EVALUATION REPORT

COMMUNITY HEALTH ADVOCATE (CHA) PROJECT

A Community Health Initiative Fund (CHIF) project sponsored by the

Vancouver Women's Health Collective

funded by

Vancouver/Richmond Health Board

CHIF Evaluation funded by

Vancouver/Richmond Health Board

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Evaluation Consultant

Persons involved with the Evaluation Consultant in discussion of the CHIF in-depth evaluation plan, analysis or final report over the past year include:

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Thank-you

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NOTE TO READERS:

In mid 1998, the CHA project was chosen as one of a number of CHIF projects to undergo an in-depth evaluation by the V/RHB. The actual evaluation work began in December 1998, and was initially intended to be completed by the end of March, 1999. However, in the early spring of 1999, when project funding was extended to the fall of 1999, an Interim Report was prepared by the Evaluation Consultant for April 1999. The Final Report was due for completion in the fall of 1999.

Rather than produce a Final Report as a separate document, the Consultant has chosen to fold the Interim Report and Final Report together. This provides the reader with a complete and integrated picture of project progress in one place. Text headings clarify which material is from the Interim Report and which was written for the Final Report. Interim Report commentary and findings contained here have not been changed from when they were first written in April/99.

SECTION 1. EXECUTIVE SUMMARY AND CONCLUSIONS

Summary - Project Process

In early 1998, The Vancouver Women's Health Collective (VWHC) received funds requested from the CHIF program for its part in the Community Health Advocate (CHA) project. Funding for other parts of the project were requested from three other funders, but not received. A CHA project coordinator was hired in July 1998.

The Community Health Advocate Project first located and visited potential community partners throughout the summer and early fall of 1998. From this work, 12 Community Health Advocates were found to work with and through these organizations. Several advocates worked on their own, out of their homes. The advocates and their partner organizations reflected the city's diverse population.

The 12 advocates went through a three-day, 16 hour training session in November 1998. The training curriculum was developed by the Project Coordinator, and a contract trainer, also funded by this project. During the fall of 1998, the CHA Project Coordinator also wrote and produced an Advocacy Manual, which was used as a basis for the training. A copy of the manual was given to each CHA. The CHA Project Coordinator wrote and produced brochures, posters and hand-outs to aid in public relations for the advocates and for the overall project.

The advocates began to work in their communities in January 1999. From then up to May 1999 they met as a group, with the Coordinator, once a month to discuss issues, share information and gain expertise and identify needs. Initially several advocates worked more than 10 hours a week doing this work, others did five hours a week or less. The initial expectation was that the advocates would volunteer an average of five hours a week on this project. The Project Coordinator maintained regular telephone and written communication with each CHA

The issues brought to the advocates from community women ranged from requests for basic health information and transportation to medical appointments, to more complicated questions about disability health rights issues and other broad needs that impact on women's health such as housing and poverty. There was not enough data from advocates or the CHA client tracking forms for this evaluation to comment on any pattern of need, or outcomes for women as a result of seeing and working with a Community Health Advocate.

In April 1999 the Interim Report noted that three CHAs had left the project due to other work arising, or travel. The project's first Coordinator left the project April 1 to pursue other interests. A new Project Coordinator was hired and started work in May 1999.

The Interim Evaluation Report of April 1999 stated that the project was at a challenging turning point, having lost its original Coordinator, and with the Community Health Advocates (CHAs) just beginning to get a sense of what the work involves and where it could go. Issues identified in

the early days of evaluation included:

- ✓ a need to affirm project direction in terms of the breadth of issues CHAs deal with;
- ✓ a need to revise the CHA tracking form to better meet the needs of advocates;
- ✓ whether or not the CHA manual should be revised to deal with identified gaps;
- ✓ if and how the advocates who have left should be replaced;
- ✓ ongoing training and resource needs of present CHAs;

On May 1, 1999 a new Project Co-ordinator was hired to continue with the CHA project on a 10 hour a week basis. A summer social work practicum student assisted her for 24 hrs a week from May 1 to August 15. Work completed to October 31, 1999 by the Project Coordinator involved:

- ✓ locating and visiting remaining CHAs over the summer months;
- ✓ organizing and running a (June) CHA training session on advocacy and disability issues;
- ✓ maintaining communication with community partners;
- ✓ organizing an (October) combined CHA/VWHC training session on diversity, meeting with session facilitators;
- ✓ working to integrate the CHA project more fully with the infrastructure of the VWHC;
- ✓ planning and putting on two social event/appreciation gatherings for CHAs and others at the VWHC;
- ✓ planning and holding CHA meetings in May and September 1999;
- ✓ contacting previous CHA Advisory Committee members and organizing a committee meeting for mid November 1999;
- ✓ meeting with several community partners about co-sponsoring community based workshops on women's health issues;
- ✓ planning a new direction for the project with the community based workshop model and working with the four remaining CHAs on this model;
- ✓ meeting with the V/RHB policy analyst (five times) and the Evaluation Consultant (four times) to discuss issues related to the V/RHB CHIF in-depth evaluation process;
- ✓ attending, on behalf of the VWHC and the CHA project, other community meetings related to women's issues;
- ✓ participating in the shared work of the VWHC, as a paid staff member. This included attending staff meetings once a week, collective meetings once a month, information centre meetings once a month, and relevant community meetings.
- ✓ responding to telephone calls about the project, usually from potential volunteers who had heard about the project through the Volunteer Vancouver website.

