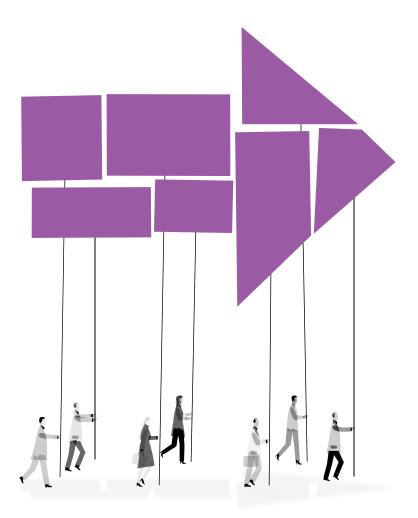# Women's Health and Safety in the Downtown Eastside

Companion Paper to the Second Generation
Strategy Design Paper

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Acknowledgments

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Executive summary

AS VANCOUVER COASTAL HEALTH EMBARKS ON A REDESIGN OF HEALTH SERVICES IN THE DOWNTOWN EASTSIDE (DTES) WITH THE SECOND GENERATION STRATEGY, WE RECOGNIZE THE URGENT NEED TO IMPROVE CARE FOR DIVERSE POPULATIONS OF WOMEN IN THE NEIGHBOURHOOD.

The absence of an explicit, coordinated and strategic approach to engaging marginalized women in the DTES and then keeping them connected to health care has unacceptable implications for the health status and overall quality of life for these women.

The first step to rectifying this exigent gap is to ensure that a gender lens – that includes an understanding of the diverse and intersecting oppressions that women experience – is embedded into the design, implementation and evaluation of health services and programs. Building our own knowledge and capacity, and fundamentally improving services for women in the DTES, is an urgent priority and critical to achieving the broader objectives of the Second Generation Strategy.

This paper is offered as a companion paper to VCH's 2015 DTES Second Generation Strategy Design Paper, which reflects on significant community and staff/physician consultation and sets high-level direction for changes to health services in the DTES.

Upon its release, the leaders of many of the women-servicing agencies in the DTES pointed out that while priorities for women's health issues were detailed in the discussion papers that preceded it, they were not adequately articulated or prioritized in the Design Paper. The Women's Health and Safety Companion Paper has been created to reaffirm the urgency in addressing women's health and safety in the DTES, and to set high-level direction and priorities in VCH's commitment to providing appropriate and adequate health services to vulnerable women in the DTES.

Through a literature review process as well as conversations with women residents and advocates in the neighbourhood, we have identified seven intersecting issues that help us to understand needs and prioritize planning. This paper is divided into short discussions and key actions on each theme:

1. **Women-centred clinical services:** A comprehensive and trauma-informed continuum of services that supports vulnerable women and their families to access the health services they need.

2. **Safe spaces:** Programs, services and spaces that are accountable for being safe, welcoming and relevant for women.

3. **Gendered violence:** Recognizing and addressing the pervasive issue of gendered violence against women and its implications on their health.

4. **Indigenous Cultural Safety:** Planning and delivering services that reflect the high proportion of Indigenous women living in the DTES and the unique marginalization they face.

5. **Gaps in services for hard-to-reach populations:** Ensuring programs and services acknowledge the specific needs of women who experience intersectional marginalization.

The use of the term "women" in this paper and in related plans for women-only and women-centred services contained in the VCH Second Generation Strategy are inclusive of trans, gender diverse, and two-spirit individuals.

6. **Keeping families together:** Championing policies and programs that support women to stay with their children and thrive as mothers.

7. **Leadership and collaboration:** Creating the governance structure and strengthening partnerships to ensure success.

VCH acknowledges the incredible leadership and resourcefulness of DTES community partners who serve women and we are grateful to them for continuing to call attention to the gaps in women's health outcomes and services. This paper would not be written had it not been for the advocacy of these groups. In the absence of VCH strategic leadership on the health and safety of marginalized women in the DTES, community partners have been carrying this critical work. Through strong collaboration and creative programming they have been providing an array of services that meet many of the diverse needs of women in the DTES – but much more is needed. As VCH embarks on a new women's health and safety strategic direction, this leadership in women's service provision needs to be learnt from, championed and built upon.

"VCH acknowledges the incredible leadership and resourcefulness of DTES community partners who serve women."

Context overview

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AS IN ANY COMMUNITY, A DIVERSITY OF WOMEN CALL THE DTES HOME. WOMEN COME FROM A VARIETY OF PLACES, CULTURES, FAMILIES AND EXPERIENCES.

