant women. It is also an important health indicator because low birthweight infants are more likely to experience increased morbidity and mortality later in life. 2. National level data may not reflect regional and other disparities, especially socio-economic status.
1-003	Infant morality	Death of any live born infant, in the first year after birth. The three components of infant mortality are: a. early neonatal mortality (birth to 6 days); b. late neonatal mortality (7 to 28 days); and c. post neonatal mortality (29 to 364 days).	1. In Canada, deaths must be registered under provincial and territorial Vital Statistics Acts or equivalent legislation. Vital Statistics Acts follow a model that was developed to promote uniformity of legislation and reporting among the provinces and territories. Provinces and territories send their death registration data to Statistics Canada, which compiles these into national databases. Live births and infant deaths are linked. Data are published annually by Statistics Canada. 2. In Manitoba, the College of Physicians and Surgeons investigates and reports on all neonatal deaths.	In order to obtain a broader measure of infant health, this indicator could be expanded, in countries where data are available, to include neonatal and postneonatal hospital readmissions.	1. Infant mortality is the single most comprehensive measure of population health (Health Canada 2003). In order to be useful as a *gender-sensitive* leading health indicator, we recommend that where possible, the data should separate neonatal and post neonatal mortality. Neonatal mortality is strongly related to maternal care during pregnancy and childbirth, and is therefore an indicator of both women's and infants' health. Post neonatal mortality (excluding deaths associated with congenital abnormalities) is more strongly related to infant care and living conditions. 2. National level data do not tell the complete story. Available data about regional and other disparities, especially socioeconomic status and

Table 1 Continued

	Indicator	Definition	Data Collection & Reporting	Comments on Data Collection & Reporting	Applicability of the Indicator
					other appropriate factors (such as information marginalized groups) should be included. 3. In countries where data are available, this indicator should be expanded to include neonatal and post neonatal hospital readmissions as a measure of infant morbidity.
1-004	Child Mortality One to Four Year Olds	Deaths of boys and girls aged 1 year to less than 5 years of age.	as per 1-003 above	Canada has one of the lowest child mortality rates in the world. However, low overall rates mask important regional differences (Brownell 2004). Reporting on more than one year of data at a time would allow for the analysis of both regional differences and causes of infant deaths.	Child mortality is an important indicator of population health. Since childhood deaths are relatively rare events in countries such as Canada, it is recommended that data be presented for more than one year at a time. This will allow for the analysis of sex-disaggregated data at the provincial and regional levels. Where data permit, information about the causes of death should also be presented.
1-005	Life expectancy at age 65	Number of years a person would be expected to live, starting at age 65, if the age and sex-specific mortality rates for a given year were held constant over the estimated life span.	Life expectancy is calculated based on 5 year age groupings using the most current mortality data. In Canada, the registration of deaths is compulsory under provincial and territorial Vital Statistics Acts or equivalent legislation. Provinces and territories send these data to Statistics Canada, which makes them freely available.	Increased life expectancy at age 65 is not necessarily accompanied by additional years of good health and functional status. Canada has adopted "Health Adjusted Life Expectancy" (HALE) in order to address this issue (Statistics Canada 2005). HALE is a more comprehensive indicator than life expectancy, including quality of life. HALE is important as a gender-sensitive leading health indicator, because it reflects women's greater burden of chronic disease.	Life expectancy at age 65 is an important indicator of the health of senior men and women. Where data are available, life expectancy data should be supplemented with a measure of the quality of life, such as Health Adjusted Life Expectancy. Since HALE data will be available through the WHO's World Health Survey, international gender-specific comparisons of women's and men's quality of life will be possible. It could be strengthened by including available data about regional and other disparities.
1-006	Self-rated depression	Persons at "probable risk of depression" based on a subset of items from the Composite International Diagnostic Interview, designed to produce diagnoses of depression in accordance with the DSM-II-R and the ICD-10.	Self-rated depression data are drawn from the *Canadian Community Health Survey.* The last year for which data are available from all provinces is 2000/01. Residents of the northern territories, First Nations Reserves, military bases and institutions are excluded. Statistics Canada makes these data freely available.	1. Rates of depression among both males and females in Canada have increased over time. 2. Risk of probable depression varies over the life course. In every age group females are at higher risk than are males. It is therefore important to report these data by both age and sex. 3. Comparison of those reported at probable risk of depression with those who were actually treated for depression (Martens et al. 2004)	This indicator is highly relevant to Manitoba and Canada. Data should be reported by both age and sex. Changes in rates of self-rated depression over time should also be monitored. Where data are available, it should be expanded to include treatment for depression, as well as self-rated depression