The Community Health Advocate Project is now setting off in a new direction. As of late October 1999, four of the original twelve advocates remain with the project. Instead of waiting for women to come to them with health related issues, they will be working with the Project Coordinator to put on women's health workshops at various community partner sites and building their advocacy work from that base. The VWHC intends to seek funding from other sources once the workshops are underway and the model is established.

Conclusions from the Interim Report - April 1999

Project Direction

✓ The outgoing Coordinator has observed, over the course of the past few months of CHA meetings, that the advocacy work is "*going off so many ways into larger issues related to health:* - such as housing, poverty, etc.

✓ Some CHAs feel that the Health Canada determinants of health should be the foundation from which they work, which would enable them to respond to, and take action on, a wide range of issues.

✓ The above ideas have implications for the overall direction of the project. For example, income is one of the major determinants of health, but there are other organizations (for example, End Legislated Poverty) doing advocacy work on low income issues. The Health Collective may need to review and/or affirm its vision for this work to ensure that the advocacy work maintains a focus that fits with the project vision, (see page 19) and the Health Collective's mandate.[1] The issue may be whether or not, or how much, the project is "led" by the issues if they move beyond what the organization is prepared to be involved with. On the other hand, if the Health Collective thinks of the CHA project as largely community development work, then they may well be prepared to let the work move in whatever areas it is going, monitor that and learn from it.

✓ Whatever the choice, the Health Collective and the new CHA Coordinator will need to be clear on their concept of this project's direction and be prepared to provide responsive leadership.

Project tools

✓ The tracking form needs re-working to better meet the needs of CHAs.

✓ If the manual's present usefulness is not to be lost, then needed revisions on topics such as housing, income support, and disability issues, should be researched, written and inserted. This would take staff time and is thus a budget issue.

✓ CHAs are requesting a copy of the Red Book, which they believe would increase their capacity to do advocacy. At $70 each, this is also a budget item.

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[1]The VWHC mission states: *The Vancouver Women's Health Collective provides education, resources and other support for women to empower themselves to take charge of their own health care.*

Attrition and replacement of Community Health Advocates

✓ The project will need to decide if it is going to replace the three advocates who have left the project, or any other advocates who choose to leave, and if so, how they will be trained and integrated into the work.

Ongoing training, information sharing, learning of CHAs

✓ Some CHAs report they are being used as resource people more than as advocates. This is to be expected given that advocacy often arises out of general discussion with someone about their situation. As well, the project is still in its infancy and its advocacy potential is not yet widely known. However, it still raises the question, for CHAs, and for the Health Collective, of how CHAs can most effectively obtain the information they need in order to be useful and ethical resource persons for the (so far) majority of their calls which are not solely advocacy related per se.

✓ The CHAs recognize the level of expertise that already exists amongst themselves and want to be sure ongoing training takes that into account.

Time and budget issues

✓ After receiving word from the V/RHB, earlier this year, that the present funding level would be continued until September 1999, the Health Collective has made the decision to operate this project on a 10 hour a week basis for the next six months. The outgoing Project Coordinator stated that fully maintaining the project and supporting the work of the CHAs took her between 16 and 20 hours a week.

✓ The outgoing Project Coordinator also noted that her experience had been that large parts of her project time, sometimes up to half, were devoted to Health Collective business and that this work was not directly related to coordinating the CHA project.[2]

✓ The CHAs expressed concern over the small amount of V/RHB funding received for the project overall, and the high expectations of what the project should achieve.

✓ Budget and time issues need to be reviewed by the Project Coordinator, the Health Collective and the funder. Issues to discuss could include:

- the Health Collective's expectations of the Project Coordinator regarding her involvement in other organizational meetings and activities;

[2]At the time of writing the final report, ongoing VWHC staff made the observation that they believed the previous CHA Coordinator spent some of her staff time as a volunteer on other VWHC committees and that this was her choice.

-the V/RHB's expectations of the overall project given the size of its budget;

-the expectations of all parties of what can be achieved in a short time frame by what is, in fact, a long term community development project being overseen by a largely voluntary organization, and being staffed by volunteer community health advocates and a part time worker.