Despite significant gains in some areas, women remain highly vulnerable to poor health outcomes, including infections, poor sexual and reproductive health, addictions and mental health issues.

There are substantial gaps in access to appropriate gender-specific and women centred services and all too often all-gender spaces and services are not safe for women or responding to their needs and interests. Many women in the DTES are the victims of past abuse and trauma, cycle through the justice system, and endure sustained and repeated acts of gendered violence. The effects of this trauma are often both compounded by, and result in, elevated risks for acute infection and chronic health conditions, suboptimal sexual and reproductive health, poverty, addictions, mental illness and increased use of the emergency department.

The current state of women's access to health services and safe spaces in the DTES is unacceptable. Women in the DTES continue to experience a high burden of both acute and chronic health issues and gendered barriers in access to care. The DTES is home to among the most horrifying experiences of gendered violence and missing women that continues to disproportionately impact the most marginalized – Indigenous women, sex workers, and women who use drugs.

The devastating impacts of gendered violence and systematic failure of health, police and other social services to protect women in the DTES over decades has led to deeply-rooted mistrust of service providers. Historical and ongoing distrust and adverse experiences with service providers further isolate women and can reinforce the traumatizing effect of experiences with health and social supports. Often concomitant with gendered violence and trauma, many women in the DTES experience a high burden of largely unaddressed mental health issues, particularly depression, anxiety and PTSD, and complex and changing substance use and addictions challenges.

To date, mental health and trauma services are fragmented and limited in scope, with few women-centred services. While harm reduction has made important gains in the health of DTES residents, few services have a gender equity lens. Housing remains a cornerstone of health and safety for women in the DTES; providing stability and respite for women and a conduit to health services.

Gendered violence, exploitation and abuse are common within all-gender housing, health and social services; particularly in the absence of services that include peer engagement and supports. In contrast, women-centred services have developed, in many cases including the voice of women in service delivery, and have been linked to reduced violence, increased stability and access to health, social and police protections. However, these services are too limited and women-specific (trans-inclusive) health and social services are not readily available to women. Further, there is a clear dearth of women's sexual and reproductive health and family-based services within the DTES, including for women living with HIV.

Key definitions

Women-only refers to programs or services that only serve women, trans-inclusive, while **women-centered** refers to programs or services that are built around and for women and their specific needs while being welcoming of all genders.

Gender-based violence is violence that is directed against a person on the basis of their gender (Women's Coalition, 2014)

Gender lens refers to thinking about all our work with an explicit focus on how it is or is not meeting the specific needs of all genders, particularly women who are experiencing multiple forms of oppression and the gendered barriers they face accessing health services and achieving equal health outcomes.

Trauma informed care means working at the client, staff, agency, and system levels from the core principles of: trauma awareness; safety; trustworthiness, choice and collaboration; and building of strengths and skills.

Re-traumatization refers to an experience that reflects a person's earlier experiences of powerlessness and loss of control.

Cultural Safety is defined and experienced by those who receive the service, and is based on understanding the power differentials and potential discriminations inherent in the health service delivery system.

Marginalized or hard-to-reach women is used to refer to women who are living with multiple and intersecting oppressions, often referring to women who experience one or more of the following: sex work, trans/gender diverse or LGBQ2S identities, drug users, poverty and Indigenous identify.

Trans-inclusive refers to services that have a comprehensive and explicit approach to creating a safe environment for people who identify as transgender, gender-diverse or two-spirit.

PRIORITY 1:
Clinical health services that respond to the unique needs of women

Outside of some exemplary programs, VCH clinical health services are not currently, in any comprehensive way, designed or delivered in response to women's specific needs and realities in the DTES. The usefulness of a gender lens in health service design has been acknowledged with some of these programs, most notably Sheway, which is co-funded with other organizations, and provides health and social service support to pregnant women and women with infants who are dealing with addiction issues.

VCH's women only clinics that occur once weekly at particular sites and some of the tailored outreach also nod to the unique health concerns of women, as well as the different types of approaches that successfully engage and retain vulnerable women into care.

However, the limited mandates and restricted hours of these services create well documented barriers for vulnerable women in accessing care. While mental health and addiction services, including harm reduction programs, continue to advance and innovate in the DTES, they rarely include an explicit focus on women's particular needs and therefore often fail to meaningfully engage women. In addition, the lack of a comprehensive approach as well as a women-centered primary health team with an inclusive mandate, means many women in the DTES are not engaging with health care easily. When women do engage they often experience stigma and re-traumatization that further isolates them from care.