Table 1 Continued

	Indicator	Definition	Data Collection & Reporting	Comments on Data Collection & Reporting	Applicability of the Indicator
				found little overlap between the two groups. Unlike self-rated depression, which is highest among young women aged 15 to 19 years (12 % over 1 year), those most likely to be treated for depression were women aged 40 to 50 (28 % over 5 years). (see Addendum).	
1-007	Self-rated health	Self Rated Health (or self-perceived health) is a measure of how individuals describe their own health. In Canada, Self-Rated Health is measured using the following five point scale: excellent, very good, good, fair and poor.	This is a standard question asked in each cycle of CCHS, every two years. Results are made freely available by Statistics Canada. See 1-006 above for exclusions.	1. This indicator is one of the core set of comparable health indicators agreed to by Canada's Prime Minister and Premiers, for annual reporting to Canadians. 2. Age is an important factor in self-rated health, and the proportion reporting their health as "excellent" or "very good" decreases with age. In every age group, women are more likely to report their health as "fair" or "poor". Data should therefore be presented disaggregated by both age and sex. 3. The self-rated health of Canadian women and men decreased from 1994 to 2003. Statistics Canada has determined that this reflects a decrease in actual, rather than perceived, health status (Statistics Canada 2004).	Self-rated health is an important indicator to include in the Core Set of Gender Sensitive Leading Health Indicators. Self-rated health has been shown to be a valid and independent predictor of both illness and mortality. Canadian data, like those from other countries, show male/female differences, which point to women's greater burden of chronic disease. The indicator as currently drafted focuses on "poor health". We believe that it is important to examine "excellent" and "very good" health as well as "fair" and "poor" health and suggest that the indicator be modified to reflect this.
1-008	Domestic violence	1. WKC Definition: "the range of sexually, psychologically, physically coercive acts used against adult and adolescent women by current or former male intimate partner". 2. Statistics Canada definition: "respondents' (aged 15 years and over) self-reported experience of physical violence or sexual violence by a current spouse/partner or an ex-spouse/partner within the past five years." Note that this definition includes violence against men.	Data are collected every five years as part of the Canadian General Social Survey, a telephone survey. Derived variables calculated include: highest level of abuse, multiple spousal violence, occurrence of injury, need for medical attention, harm of others in the incident, whether a child under 15 years was harmed, whether a child witnessed violence, whether respondent felt their life was in danger, and whether abuse was reported to police. The time at which abuse occurred is distinguished as either within the past five years, within the past 12 months, or within the respondents' lifetime. Data are reported for male and female victims separately.	1. Some groups of women are at increased risk of domestic violence. In Canada, young women and Aboriginal women are at greater risk of spousal violence (Federal-Provincial-Territorial Ministers 2002). 2. The current WKC definition excludes same-sex partner violence. Canadian data about same-sex partner violence are available, but do not distinguish between lesbian women and gay men. 3. Spousal homicide data cannot be gathered by survey and should be included. In Canada, the sources for these are police data, as reported by Statistics Canada.	1. This indicator is applicable in Manitoba and does not require any modification. 2. Where additional data are available about groups of women at increased risk of violence (e. g. younger women, Aboriginal women, women working in the sex trade) these should be included. 3. Data about spousal homicide, from other sources, are also important to add to this indicator. 4. Survey language should be open enough to collect information about same-sex spousal violence.