Conclusions for the final evaluation report, November 1999

Both Coordinators for this project have worked hard and are to be commended on their energy, vision and stamina. The initial work of the first Coordinator (June 1/98 to April 1/99), carried out under difficult circumstances, was an excellent effort to put the original proposal in place. The ongoing work of the second Coordinator (May 1/99 to the present) shows creativity in re-working and adapting the project to become more realistic and hopefully, more effective.

There were nine project goals, three were outcome related, six were process related. Of the outcome goals, one was not achieved, two were partially achieved. Of the process goals, two were partially achieved, four were were achieved to some degree. (See Section Six for a full discussion of this.)

However, this project has not worked as it was originally envisioned for the reasons described in the following conclusions. There are lessons to be learned from this for the CHIF program, the V/RHB and the organization receiving the funds - the Vancouver Women's Health Collective.

Benefits of this project to the Vancouver Women's Health Collective

✓ Being involved in the CHA project has taken the VWHC out into a diverse community of women. This is enabling it, as an organization, to better mirror and serve the women in the lower mainland. One of the results of this is an intended move from present premises in an upstairs office on West 8th Avenue to a storefront on Main Street.

✓ Internal challenges to the CHA project have forced the VWHC to revisit and revise its hiring and collective processes, thus helping to strengthen the organization.

Benefits of this project to women of the Vancouver/Richmond Health Region

✓ A community development project such as this was not expected to be showing long term benefits until at least this time, but a number of challenges have delayed consistent delivery of the benefits. *After a year and a half of funding, the evaluation concludes that this project has yet to reveal consistent benefits for women in the Vancouver/Richmond health region.*

✓ *Nevertheless, it must be said that concept of this project - that of advocates working directly with women, listening to their health stories, and providing them with information and strategies that they can then use to empower themselves to act on their own behalf - is still worthy.*

The new direction of the Community Health Advocate Project

✓ As of October 1999 the CHA project has a new direction. It is now developing a plan to deliver community-based workshops with women already attending programs at some of the community partners the project is affiliated with. These workshops will be carried out by the Project Coordinator and the four remaining Community Health Advocates.

✓ The Project Coordinator reports that the purpose of the workshops is to provide project direction in a different way, specifically: to work in a group setting to get information directly from women that the tracking forms were not doing; provide women with information that will empower them about their health concerns; and offer advocacy as issues or needs emerge from the workshop setting.

✓ The Project Coordinator and the remaining advocates plan to follow up the workshops with advocacy as needed. The intent is to encourage women to "tell stories" about their health issues or concerns towards the end of each workshop. From this, the advocates hope to be able to make connections with specific women and follow through with support or advocacy.

✓ Once this work is underway, the Coordinator intends to look for other funding partnerships for the project.

Recommended ongoing planning and evaluation work for the project

✓ *Because this is, in effect, a new project, or at least an adapted one, the VWHC should, as soon as possible, develop realistic goals and objectives that fit the intended work, and produce a realistic time line and work plan.* For example, although the Project Coordinator, as of mid-November/99, is working 12 hours a week on the CHA project, it will likely take most of that time to plan and follow-up on perhaps one community workshop every six to eight weeks.[3]

✓ *Although this CHIF-funded in-depth evaluation is now over, the VWHC should develop a new set of success indicators and some basic evaluation tools,* so it can properly

[3]For example, discussion of a proposed workshop at South Vancouver Neighbourhood House began in early fall/99. The actual November 25 date was postponed because, due to its timing, no one came. A January meeting focus group meeting date has recently been set with women's groups in the Downtown Eastside to discuss a potential workshop in February/00.

document how the project adaptation is working, especially since the project funding was extended (in June 1999) to September 2000.

Lessons to be learned from the CHA project

✓ The initial concept of the Community Health Advocate Program, submitted to the Community Health Innovation Fund (CHIF) of the V/RHB by the Vancouver Women's Health Collective (VWHC) in the fall of 1997 was, (and remains), compelling. The thought that Community Health Advocates could help women to act on their health issues has kept up interest in the project despite consistent challenges to the work. *"It should work"*, *"It's needed"*, and *"women are calling out for this"*, were typical comments heard from staff and advocates during the evaluation.

✓ However, the project has been impacted from the start by factors largely related to the challenge of depending on volunteers, VWHC internal issues, the lack of dollars to run the project as planned, and the lack of planning by the VWHC to adapt the project to a smaller budget. To a lesser degree, it was also impacted by the V/RHB's process of funding and reviewing this project.

The challenge of depending on volunteers

- *The days of being able to run a major project on women's volunteer time and effort are over.* Although the volunteer CHAs believed it would be possible to commit five hours a week of their time to this project, as requested, this proved difficult. Each CHA did commit to doing the work for a year, and each did receive a small stipend for attending the training sessions. However, real life intervened all too quickly, in the shape of illness, stress, family commitments, job changes, lack of time, and for some, a sense of inadequacy around doing the actual advocacy work. The figures tell the story. Twelve CHAs attended the training in November 1998. By April 1999 nine remained in place and by September 1999 four CHAs were interested in staying involved. The fact that this level of attrition is now considered normal by most community organizations only emphasizes that this project's major dependence on volunteer efforts was not realistic.