While the health needs of women in the DTES are diverse, there are telling trends in the population. Often concomitant with past trauma, untreated mental illness remains a major challenge and we continue to see high rates of depression, anxiety, and PTSD among women in the DTES (Puri et al, 2016; Pierce et al, 2015). Severe mental health issues that require psychiatric support are among the top reasons for hospitalization and there remain major gaps in access to treatment and care supports for women with mental health issues including the fragmentation of services and limited access to trauma-informed care.

Drug use patterns continue to evolve among women in the DTES with persistent challenges related to ongoing stimulant use that are heavily linked to gendered violence (Duff et al., 2011; Shannon et al., 2011) While important new steps are being made in treatment of opioids, few existing services are women-centred and trauma-informed (Fairbairn et al., 2009; Shannon et al., 2008). There is also concerning data of increasing rates of diverted non-prescription opiates among women in the DTES (Argento 2014), particularly among youth and sex workers.

Alcohol use is a largely unaddressed issue among women in the DTES that is heavily linked to infection risks, homelessness, and reduced engagement in conventional health care. There are few women-only drug treatment options and even less for mothers with children; this alongside evidence that an unsuccessful attempt to access drug treatment on demand is empirically linked to three-fold increased risk of gendered violence (Shannon 2009). There are also significant gaps for women moving in and out of the DTES including abstinence-based women-specific beds for women transitioned out of detox and drug treatment.

"To date, mental health and trauma services are fragmented and limited in scope, with few women-centred services."

When they do access care women commonly report re-traumatization, both from poor treatment by health providers and from involuntary hospital admissions. The result is further distrust and reluctance in accessing care. For instance, DTES women report low access to counselling for past trauma and mental health issues, particularly anxiety and depression (Puri et al, 2016; Torchalla et al, 2015).

In contrast, there is significant best-practice and research that outlines what a comprehensive approach to women's clinical health services could look like. Women-only mobile and peer outreach services have empirically shown to be critical to increasing engagement in services for women, building women's agency in their health care, and promoting connections to care (Deering et al, 2013; Janssen et al, 2009). Trauma-informed services remain critical to promoting a culture of women's safety in service delivery by placing priority on women's choice; this is particularly important as a low-threshold approach for women not wanting to engage in treatment for mental health issues (TIP Guide, 2013). Key to operationalizing trauma-informed services within a gender lens is to create an environment where women do not experience re-traumatization and can make decisions about their treatment at a pace that feels safe (TIP Guide, 2013).

A continuum of services applied with a gender lens remains critical – from low-threshold harm reduction and addiction treatment models to increased access to detox and drug treatment beds for women (Smye, et al, 2011). In the European Union, women-specific drug consumption rooms have long shown to provide critical harm reduction and respite for women who use drugs, including reduction of HIV and HCV infections and drug overdose risk, as well engagement in treatment.

Key actions

New or enhanced services:

- Develop a full-time women's integrated health team with a mandate to meet women where they are, non-standard hours, embedded peer roles and an Indigenous lens

- Develop flexible outreach services, that includes Indigenous and non-Indigenous peers, designed to meet women where they are, with a specific emphasis on hard-to-reach women

- Expanding options for women who use substances along a continuum from harm reduction to abstinence-based services, including women only (trans-inclusive) treatment and increased treatment beds and other supports for young mothers using an Indigenous lens

- Expanding peer-based support and outreach models for hard-to-reach populations to deliver harm reduction and support after experiences with gendered violence

- Expanding peer navigator programs that includes Indigenous peers and a mandate to accompany women to health appointments

- Require all VCH DTES staff to develop competencies in trauma-informed care and competencies related to the needs of marginalized DTES women

- Prioritize gender-specific and women-centred supervised consumption rooms and other harm reduction services

Staff competencies and ways of working:

- Apply a gender lens across all internal DTES VCH operations; including reporting of differential health outcomes and access by sex and gender and Indigenous identity

- Ensuring specific positions for DTES women residents at steering committees and working groups where work is being done to address DTES related health planning and implementation

- Ensure a gender lens on health programs in relevant programs with strong health/police partnerships, such as ACT (Assertive Community Treatment)

PRIORITY 2:
Ensuring safe, welcoming spaces and relevant services and programs

Women are 38% of the population in the DTES and 31% of VCH's DTES client base; however VCH direct and contracted services are not adequately engaging or delivering services to the women who live in the neighbourhood – particularly the most marginalized. Currently, only 8 out of 55 VCH contracts in the neighbourhood provide women-only services with only $2.2 of the $58 million annual VCH DTES budget supporting women-only services.