Table 1 Continued

	Indicator	Definition	Data Collection & Reporting	Comments on Data Collection & Reporting	Applicability of the Indicator
1-009	Sexual violence	1. WKC Definition: "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work". 2. Statistics Canada Definition: as above, plus unwanted sexual touching.	Data are collected every five years as part of the Canadian General Social Survey, as in 1-008 above.	1. The GSS is limited because it does not ask about lifetime experiences of violence, including childhood sexual assault. 2. Police data are more limited than surveys such as the GSS, as many victims of sexual violence do not report these assaults to the police.	1. This indicator is applicable in Manitoba and does not require any modification. 2. Where additional data are available about groups of women at increased risk of violence (e. g. younger women, Aboriginal women, women working in the sex trade) these should be included. 3. Women's experiences of childhood sexual abuse, and their consequences for women's health, are important issues not captured by this indicator, because the GSS collects information only about the recent past.
1-010	Suicide	Deaths from suicide	In Canada, deaths must be registered under provincial and territorial Vital Statistics Acts or equivalent legislation. As described in 1-001 above, provinces and territories send their death registration data to Statistics Canada, which compiles these into national databases. These are freely available by age and sex.	1. Cases are limited to those where the physician certifying death states suicide as the cause of death. 2. Examining suicide alone underestimates the importance of non-lethal self-inflicted injuries among women.	1. Suicide is an important gender-sensitive leading health indicator for men. 2. Non lethal self-inflicted injuries are much more prevalent among women than among men. Where data are available about self-inflicted injuries (e. g. hospitalizations for self-inflicted injuries), this indicator should be expanded to include these.
1-011	HIV Prevalence	Prevalence of HIV positive among total population	1. Physicians are required by law to report all cases of HIV to Manitoba Health. 2. Manitoba Health issues public reports about HIV cases by age, sex and identifiable risk factors. 3. Manitoba Health verifies all cases with laboratory data, prior to inclusion in their reports (Manitoba Health 2005).	Provincial and national data mask the higher risk of HIV infection among certain sub-populations.	HIV prevalence is an important gender-sensitive indicator, as evidenced by the growing number of new infections attributable to heterosexual activity and the increasing proportion of women among those newly diagnosed with HIV. Wherever possible the data should be collected and reported to reflect the rates among sub-populations.
2-001a	Access to potable water	Percentage of population with access to potable water, rural and urban	Not collected in Manitoba. Boil-water advisories are issued when provincial drinking water standards are not met. We have included data about boil-water advisories.	The mechanisms and means to monitor access to drinking water should be in place. Recent publicity surrounding unacceptable drinking water and boil-water advisories in many First Nations communities has highlighted the importance of this issue in Canada.	Yes, but data are not currently available in Manitoba.

Table 1 Continued

	Indicator	Definition	Data Collection & Reporting	Comments on Data Collection & Reporting	Applicability of the Indicator
2-001b	Access to adequate sanitation	Percentage of population with access to adequate sanitation	Not collected in Manitoba.	These data are not collected since access to adequate sanitation is assumed for all. However, many remote communities (mostly Aboriginal) do not have access to adequate sanitation systems. In addition, many rural residents rely on private septic fields and septic tanks, which, when not properly maintained, may contribute to pollution of groundwater.	Yes, but data are not currently available.
2-002	Proportion of population using biomass fuel	Bio-mass fuel is any material, derived from plants or animals, deliberately burnt by human, for example, wood, animal dung, crop residues, and coal. Solid fuel use is the household combustion of coal or biomass (such as dung, charcoal, wood or crop residues)	Not collected in Manitoba	Bio-mass fuel is not used in Manitoba.	Not relevant for Manitoba.
2-003	Literacy rate for population aged 15–24, male and female	WKC Definition: A person is considered literate if he/she can read and write with understanding a simple statement relating to his/her daily life. Statistics Canada Definition includes four domains: prose literacy, document literacy, numeracy and problem solving.	Canada collaborates in UNESCO's reporting (2004) as well as other surveys conducted with the OECD and Statistics Canada. In most cases the information is collected both by sex and by province, allowing a closer understanding of literacy level rates in Manitoba. Data sources for this indicator come from OECD Programme for International Assessment, and from the International Adult Literacy Survey (IALS).	Research illustrates that literacy, as with other health indicators, does vary with socio-economic factors in Canada. Culture and population history may explain regional and sub-population variations and disparities.	Yes.
2-004	Percentage of population living below national poverty line	WKC definition: National definition of poverty line will be defined based on the country statistical methods. Canadian definition: Canada does not have a "national poverty line". Statistics Canada's Low Income Cut Off Rate (LICO) is the most widely accepted measure of poverty, and that is the one used for this report.	1. LICOs are based on family and community size. Canadians with income below the LICO spend disproportionate amounts of money for food, shelter, and clothing. The cut-offs are updated to account for changes in the consumer price index over time. All sources of income are included – both market income and government transfers. 2. There are two ways of measuring LICOs – before-tax and after-tax. Statistics Canada prefers the after-tax LICOs. Low income rates are lower on an after-tax	1. While poverty rates decreased in Canada from 1999 to 2003, the gender gap remained constant, pointing to the importance of gender-based analysis of income as a determinant of health, and the ways in which gender and income interact with other determinants to influence health. 2. Income and income inequality are well understood as important determinants of health. However, Canadian policy makers have been slow to use this information to change public policies to reduce poverty and income inequality. Health	Yes. Income is strongly connected to health. Women of every age are at greater risk of poverty than men. Data about vulnerable sub-populations should be included where available.