- Successful advocacy requires times, knowledge, resources, commitment and, like any job, monetary support. The four women still working on a voluntary basis with the VWHC CHA project all happen to have pre-existing and continuing work as advocates in similar fields. Thus they were able to access and use the time, resources and monetary support from that other work to help support their commitment to "voluntary" work on women's health issues with the CHA project. In fact, they were able to incorporate the CHA advocacy in to their other advocacy responsibilities.

Lack of dollars and planning

Background: The VWHC received the CHA project funding at a point when it was in early recovery from a time of serious organizational difficulty. The VWHC actually closed its doors for a period of time in 1997, and new paid staff did not begin work until late 1997 and early 1998.

The CHA proposal was originally conceived in 1996 and written sometime in 1997. The proposal was submitted to the V/RHB in October 1997 by an interim administrator, with the approval of the ongoing volunteer collective. Between the time of project conception and the receipt of funding in early 1998 there was a complete turnover of paid staff and collective members. As the then Project Coordinator said in her interview: "*When I started no one was familiar with the project as everyone who had written it was gone. The job description was vague, just to write a manual and train advocates.*"

The initial project proposal to the V/RHB indicates that the VWHC intended this project to be run on a budget of $111,000 in its first year, with funding requested from the V/RHB, a provincial government ministry, another health-related agency, the United Way, as well as resources and volunteer hours from VWHC. (See the original project budget in the appendix.) Instead, in early 1998 the VWHC received only what had been requested from the V/RHB. A lump sum of $19,050 was received in late March 1998 for the fiscal year 1997/98. The 1998/99 allocation of $16,800 was received in monthly disbursements of $1,400 from April 1998 to March 31, 1999.

- The collective, which at that time consisted of two new paid part time staff and a small number of volunteers, felt affirmed by the fact that they had received monies from the V/RHB, and went ahead with the project. *However, the organization, hoping to still receive monies from other funders, did not revise the work to take into account the decreased budget.*

- The VWHC, in trying to make the project work with about 1/7th of the planned budget, while in recovery from a time of serious organizational decline, and without sufficient oversight expertise from other staff or volunteers, experienced stressful and high expectations, as well as differences of opinion about what the project could accomplish, how it should go ahead and who should be hired.

- *The bottom line is that there was never enough money to run the CHA project as it was intended.* The funds required to run the originally conceived project were never received from the range of funders that the proposal was sent to, but, using the small amount of dollars requested and received from the V/RHB, the VWHC moved the project ahead anyway.

VWHC internal issues and planning

- As well, internal disagreements within the VWHC around who should be, and was, hired to run the project, and the proper process for hiring, (present VWHC staff report that they believed the confidentiality of the hiring process was breached at the start of the project) led to a situation where the person who was first hired as project coordinator felt a lack of support from some people within the organization. In turn, those people felt the new CHA coordinator did not know how to, or wish, to work in an open collective manner. *These internal disagreements, combined with the organization's still weakened overall state, led to an atmosphere that was not conducive to encouraging the internal joint planning, problem-solving and guidance that this project clearly needed from the start.*

The CHA project and the V/RHB /CHIF project funding and review process

Background: The V/RHB received a well-written proposal from the VWHC that looked clever, insightful, and was clearly a good fit with the V/RHB goals and objectives and the Women's PHAC priority health issues. CHIF staff report[4] that they did speak with one of the other proposed funders of the CHA project in February 1998 and learned that a decision had not yet been made on that funder's involvement in the CHA project. They also report that their early 1998 discussions with VWHC interim administrative staff and volunteers apparently indicated the organization was excited about the project and keen to go ahead, despite no word of project funding from the other partner sources. Thus, in early 1998, V/RHB staff saw no obvious signs that the organization had been having any more internal difficulties than it might normally have. In turn, the organization, keen to get back on track after its period of organizational disarray, did not raise those recent internal organizational challenges with the funder.

- *However, this evaluation concludes that the V/RHB could have offered more specific intervention and planning guidance, especially after the July/98 CHA project report was received at the CHIF office.* That report, written by the Project Coordinator, indicated (a) that no other funds had been received for the CHA project to date, (b) that the project had decided to proceed as planned only on the V/RHB funds despite a planned project budget of over $100,000, and (c) the VWHC had received V/RHB monies in late March/98 and had not hired a staff person until July 1/98. The V/RHB Women's Advisory Committee reviewed the first Interim Progress Report received from the project on August 6, 1998, and flagged their concerns to the V/RHB Planning and Evaluation Department in the

[4] Personal Communication between Evaluation Consultant and F. Shroff, V/RHB Health Planning and Policy Analyst, December 2/99

usual review format later that month.[5] But by the time this feedback went through the V/RHB system and was received by the CHA Project Coordinator it was November, and project had already proceeded with its original plans. Apparently there was a meeting between the Project Coordinator and the V/RHB on November 5th/98 to discuss concerns, but there is no written record of that meeting in the files available to the Evaluation Consultant.