While some women find sanctuary in these women-only spaces, others prefer programs and spaces that are more diverse and where they can attend alongside male family and/or friends. All too often these all-gender services, which make up the vast majority of VCH funding, do not offer safe, welcoming and relevant programs for women – including unchecked experiences of gendered violence and individual and systemic gender-based discrimination.

Gendered violence and institutional gender discrimination have substantial and long-term impact on how women experience health services and their willingness to re-engage. Gendered violence and discrimination are commonly reported within all-gender services that lack peer engagement and within the largely male-dominant culture of primary care, housing, and social support in the DTES.

In contrast, the current women-only and women-centered spaces in the DTES (e.g. WISH, DEWC, BWSS, Atira, Vivian, Sheway, Women's Health Collective etc.) offer unique services that meet many of the diverse needs of women in the community and also provide learnings and models that could, with additional funding, be expanded to reach more women and address gaps. These services, which often include peer populations in service delivery design, as well as flexible women-centred care approaches, have consistently been shown to be highly effective in engaging women along the continuum of care.

Research has shown links between women-only spaces with increased access to primary care and sexual and reproductive health services for women in the DTES (Dension et al., 2014; Krüsi et al, 2012; Janssen et al, 2009). Peer navigators and peer outreach as models of peer-programming have been shown in many settings to be instrumental in creating safety in health care environments and acting as a low-threshold entry point (e.g. harm reduction, violence support).

Community consultations have clearly voiced that a two-pronged approach is needed:

1. Increase women-only, trans-inclusive, services; and

2. Ensure that all-gender services are safe, welcoming and relevant for women, and all transgender people

A continuum of gender-specific and family-centred housing is also critical to women's safety, health, and stability. Precarious and unstable housing continues to be a challenge for the health of many residents. The lifetime prevalence of absolute homelessness (sleeping on the street) has been estimated to be as high as 88% among women in the DTES, with 43% of participants reported being homeless at least once over 18 month period, suggesting that many women in the DTES cycle in and out of homelessness (Duff et al, 2011). Homeless and marginally housed women in the DTES contend with an array of challenges that are amplified, including poverty, gendered violence, mental health issues, ubstance use, and enhanced barriers to health care and other services.

Increasing evidence has shown high rates of gendered violence and discrimination among women living in all-gender SRO (single

room occupancy) supportive and transitional housing spaces in the DTES (Duff et al., 2011; Lazarus et al, 2011). Gendered exploitation by male managers and staff, particularly when women are known to be sex workers, together with a lack of recourse in cases of abuse, put women at high risk for violence and further isolates them from supports (Lazarus et al. 2011). There is also a complete dearth of availability of family-centred housing options for women; representing a key gap in supporting women's overall health and keeping families together.

In contrast, innovative women-centred supportive housing models by RainCity (Vivian) and Atira – with women staff and engagement of women residents in service design – have been demonstrated to create critical protections and promote health and safety (Krüsi et al, 2012). Importantly, these housing models have been linked to improved access to health services.

Key actions

Contract requirements and ways of working:

- Require all VCH contracted services to put in place gender equity and gendered violence policies that includes an Indigenous lens

- Set goals and accountability for gender equity in staff and utilization of services by women, as well as by Indigenous women

- Include specific reporting requirements for VCH contracted services to increase patient/ peer engagement, including with Indigenous peers, in service delivery design and implementation

New or enhanced services:

- Work with partners to build on existing women-centred housing programs for both Indigenous and non-Indigenous populations, that provide a critical conduit to health and safety for women in the DTES and ensuring a continuum from low-threshold to transition supports in/ and out of the DTES

- With partners and women residents, create a better mechanism to increase safety and allow women to report abuse within all-gender VCH funded housing and within VCH funded or operated programs and services

- As the DTES population evolves, work with partners to ensure increased family-centred housing and programming, for both Indigenous and non-Indigenous populations, remains paramount

PRIORITY 3:
Recognizing violence against women as a systemic and urgent priority

Over the last three decades, the DTES has experienced epidemic proportions of gendered violence and missing women, particularly among Indigenous women, sex workers and women who use drugs (Opal, 2012). In a 2014 participatory action research project led by the Women's Coalition, 48% of the 157 DTES women who completed a safety audit identified that they had experienced violence within the last two years, while 18% expressed that they "live in fear" (Women's Coalition, 2014). Violence against women has been linked to devastating and acute health issues including physical and sexual injury, poor reproductive and maternal health and unwanted pregnancies, HIV and STI infections and depression (Garcia-Moreno & Watts, 2009).