Table 1 Continued

	Indicator	Definition	Data Collection & Reporting	Comments on Data Collection & Reporting	Applicability of the Indicator
			basis than on a before-tax basis, reflecting the entire redistributive impact of Canada's tax/transfer system.	services organizations often also have not used this knowledge in the development, delivery and evaluation of health services. 3. National and provincial level data mask the increased risk of poverty among sub-populations, including Aboriginal people, unattached senior women, single mothers, and families whose major income earner is female.	
2-005	Decision-making on own income	Proportion of women making their own decisions about their income	Not collected for Manitoba	We agree that this is an important issue. Women may or may not have access to "family income". This would require survey research beyond the scope of our project.	Yes, but data are not currently available.
2-006	Percentage of regular smokers in population 15+, by age	WKC Definition: Regular smoking is defined as daily smoking.	Data are from the Canadian Tobacco Use Monitoring Survey (CTUMS), a random, telephone survey. It excludes residents of Nunavut, Yukon Territories and Northwest Territories, as well as residents of institutions. CTUMS data are made freely available by Health Canada.	1. As well as daily smokers, CTUMS includes data on occasional smokers, former smokers, and those who have never smoked. We have also included these categories. 2. Smoking prevalence among Canadian men and women has decreased. However, these data do not reflect the experience of groups including Aboriginal women and men and those living in poverty. 3. CTUMS reports on 15 to 24 year olds as a group. However, data from the Canadian Community Health Survey show that the highest rate of smoking occurs among girls aged 15 to 19 years (21.3 % compared to 12.7 % of boys their age). 4. Exposure to second-hand smoke is an important health issue not covered by CTUMS.	Yes.
2-007	Proportion of population aged 15+ indulging in heavy drinking, male and female; by age	WKC Definition: Heavy drinking and/or binge drinking to be defined (e.g. national gender-specific standards) Statistics Canada Definition: heavy drinking is the population aged 12 and over who are current drinkers and who reported drinking 5 or more drinks on one occasion, 12 or more times in the past 12 months (CCHS).	This is a standard question asked in each cycle of CCHS, every two years. Results are made freely available by Statistics Canada. See 1-006 above for exclusions.	1. The current Canadian standard for heavy drinking is the same for males and females. However, Canadian research has shown that a lower standard may be appropriate for women (4 drinks instead of 5). The application of the same standard for both sexes may underestimate binge drinking and its negative health risks for women (Wechsler et al. 1995). 2. Binge drinking carries a heavier	Yes.

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Table 1 Continued

	Indicator	Definition	Data Collection & Reporting	Comments on Data Collection & Reporting	Applicability of the Indicator
				social stigma for women than for men, which may effect their self-reporting, especially of drinking during pregnancy.	
2-008	Prevalence of illicit drug use in population (particularly aged 15-24) by substance	WKC Definition: Illicit drug defined as in national legislation. Statistics Canada Definition: Illicit drug use refers to the current (within the past year), or lifetime use of any of the following: cannabis; cocaine/crack; amphetamines (speed); ecstasy; hallucinogens (PCP, LSD); sniffed glue, gasoline, other solvents; heroin; steroids.	This is a standard question asked in each cycle of CCHS, every two years. Results are made freely available by Statistics Canada. See 1-006 above for exclusions.	Illicit drug use carries a heavier social stigma for women than for men, which may effect self-reporting, especially during pregnancy.	Yes
2-009	Overweight and obesity, by age	WKC Definition: Percentage of adults with body mass index 25–29.9 (overweight) or 30.0 or more (obesity). Body mass index calculated as weight (in kilos) divided by (height in metres)^2	1. This is a standard question asked in each cycle of CCHS, every two years. Results are made freely available by Statistics Canada. See 1-006 above for exclusions. 2. In 2004, a special one-time CCHS survey included direct measurement (by a trained person) of respondents' height and weight, allowing a calculation of BMI.	1. The 2004 direct measurement survey yielded sharp increases in rates of obesity. 2. BMI is not a direct measure of body fat. Therefore, it cannot distinguish between very muscular individuals and those with excess fat. 3. BMI does not account for the difference in male/female body compositions, men on average being more muscular. 4. BMI is not an appropriate measure of weight for pregnant women. 5. Eating disorders, related to body image issues, are much more common among women than among men, especially among young women. They can lead to ill health and death.	1. We suggest that this indicator be renamed "healthy body weights" and that all four weight groups (underweight, normal weight, overweight and obese) be included. 2. The limitations of BMI as a means of measuring healthy body weights should be explained. 3. The Gender-sensitive Leading Health Indicators should make the connections among the issues of body image, healthy body weights and physical activity among women.
2-010	Percentage of young people aged 15-24 reporting using condom at last high risk sex	WKC Definition: High risk sex defined as penetrative sex with non-married and non-cohabiting partner within 12 months. Statistics Canada Definition: Condom use during last intercourse, asked only of those who were sexually active in the last year and who were either single, or if married or living common-law, identified themselves as having more than one sexual partner in the last year.	This is a standard question asked in each cycle of CCHS, every two years. Results are made freely available by Statistics Canada. See 1-006 above for exclusions.	The social stigma attached to having multiple sexual partners, and discomfort with discussing sexual matters, including condom use, may have affected responses.	Yes.