- *This evaluation report finds it difficult to conclude that the CHIF in-depth evaluation process applied to this project provides information useful to the intent of the V/RHB in-depth evaluation process, namely to "learn from this project's innovative design and volunteer-community development model." A careful and more probing reading by the V/RHB of both the July/98 CHA Interim Progress Report and the subsequent Women's PHAC review, could have changed what appears to have been a very early, and, in retrospect, perhaps an inappropriate decision, to include this project in the CHIF-funded in-depth evaluation process.* CHA project records indicate that they were to meet with the V/RHB to discuss being part of the in-depth evaluation as early as August 13/98, only six weeks after the Project Coordinator began her work and shortly after the V/RHB received the CHA Interim Progress Report. As it happens, the in-depth evaluation process with this project did not actually get underway until December 9/98. By then, it was even more clear to all attending the first evaluation meetings that the long-term community development nature of the CHA project and the delays in getting the advocates in place meant the evaluation was not likely to provide information on CHA project outcomes by the end of March/99 - the original deadline for the in-depth evaluation reports. (In fact, the initial evaluation plan intended only to focus on the project's process objectives, not outcome objectives.) Although the in-depth CHIF evaluation time line was subsequently extended to September 1999, with a focus on outcome objectives added to the evaluation plan, the challenges already described in the Interim Evaluation Report of April 1999, and in this report, prevented the project from moving forward as initially conceived and hoped.

✓ *Overall, this evaluation concludes that the VWHC has found itself in a place of continued vulnerability with the CHA project.* The V/RHB told them they were getting the money they had asked for from them. In fact, due to delays in the CHIF funding and approval process, the VWHC received all V/RHB requested monies for the 97/98 fiscal year in one lump some in early 1998, and then started receiving their monthly funding disbursement

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[5] The Interim Progress Report review form submitted to V/RHB's Planning and Evaluation Department by the Women's PHAC described that the weaknesses as *"too ambitious, not enough resources, not focussed enough"* and suggested that the project *"build on the info centre and do project from there, or stop project and strengthen information service, to focus, or hold a few workshops, produce manual quickly."*

for 98/99.[6] They had completely new staff. The V/RHB funding made them feel affirmed, especially after their troubled times, and they started off with a sense of "*we can do this*!" The fact that other funders had not yet come on board for the CHA project was possible to overlook at first, given the receipt of the 97/98 fiscal year funding in one lump sum in early 1998. Meanwhile, they were still hoping for other funders to kick in but did not plan soon enough for the possibility of that money not coming through. Concurrently, new internal differences isolated the first CHA Project Coordinator, and the project, within the organization, thus hampering the adequate development of necessary internal project oversight and planning mechanisms. Then the funder, as yet unaware of the organization's internal challenges, asked the CHA project to be involved in the CHIF in-depth evaluation process. The organization, thinking it was an honour to be asked, accepted, but they were also not yet aware of how the lack of funding and planning, plus their internal organizational difficulties, would affect the project's process and outcomes.

✓ *Once we strip away this project's issues of inadequate planning and funding, internal organizational challenges, and perhaps a lack of funder insight into the need for early guidance and oversight, the evaluation concludes that the major finding to date of this project is that it is no longer possible to build and run long term community development projects with a dependence on women's volunteer labour. In understanding this, it is possible to see that the project's focus on the concept of voluntary Community Health Advocates to be the drivers of this community development work was flawed from the start.*

Other issues of concern to the VWHC and the CHA project

✓ *It is the perspective of VWHC staff that regionalization of health services has inadvertently impacted on the core funding to the VWHC.* Although this is not directly related to the CHA project, it is related to the overall viability of the organization which in turn impacts on those working within it. Specifically, the VWHC used to receive a core grant of $16,000 from the City of Vancouver and this grant was historically used to pay a portion of the salary of an information centre staff person. With the advent of the V/RHB, the City cut their core funding to the VWHC over a several year period, suggesting that the VWHC should apply to the V/RHB for funds as the VWHC work appeared to be more under their mandate instead of the City's. . Eventually the VWHC did apply for funds through the V/RHB's CHIF program, which ties its monies to a specific project. As a result of these funds being tied to a project, the information centre, which is the core work of the VWHC, is now staffed only by volunteers and part time paid staff person working 16 hours a week. One impact of this is the expectation that staff funded through other projects, such as the CHA project, should put in paid and unpaid time to help with

[6]VWHC financial records show receipt of a lump sum of $19,050 in late March 1998, for the fiscal year 1997/98, and receipt of monthly disbursements of $1,400/month for the 1998/99 fiscal year. Total V/RHB funding received between March 1998 and March 1999 was $35,850.

the operational work of the VWHC. Although this is a laudable expectation for a collectively operated organization, in this case the first CHA Project Coordinator was trying to start up and run a project on what were already minimal hours.