The direct health issues that materialize due to experiences with gendered violence are compounded by systems, including health, that are failing to adequately respond. The lack of policy protections for women and the failures of both health and police contributed to one of the most horrifying chapters in the life of this community and created deeply rooted trauma and mistrust that shapes access to health care to this day (Pearce, et al., 2015; Opal, 2012; Shannon et al, 2009; Shannon et al., 2008).

Results from the community safety audit suggest that women in the DTES have low trust in the systems that are meant to be keeping then safe, including health, and that instead "formal and informal community connections… have been made integral parts of women's safety." (Women's Coalition, 2014) Avoidance of health services within the DTES due to gendered violence, fear of violence, and negative interactions with police has been empirically shown to displace more marginalized women away from health services to more isolated spaces – particularly youth, sex workers, and Indigenous women (Shannon et al., 2008; Benoit et al., 2003).

There are clear ways forward to address the glaring gaps in services for women in the DTES who are experiencing gendered violence as well as critical improvements to be made to the larger system and clinical care with individuals. VCH needs to know more about how this issue impacts the health system, be louder about its understanding of gendered violence in the DTES as a critical health issue and be part of a strategic push towards coordinating a response alongside key partners. When women experience gendered violence, health services, including outreach and peer components, need to provide a safe, respectful and clear pathway to support their healing and keep them safe.

Key actions

Data collection, analysis and call to action:

- Ensure clinicians are screening for experiences of gendered violence and connecting or referring clients to appropriate services

- Use data to inform or enhance programs and services

- Analyze and share data related to women's experiences with violence and the health impacts on both women and the system, stratified by Indigenous identity

- Develop a call to action identifying violence against women in the DTES as a critical health issue alongside a strategic response that includes an Indigenous lens

Enhanced services and ways of working:

- With partners, develop a coordinated gendered violence response (e.g. similar to the overdose response) including better connections between support services, reduction of service delivery silos and clear mechanisms for women to come forward in cases of gendered violence

- Develop a clear client pathway for clients who present with experiences of gendered violence

- Establishing peer-to-peer gendered violence support for women

- Create services that respond to the different needs of Indigenous women who have experienced gendered violence

PRIORITY 4:
Indigenous cultural safety

Indigenous women are disproportionately represented in Vancouver's DTES and face multiple barriers to accessing health care. Despite accounting for 4-5% of the population in British Columbia, Indigenous women account for 30-40% of the DTES women residents. Indigenous women in the DTES contend with a historical and intergenerational trauma and racism that shape social marginalization and risk within service delivery settings and increased health burden (Denison et al, 2014; Duff et al, 2014; Smith et al, 2005). Of the approximately 96 Indigenous participants in the community safety audit, 24% reported experiencing cultural discrimination.

In another study, Indigenous women living in the DTES reported the following as their priorities for healthcare services:

1. Supportive and safe places for them to seek refuge;

2. Health staff who understand how historical and ongoing racism negatively impact their health, language, identity and self-respect;

3. Health services that incorporate both traditional healing and modern health care; and

4. Spaces that welcome their families, especially their children (Benoit et al, 2003)

There remains a critical need for cultural safety in primary care and service delivery settings to reduce stigmatization and increase access to care (Czyzewski et al, 2016; Denison et al, 2014; Benoit et al, 2003).

Educating healthcare providers about culturally safe approaches to care is critical to mitigating the ongoing impact of colonialism and its effects on the health of Indigenous women (Czyzewski et al, 2016; Denison, et al, 2014). Equally as important is to think beyond training to what a culturally safe health care experience looks like at the system level and in a holistic way. A lack of Indigenous-led programming and Indigenous service providers/ staff continues to be identified as a major gap in creating cultural safety in care settings. Services that honour and promote Indigenous ways of healing, traditional knowledge, peer and family-based support, and self-determination remain critical within a trauma-informed care approach for Indigenous women.