Table 1 Continued

	Indicator	Definition	Data Collection & Reporting	Comments on Data Collection & Reporting	Applicability of the Indicator
2-011	Contraceptive prevalence rate (particularly aged 15–49); male and female; by contraceptive	WKC Definition: Percentage of population of reproductive age (15–49) who are using (or whose partner is using) a contraceptive method at a particular point in time	1. Data about contraceptive use are not routinely collected by Statistics Canada. 2. Data about non-prescription and non-surgical contraceptive use are not collected through Manitoba Health's Administrative data. 3. Some national data about contraceptive use by women only, are available from the privately funded 2002 Canadian Contraception Study (Fisher, Boroditsky and Morris 2002).	Given the importance of contraception to women's health and well-being, the paucity of data about contraceptive practices points to a gap in knowledge about women's health.	Yes, but data are not currently available.
2-012	Access to safe abortion	WKC Definition: Safe abortions are performed by a trained provider with proper techniques and appropriate sanitary facilities. Although the legality or illegality of the services may not be the defining factor of their safety, for the purpose of these tabulations, unsafe abortion has been defined as an "abortion not provided through approved facilities and/or persons". If safe induced abortion (not necessary legal) is available or not, also taking into account different population groups.	1. Abortion has been legal without restrictions in Canada since 1988. However, access to abortion remains uneven. In many provinces, abortions remain available only in hospitals. 2. Statistics Canada publishes an annual Therapeutic Abortion Survey.	Data about abortions in Canada are incomplete. The annual Therapeutic Abortion Survey (TAS) includes all abortions performed in hospitals. Reporting of abortions done in clinics is voluntary and only aggregate data are provided. The Canadian Institute for Health Information estimates that the TAS includes approximately 90% of all abortions performed in Canada on Canadian residents. The TAS also includes information from 13 U.S. states about abortions performed on Canadian women (Statistics Canada 2005).	Although the data about abortions in Canada are incomplete, access to safe abortion is critical to women's health. It should therefore be included in the Gender Sensitive Core Set of Leading Health Indicators.
2-013	Proportion of population aged 15+, receiving regular health examination within 12 months, by age group.	WKC Definition: Regular health examination defined as in the national health care system. Excluding health visits due to medical condition.	1. Data for health visits for preventive purposes only are not available in Manitoba or Canada. 2. Data are available for three related topics: complete physical exams (CPE) (from the Manitoba Health administrative data); ambulatory care visits (ACV) (from the Manitoba Health Administrative data); and "difficulty obtaining health information and advice" (from the Statistics Canada Health Access Survey). 3. Data are not available about preventive services provided by professionals other than physicians.	Finding better ways to measure Canadians' access to, and use of, preventive health care services, is an important and timely issue. However, this indicator, as currently proposed, does not adequately address this issue.	The indicator as proposed is not a good measure of access to preventive health services in Manitoba.