On the other hand, it must be said, that even though the VWHC staff believe that the regionalization of health services has impacted on funding to the VWHC, the V/RHB did respond to the VWHC's CHA proposal, funding it to the level originally requested and eventually extending that funding.

✓ According to the VWHC administrator, the V/RHB allows 4% of project funds to cover organizational administrative costs. She states that this further undermined the resource capabilities of the CHA project as its budget did not adequately reflect the project expectations yet the VWHC's financial situation at the time was such that it did not have the funds to subsidize the administration of the CHA project. As a result, the VWHC has had to take more than 4% ($56) out of the monthly CHA budget of $1400 to cover the organization's administrative costs. (See the appendix for a copy of the 98/99 and 99/00 VWHC CHA budget.)

SECTION 2. PROJECT DESCRIPTION

The Community Health Advocate (CHA) Project is a project of the Vancouver Women's Health Collective. The project, funded by the Vancouver/Richmond Health Board, was designed to provide women in the Vancouver Richmond region with a consistent way to deal with violence, abuse and/or disrespect they may experience in the health care system through the training and support of community advocates for women's health.

The CHA Project sought to address the barriers women face in accessing safe, respectful and appropriate health care. The advocates intended to raise awareness of the needs of women in their communities, educate women on their rights, and help women develop tools to access proper care. The work of this project was intended to feed into the mission and mandate of the Women's Population Health Advisory Committee of the V/RHB.

The Vancouver Women's Health Collective assumptions underlying this project were:

- ✓ the issues of violence, disrespect and abuse in the health care system will be addressed when women's stories are heard;
- ✓ women are experts in their own health if they are encouraged, supported, and have access to resources enabling them to take charge of their own health;
- ✓ when women's stories about their experience in the health care system are listened to, much is learned. This information will be used to raise awareness of the needs identified by women.

The Community Health Advocates planned to provide opportunities for women in the self-defined communities (disabled, ethnic, geographic, age, income level, mental health) to empower themselves through provision of knowledge about their rights in health care system; support women in their community to overcome barriers that prevent them from receiving safe health care; work with women in their community to identify concerns related to health care; and advocate for change as necessary and appropriate.

The Vancouver Women's Health Collective was to select, train and support the advocates in their role, to administer the project, and to continue to steer the overall vision of decreasing violence, abuse and disrespect towards women in the health care system.

This project was largely volunteer-based. The volunteer Community Health Advocates worked approximately five hours a week and were paid an honorarium for their training time. A volunteer Community Health Advocacy Advisory Committee met occasionally early in the project to provide guidance to the CHA Coordinator. CHAs attended three initial advocate training sessions totalling 16 hours, received a CHA manual, plus ongoing support, communication and information from the Project Coordinator. Further CHA training was provided in June and October 1999.

From July 1998 to January 1999 the project budget allowed 20 hours of Coordinator time per week, as well as funds for a trainer to work about 150 hours over a three month period in late 1998 and early 1999. The collective's steering committee, recognizing a potential budget shortfall, shifted the coordinator's time to 16 hours per week from January to March/99, and 10 per week as of April/99. Budget re-allocation by the collective in mid November 1999 increased the Coordinator's hours to 12 per week.

Nursing and social work practicum students worked with the CHA Project Coordinator from February to March/99 and May to August/99 respectively. Over 400 hours of time were contributed to the project in this way.

SECTION 3. COMMUNITY HEALTH ADVOCATE PROJECT GOALS AND OBJECTIVES

GOAL	To empower women to know their rights in the health care system and support them in overcoming barriers that prevent them from receiving safe health care.
OBJECTIVES	
Process	A. To place 9-12 Community Health Advocates in self-defined communities in the Vancouver/Richmond health region.
Process	B. To provide CHAs with tools and guidance to carry out their work.
Process & Outcome	C. To assist CHAs in developing their advocacy plans and in taking action on those plans in a way that works best for them and their community.
Process	D. To work to have CHAs and the project create partnerships that support and provide input to the project.
Process	E. To develop a manual to support the advocates in their work, to maintain manual and change as needed.
Process	F. To provide information and support to the CHAs.
Outcome	G. To identify women's health care issues that are not being met in the specific communities CHAs are working in.
Outcome	H. To develop ways that women's health care issues can be met through the CHAs, Vancouver Women's Health Collective, community partners, and, when appropriate, by reaching out to the Centre for Excellence in Women's Health, Women's Population Health Advisory Committee of the V/RHB etc.
Outcome	I. To provide, in all aspects of the project's work, the opportunity and atmosphere for community women to empower themselves regarding their health care issues.