Key actions

- Ensure that all DTES services follow the principles and processes outlined in the VCH Aboriginal Cultural Competency Policy

- Provide Indigenous Cultural Safety training opportunities to all VCH DTES staff

- Increase the number of Indigenous women working at VCH DTES facilities

- Incorporate Indigenous ways of healing and Indigenous-led programming into services in the DTES (including opportunities for Indigenous women to engage with Elders)

- Provide opportunities for Indigenous women to influence and participate in DTES health services planning

PRIORITY 5:
Addressing gaps amongst hardest-to-reach women in the DTES

While the population of women in the DTES is estimated to make up between 30-40% of the community, the diversity of these women's' needs have meant that some populations experience the worst health outcomes while being the least engaged in health and support services.

Sex workers

Sex workers are estimated to represent a sizable proportion of women in the DTES and yet there exists little to no health services specifically tailored to this population. Many of the sex workers in the DTES are among the most visible and impoverished sex workers in Canada, struggling with a disproportionate burden of complex and intersecting health and social inequities, including poverty, poor sexual health, addictions, trauma, and mental health issues. Rates of unaddressed PTSD are particularly high among women sex workers in the DTES, with an estimated 45% reporting having attempted suicide in their lifetime (Puri et al, 2016). Stigma by providers and fear of disclosure of sex work status remain major drivers of gaps in accessing primary care services (Lazarus 2012).

A recent Vancouver study of gendered institutional barriers to care found 70% of women sex workers experienced institutional barriers to care – including long wait times, limited hours of operation, lack of provider of preferred gender, and disrespect by health providers (Socias, et al, 2016). Violence by partners, clients, police or community, remain the strongest driver of institutional barriers to care. Those experiencing the highest barriers to care are also those with the highest markers of vulnerability: gender/sexual minority (LGBTQ2S) women, those with mental health issues, migrant/ refugee, and homeless women.

WISH Drop-In Centre Society provides the longest standing and only late-night drop-in and low-threshold service for women sex workers in the DTES. Several peer/sex worker-led non-for profit services (e.g. SWUAV; MAP; Aboriginal Wellness Program of WISH; PACE) provide critical peer-support and outreach to women sex workers. Research demonstrates the high uptake of WISH's low-threshold services and the role it plays increasing access to sexual and reproductive health care (Kim et al, 2015) as well as the critical role that peer sex worker-led programming has in improving access to care and health outcomes (Deering et al, 2013; Janssen et al, 2009).

Trans, gender diverse, and LGBQ2S individuals

Trans persons, including transgender, transsexual, two-spirit and gender diverse individuals, in the DTES experience high rates of transphobic violence and stigma, alongside criminalization that impact their experiences with providers and safety in accessing care. Furthermore, with roughly one-fifth of women in the DTES identifying as lesbian or bisexual, and a higher proportion of LGBQ2S women among youth and stimulant users, efforts to understand and address this in DTES women remains critical (Lyons et al, 2014).

Research with trans people who use drugs describes major gaps in accessing residential drug treatment, including stigma and lack of inclusivity for trans women. While women-specific services in the DTES have largely embraced inclusivity of trans persons, few services have explicit policies and staff training in place on trans-inclusive service provision (Lyons et al, 2016). When accessing health services, many trans persons report discrimination related to their gender identity and discrimination based on gender expression (e.g. requirement of a feminine gender expression and gender policing by providers and service users), and lack of staff intervention in harassment.

Elders/seniors

There is a growing population of seniors in the DTES. Within this group, there is an increase in Elder Chinese women who do not speak English. There is a lack of culturally safe services for this population and few Cantonese-speaking advocates available to accompany them to health care appointments and hospitals.

Understanding and addressing gaps in the diverse health needs of the senior population in the DTES and the specific needs of Elder Chinese women will be important moving forward.

Key actions

Enhance staff competencies and ways of working:

- Integrated women-centred care needs to be mindful of intersecting cultures and identities (e.g. trans and two spirit persons) and ensure holistic health services inclusive of social determinants and lived experiences of women

- Require all DTES VCH staff to have training that specifically addresses health care issues for sex workers and on trans and gender/sexual diversity and service provision, which includes an Indigenous lens

- Require all contracted agencies to develop trans and LGB2QS inclusive policies

New or enhanced strategies or services:

- Work with partners and people with lived experience to develop working groups and strategic plans that address the health care needs of sex workers, trans/gender diverse and LGBQ2S individuals, and Elder Chinese seniors in the DTES, all with Indigenous and gender lenses

PRIORITY 6:
Keeping families together and women's reproductive health

Women in the DTES experience high rates of stigma trying to access sexual and reproductive health (SRH) and parenting services (Torchalla et al, 2015; Duff et al, 2015; Lazarus, et al., 2012). There is limited access to contraceptives, low reports of accessing family planning and preconception counselling, high rates of unplanned pregnancies, and poor reproductive outcomes among women in the DTES compared to rates in the general population across BC (Duff et al, 2015; Torchalla, et al, 2015). This is particularly the case for women living with HIV (Duff et al, 2016). With an aging population of women in the DTES, access to mammograms and cervical cancer screening are also needed.