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Table 1 Continued

	Indicator	Definition	Data Collection & Reporting	Comments on Data Collection & Reporting	Applicability of the Indicator
2-014	Prevalence of anemia in women	Percentage of women of reproductive age (15–49) screened for haemoglobin levels with levels below 110 g/l for pregnant women and 120 g/l for non-pregnant women .	Not available for Manitoba.		Not for Manitoba.
3-001	Ambulance (medical transport) by age	WKC Definition: Medical transportation to health care facility by ambulance	Data are not available for Manitoba. Ambulance services are not provided through the medicare system. Coverage may be purchased through private, extended health insurance plans, mostly provided as a benefit of employment. Those without these plans must pay privately for ambulance services. Access is an issue for those on limited incomes, and for rural residents. The province funds some service for rural residents.		Not available for Manitoba.
3-002	Rate of cataract procedure by sex, by age	WKC Definitions: a) The number of cataract procedures per 100000 population (age standardized or by age) b) The proportion of survey respondents reporting cataract surgery in the past five years (by age) Manitoba Definition: Rate of cataract surgeries per 1000 residents aged 50 years and older during the 3 year period April 1, 2001 to March 31, 2004	Data collected by Manitoba Health, for all Manitobans, based on physician billings for cataract surgeries and published by the Manitoba Centre for Health Policy (Fransoo et al. 2005).	1. Data have not routinely been reported. Sex disaggregated data were published for the first time in 2005. 2. Manitobans may have had more than one procedure, since surgery to each eye counts as a separate procedure (Fransoo et al. 2005).	Yes. Waiting times for cataract surgery is a topical issue. Manitoba Health has expanded the sites for cataract surgery.
3-003	Utilization of medication for cardiovascular disease, men and women, by age	WKC Definitions: a) The number of population having medication for cardiovascular disease per 1000 population. b) The proportion of respondents reporting use of medication for cardiovascular disease. Manitoba Definitions: Percentage of residents who received at least one prescription for statins (anti-hypertensive) and the percentage of residents who received at least one prescription for Angiotensin Converting Enzyme (ACE) Inhibitors from April 1, 2003 to March 31, 2004 (Fransoo et al.).	Data collected by Manitoba Health, for all Manitobans, based on pharmaceutical claims from the Drug Program Information Network, and published by the Manitoba Centre for Health Policy (Fransoo et al.).	1. Data have not routinely been reported. Sex disaggregated data were published for the first time in 2005. 2. These data do not address the appropriateness of prescribing practices. 3. These data do not show the extent to which patients persevere in their use of prescribed medications (Metge et al. 2003).	Yes, with limitation as noted in Data Collection and Reporting.

Table 1 Continued

	Indicator	Definition	Data Collection & Reporting	Comments on Data Collection & Reporting	Applicability of the Indicator
3-004	Percentage of births attended by skilled health personnel (excluding trained or untrained traditional birth attendants).	WKC Definition: The proportion of births attended by skilled personnel per 100 live-births. Skilled health personnel refer exclusively to those health personnel (for example, doctors, nurses, midwives) who have been trained to proficiency in the skills necessary to manage normal deliveries and diagnose or refer obstetric complications. Traditional birth attendants trained or untrained are not included in this category.	Maternity care provider(s) is recorded in the perinatal health record. Nearly all women are attended in birth.	1. In Manitoba "skilled health personnel" would apply to those who are licensed and regulated to practice (doctors and midwives), who have been trained to proficiency in the skills necessary to manage normal deliveries and diagnose, refer or manage obstetric complications. 2. Prenatal, intrapartum and postnatal care are provided at no cost through Manitoba's universal medicare system. 3. Access is an issue for many rural and northern women, forcing them to travel away from home in order to give birth.	As nearly all birthing women are attended by either a physician or a midwife, this indicator is of little relevance. Important related issues in maternity care not captured by this indicator include: distance travelled by birthing women; availability of maternity care in one's home community; decreasing numbers of family physicians providing maternity care; and access to midwifery services; rates of interventions in the birthing process (including Caesarean sections and induction of labour).
3-005	Proportion of health facilities that offer gender-sensitive patient-centred care (e.g. Rape Crisis Centre, Voluntary Counselling and Testing Services for HIV)	WKC Definition: to be developed.	Data are not available. A survey of facilities and programs was beyond the scope of this project.	1. Manitoba does not have a comprehensive inventory or directory of women-centred or gender-sensitive clinics, community centres or counselling services. 2. We understand gender-sensitive care to be appropriate for all aspects of women's health care, not just for sex-specific care, as suggested by the examples provided.	1. A means to monitor the availability of gender-specific, gender-sensitive and women-centred health care services and delivery is valuable where available. 2. The definitions of these terms (gender-specific, gender-sensitive, and women-centred) should be made more clear, even if to note they may be interchangeable in some circumstances.
3-006	Proportion of respondents reporting being treated with respect for men and women	WKC Definition: from World Health Survey "How would you rate your experiences of being greeted and talked to respectfully (outpatient care and hospital care asked separately)?" – very good, good, moderate, bad, very bad	Data are not available. The Canadian Community Health Survey Cycle 3.1 included questions about patient satisfaction with hospital, physician and community based care, which might be used in lieu of this.		Yes, but currently unavailable for Manitoba. Patients' satisfaction with care and patients' perception of quality of care are available.
3-007	Average waiting time for coronary interventions OR Average waiting time in primary care for patient to see doctor	WKC Definitions: a) Coronary interventions to be defined. b) World Health Survey: How would you rate the amount of time you waited before being attended? – very good, good, moderate, bad, very bad	National work is underway, commissioned by the Prime Minister and the Premiers, to better collect and report on wait times for key health interventions, including cardiac bypass surgery and angioplasty (CIHI 2006).	1. Data are not currently available disaggregated by sex. 2. How wait times are defined is critical. For example, are they measured from the time the patient first experiences the problem, or from the time the patient sees a primary care physician, or from the time the primary care physician makes a referral for specialist care, or from the time the specialist determines that the intervention is necessary?	Yes, but sex disaggregated data are not available at this time.