SECTION 4. EVALUATION APPROACH AND ASSUMPTIONS

These assumptions were developed by the Evaluation Consultant, and representatives of VWHC and the V/RHB at the start of the in-depth evaluation process.

1. The Vancouver Women's Health Collective Community Health Advocate Project is involved in the V/RHB CHIF evaluation, at the request of the V/RHB, because the Board believes there are useful lessons to be learned from this project's innovative design and volunteer/community development model.

2. The evaluation is qualitative and participatory in its design. The method will involve participants (VHWC, V/RHB and Community Health Advocates) in the identification of project goals and objectives, success indicators and appropriate evaluation tools. The evaluation plan and subsequent reports are to be reviewed by participants. The evaluation will describe the experience and process of the project from the experience of those involved.

3. This is an evaluation of the project's process and outcomes.

4. It is recognized that the long term community development oriented outcomes of the Community Health Advocate project will likely take longer to emerge than the time period of this evaluation. However, care will be taken to track initial outcomes through a case study process.

5. In its design and use of tools, the evaluation will take into account the short time frame allotted to the V/RHB evaluation process and the limited time available to the CHAs and VWHC project staff/volunteers for participation in evaluation work.

SECTION 5. EVALUATION GOAL, OBJECTIVES AND METHODS

GOAL: To monitor and assess the Community Health Advocate Project's process and outcomes.

OBJECTIVES	EVALUATION METHODS
A. The evaluation will assess the effectiveness and impact of the initial and ongoing training.	Review of training feedback forms Questions/probes in CHA focus group Question/probe in interview with Project Coordinator
B. The evaluation will assess the effectiveness of the CHA project structure, including communication, support, bases of operation, staffing, community partners etc.	Review of project records Questions/probes in CHA focus group Question/probe in interviews with Project Coordinator Question - in depth interviews with 4 CHAs* Survey of Community Partners* Site visit, as appropriate, to several CHAs*
C. The evaluation will assess the level of empowerment reached by CHAs and the community women, and the impact of that on the CHAs and the women.	Review of CHA Advocacy Plans Questions/probes of CHAs at focus group re involvement of women, identification of problematic health care policies and practices etc. Questions in in-depth interviews with 4 CHAs* Case studies with 5 women who are being or were assisted by the CHA.*
D. The evaluation will assess the impact of the CHA strategy as a way to assist women in overcoming barriers they experience in accessing safe, respectful and appropriate health care.	Case studies, as above* Survey of service providers who were targeted in awareness raising etc.* Focus group with selection of women who have worked with CHAs* Focus group with CHAs Review of ongoing project records

NOTE: The asterisk indicates methods that, although identified at the evaluation's start, were not actually used in the evaluation due to the challenges within, and changes to, the project. Specifically, the in-depth evaluation was extended past its original deadline of March 1999 to the fall of 1999. By the summer of 1999, when the in-depth interviews with CHAs, case studies with specific women, and survey of community partners were scheduled, the CHAs were reduced to four, none had been doing active advocacy on behalf of this project since May/99, and at no time

in the project to date had they carried an "advocacy case" per se.

For the interim report, the Evaluation Consultant:

- ✓ held a focus group with the CHAs in place of their April/99 meeting;
- ✓ interviewed the first Project Coordinator in March/99, just prior to her April 1st departure;
- ✓ reviewed project records.

For the final report, the Evaluation Consultant:

- ✓ held two interviews with the Project Coordinator;
- ✓ interviewed two other VWHC paid staff persons;
- ✓ reviewed notes kept by the summer/99 practicum student who worked on the CHA project;
- ✓ reviewed other project records provided by the Project Coordinator;
- ✓ facilitated an evaluation review meeting with the Project Coordinator, two VWHC staff persons, and the V/RHB Health Systems Analyst responsible for this project;
- ✓ spoke with one CHA about her advocacy work and findings.

SECTION 6. EVALUATION PLAN AND COMMENTARY ON INTERIM REPORT AND FINAL REPORT RESULTS

NOTE TO READERS:

In mid 1998, the CHA project was chosen to be one of a number of CHIF projects to undergo an in-depth evaluation. The actual evaluation work began in December 1998, and was initially intended to be completed by the end of March, 1999. However, in the early spring of 1999, when the project funding was extended to the fall of 1999, an Interim Report was prepared by the Evaluation Consultant for April 1999. The Final Report was due for completion in the fall of 1999.