Fear of child apprehension creates barriers to accessing health services and supports for women and distrust in SRH and maternal health services (Denison et al, 2014; Smith et al, 2005). Many women have contended with being apprehended themselves as children, and research suggests upwards of one-third of women in the DTES have had one or more of their children apprehended in their lifetime (Duff et al, 2014). Indigenous women's experiences of child apprehension and custody loss are embedded in historical and intergenerational trauma and the legacy of colonization and residential schools.

Outside of Sheway, a women-centred care program that provides trauma-informed clinical care and support to women who are pregnant or parenting and use drugs (Salmon, 2014), there are few if any services for this population of women in the DTES, including a dearth of supportive family housing and addictions treatment that provide childcare.

Women-centred and family-based programs that are children-inclusive are urgently needed, alongside expanded access to safe, non-judgemental SRH services for women.

Key actions

New or enhanced services:

- Alongside partners, increase or enhance services for sexual, reproductive and maternal health within integrated care models – that include gender and Indigenous lenses and take multiple forms of marginalization into account

- Address service gaps for women with families and children including women-centred housing and supports for mothers with complex challenges who do not meet Sheway criteria

Enhance staff competencies and ways of working:

- Work with women with lived experience, MCFD and Vancouver Aboriginal Child & Family Services Society to understand gaps and develop a policy framework for family-centered services, particularly a common approach to working with substance-using parents with the aim of keeping families together.

PRIORITY 7:
Leadership and collaboration

The changes outlined in this paper are not going to happen without a governance and accountability structure and strong collaboration, relationships and trust with community stakeholders and regional partners. VCH recognizes there are systemic barriers that have prevented the prioritization of health care services for vulnerable women in the DTES and is committed to working differently and better to change them.

Key actions

New or enhanced ways of working

- Designate a dedicated VCH lead for women's health in the DTES

- With partners, identify a process to oversee the implementation of the commitments and goals outlined in this document
- Collaborate with regional partners (BC Women's, RICHER, BCCDC) to coordinate service delivery and ensure no gaps or duplications exists

- Work with the Gender and Sexual Health Initiative of the BC Centre for Excellence in HIV/AIDS and others to ensure better linkage of research to VCH programming

- Create formal processes of relating across health authorities, services and between sectors (e.g. City of Vancouver) for planning women specific and women-centered services

"Research suggests upwards of one-third of women in the DTES have had one or more of their children apprehended in their lifetime."

Table of key actions

Theme	Key actions
Clinical Health Services that respond to the unique needs of women	**New or enhanced services:** ▪ Develop a full-time women's integrated health team with a mandate to meet women where they are, non-standard hours, embedded peer roles and an Indigenous lens ▪ Develop flexible outreach services, that includes Indigenous and non-Indigenous peers, designed to meet women where they are, with a specific emphasis on hard-to-reach women ▪ Expanding options for women who use substances along a continuum from harm reduction to abstinence-based services, including women only (trans-inclusive) treatment and increased treatment beds and other supports for young mothers and includes an Indigenous lens ▪ Expanding peer-based support and outreach models for hard-to-reach populations to deliver harm reduction and support after experiences with gendered violence ▪ Expanding peer navigator programs that includes Indigenous peers and a mandate to accompany women to health appointments ▪ Require all VCH DTES staff to develop competencies in trauma-informed care and competencies related to the needs of marginalized DTES women ▪ Prioritize gender-specific and women-centred supervised consumption rooms and other harm reduction services
	Staff competencies and ways of working: ▪ Apply a gender lens across all internal DTES VCH operations; including reporting of differential health outcomes and access by sex and gender and Indigenous identity ▪ Ensuring specific positions for DTES women residents at steering committees and working groups where work is being done to address DTES related health planning and implementation ▪ Ensure a gender lens on health programs in relevant programs with strong health/police partnerships, such as ACT (Assertive Community Treatment)
Ensuring safe and welcoming spaces and relevant programs and services	**Contract requirements and ways of working:** ▪ Require all VCH contracted services to put in place gender equity and gendered violence policies that includes an Indigenous lens ▪ Set goals and accountability for gender equity in staff and utilization of services by women, as well as by Indigenous women ▪ Include specific reporting requirements for VCH contracted services to increase patient/ peer engagement, including with Indigenous peers, in service delivery design and implementation
	New or enhanced services: ▪ Work with partners to build on women-centered and gender-specific housing programs for both Indigenous and non-Indigenous populations, that provide a critical conduit to health and safety for women in the DTES and ensuring a continuum from low-threshold to transition supports in/and out of the DTES ▪ With partners and women residents, create a better mechanism to increase safety and allow women to report abuse within all-gender VCH funded housing and within VCH funded or operated programs and services ▪ As the DTES populations evolve, work with partners to ensure increased family-centred housing and programming for both Indigenous and non-Indigenous populations