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Table 1 Continued

	Indicator	Definition	Data Collection & Reporting	Comments on Data Collection & Reporting	Applicability of the Indicator
3-008	Proportion of men and women accessing provider type of choice	WKC Definition from World Health Survey: "How would you rate the freedom to choose your health care provider – very good, good, moderate, bad, very bad?"	1. Physician care and hospital services are provided through the medicare system. Patients are free to seek care from the physician of their choice. Access to services is an issue for reasons including: number of providers, availability of specialists and distance. 2. Cycle 3.1 of the Canadian Community Health Survey included individual questions about access to specialist physicians, non-emergent surgery, diagnostic procedures (MRIs, CT scans and angioplasty). 3. Other health services, including, for example, dental care are not provided through the medicare system.		Not available for Manitoba.
3-009	Percentage of population covered by insurance, men and women; by age; also by gender-specific services	WKC Definition: Both mandatory and voluntary health insurances to be included.	Manitoba's universal, medicare system provides access to physician and hospital services at no cost, as well as some prescription drug, home care, and long term care services.	Private insurance coverage, often provided through employment, is important for care outside of physician and hospital care including, dental care, routine eye exams, physiotherapy, and "alternative therapies". There are no comprehensive data sets to record proportion of the population who have private coverage. Since these benefits are normally linked to employment, and since women are more likely to be employed in industries which do not provide extended health benefits, this would be an important issue to monitor for male/female differences.	Yes. However it is only applicable for services not covered by the medicare system. Comprehensive data are not currently available.
3-010	Out-of-pocket health expenditure, men and women	WKC Definition: Both formal and informal payments to be included. World Health Survey: The amount of payments to doctor's fee, medicine, transport, tests, other causes in local currency; both own and household contributions included (outpatient care and hospital care asked separately). Also question, if the client/patient paid less than normal due to government discount or exemption.	Not collected in Manitoba for individuals; household data only.		Yes. Qualitative research finds that rural residents have substantial additional costs when seeking health care, for transportation, accommodation and by lost income. Other residents may also incur costs not yet documented.

Table 1 Continued

	Indicator	Definition	Data Collection & Reporting	Comments on Data Collection & Reporting	Applicability of the Indicator
3-011	Not seeking or deferring care due to healthcare cost, men and women	World Health Survey: What are the reasons you did not get health care (11 alternatives, of which the first is related to costs)	Statistics Canada's Health Access Survey included a question about deferring treatment due to costs. However, since household level data were collected, data cannot be disaggregated by sex (CCHS cycle 3.1 forthcoming).	Manitoba's universal, medicare system provides access to physician and hospital services at no cost, as well as some prescription drug, home care, and long term care services. Cost is an issue for non-insured services, notably dental care, optical care and prescription drugs up to the ceiling at which the public Pharmacare system begins coverage.	Yes, but sex disaggregated data are not currently available.