Theme	Key actions
Recognizing violence against women as a systemic and urgent priority	**Data collection, analysis and call to action:** ▪ Ensure clinicians are screening for experiences of gendered violence and connecting or referring clients to appropriate services ▪ Use data to inform or enhance programs and services ▪ Analyze and share data related to women's experiences with violence and the health impacts on both women and the system, stratified by Indigenous identity ▪ Develop a call to action identifying violence against women in the DTES as a critical health issue alongside a strategic response that includes an Indigenous lens
	Enhanced services and ways of working: ▪ With partners, develop a coordinated gendered violence response (e.g. similar to the overdose response) including better connections between support services, reduction of service delivery silos and clear mechanisms for women to come forward in cases of gendered violence ▪ Develop a clear client pathway for clients who present with experiences of gendered violence ▪ Establishing peer-to-peer gendered violence support for women ▪ Create services that respond to the different needs of Indigenous women who have experienced gendered violence
Indigenous cultural safety	**Staff competencies and new or enhanced ways of working:** ▪ Ensure that all DTES services follow the principles and processes outlined in the VCH Aboriginal Cultural Competency Policy ▪ Provide Indigenous Cultural Safety training opportunities to all VCH DTES staff ▪ Increase the number of Indigenous women working at VCH DTES facilities ▪ Incorporate Indigenous ways of healing and Indigenous-led programming into services in the DTES (including opportunities for Indigenous women to engage with Elders) ▪ Provide opportunities for Indigenous women to influence and participate in DTES health services planning
Addressing gaps for the hardest-to-reach women in the DTES	**Enhance staff competencies and ways of working:** ▪ Integrated women-centred care needs to be mindful of intersecting cultures and identities (e.g. trans and two spirit persons) and ensure holistic health services inclusive of social determinants and lived experiences of women ▪ Require all DTES VCH staff to have training that specifically addresses health care issues for sex workers and on trans and gender/sexual diversity and service provision, which includes an Indigenous lens ▪ Require all contracted agencies to develop trans and LGB2QS inclusive policies
	New or enhanced strategies or services: ▪ Work with partners and people with lived experience to develop working groups and strategic plans that address the health care needs of sex workers, trans/gender diverse and LGBQ2S individuals, and Elder Chinese seniors in the DTES, all with Indigenous and gender lenses
Keeping families together and women's reproductive health	**New or enhanced services:** ▪ Alongside partners, increase culturally safe services for sexual, reproductive and maternal health within integrated care models ▪ Address service gaps for women with families and children including women-centred housing and supports for mothers with complex challenges who do not meet Sheway criteria
	Enhance staff competencies and ways of working: ▪ Work with MCFD and Vancouver Aboriginal Child & Family Services Society to understand gaps and develop a policy framework for family-centered services, particularly a common approach to working with substance-using parents with the aim of keeping families together
Leadership and collaboration	**New or enhanced ways of working:** ▪ Designate a dedicated VCH lead for women's health in the DTES ▪ With partners, identify a process to oversee the implementation of the commitments and goals outlined in this document ▪ Collaborate with regional partners (BC Women's, RICHER, BCCDC) to coordinate service delivery and ensure no gaps or duplications exists ▪ Work with the Gender and Sexual Health Initiative of the BC Centre for Excellence in HIV/AIDS and others to ensure better linkage of research to VCH programming ▪ Create formal processes of relating across health authorities, services and between sectors (e.g. City of Vancouver) for planning women specific services

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