Rather than produce a Final Report as a separate document, the Consultant has chosen to fold the Interim Evaluation Report and the Final Evaluation Report together. This provides the reader with a complete and integrated picture of project progress in one place. Text headings clarify which material is from the Interim Report, and which was written for the Final Report. Interim Report commentary and findings contained here have not been changed from when they were first written in April/99.

In this section of the report, each project objective is listed separately along with its success indicators. This is followed by the Consultant's commentary on the activities related to the objective. The commentary is summarized in two parts:

- ✓ the activities up to the Interim Report of April 1999 (including the summary contained in the Interim Report);
- ✓ the activities for the period May 1up to the final report of October 31, 1999.
- ✓ The overall learnings and impacts for each objective are noted at the end of each section describing individual project objectives.

OBJECTIVES	SUCCESS INDICATORS	EVALUATION TOOL	ACHIEVED
A. We will place 9-12 Community Health Advocates in self-defined communities in the Vancouver/Richmond health region.	-the project can consistently maintain 9-12 CHAs effectively, within its time and resources capability -the CHAs maintain work in self-defined communities, including disabled, ethnic, geographic, age, income level, mental health consumers	-Project Records -Interview with Project Coordinator Focus group with CHAs	Initially achieved but not sustained.

Comment on activities for Objective A, to April 1999, for Interim Report

✓ 12 women were selected as Community Health Advocates in the fall of 1998, completing their training in November. Two CHAs left in January/99 due to changes in work and travel plans. Those advocates were to work with African women and women mental health consumers. Another advocate, working with disabled women, left the project in April/99.

✓ 9 women remain as Community Health Advocates:

-one woman is a health advocate for *Somali women*, doing drop-in advocacy at the South Vancouver Neighbourhood House twice a week for several hours.
-one woman is an advocate for *lesbian, bisexual, and transgendered women, Aboriginal women, women of colour and poor women*. She works on her own and is available for appointments at various times and location.
-two women are advocates for *South Asian women*. One of these women does drop-in advocacy at the South Asian Women's Centre, her colleague does education on the CHA and health issues on a South Asian radio program.
-one woman is an advocate for *women with disabilities*. She works out of her home and is available for advocacy at various times.
-one woman is an advocate for *Latin American women* and is available for appointments at the Multi-Cultural Family Centre.
-one woman is an advocate for *Chinese women and mental health consumers*, working out of her home and various centres in Richmond. She is available through the Richmond Women's Resource Centre.
-one woman is an advocate for any *women in the Downtown Eastside*, available for drop-in advocacy Thursday evenings at the Downtown Eastside Seniors Centre.
-one woman is an advocate for *UBC women and Farsi-speaking women*, available for drop-in advocacy two mornings a week at the UBC Women's Centre.

Interim report summary for Objective A

The CHA project completed outreach into the community by successfully placing 12 CHAs in 10 diverse locations. The women taking on the CHA role represent a range of diversities and issues. As should be expected in largely voluntary run efforts, some attrition has taken place, with three women leaving their CHA function by early April 1999. The Health Collective and CHA group have not yet discussed if or how to replace those women, or train any new women if they do come on to the project.

Commentary on activities for Objective A, from May 1/99 to October 31, 1999, for Final Report

✓ As of September 1999, continued involvement in the CHA project is confirmed with four CHAs, and the possibility of one more.

✓ As of September 1999, the project has decided to adapt the CHA work to incorporate a community workshop model with community partners. The first community-based workshop will take place in November 1999, and the template developed there will be used at other community partner sites. The intention is to hold one workshop per month for already existing groups of women involved in some way at a community partner site. The Mt. Pleasant Family Centre, the Downtown Eastside Women's Centre and the Lesbian, Bisexual, Gay and Transgendered Centre are all interested in hosting a women's health workshop. A CHA and the Project Coordinator will deliver the workshop, ensuring that the CHA gains visibility and credibility through this process. The women will then be aware of the CHA, her accessibility, and how she can provide ongoing advocacy as needed.

The learnings related to Objective A up to October 31/99 are:

✓ The expected commitment of five volunteer hours a week from each CHA proved, over time, difficult to maintain.

✓ Some CHAs also found it difficult to develop and maintain visibility in their communities while volunteering only five hours a week.

✓ The attrition of volunteers happens normally over time. Two CHAs changed their jobs, others moved on, some stopped their involvement because of ill-health or other commitments.

✓ The four remaining CHAs were already doing advocacy work as part of their other jobs when they took on the CHA work. They were able to fold the VWHC CHA advocacy into their existing advocacy work, thus accessing and using the time, resources and monetary support from that other work to help support their voluntary commitment to the VWHC

CHA project.

✓ VWHC now knows that they cannot support 12 or 10 CHAs on the amount of money they have for this work. Although the CHA project, in February of 1998, received all funding requested from the V/RHB, ($35,850 over a two year period), hoped for funding from other sources was not received (approx. $94,500 per year). VWHC began the project by putting 12 CHAs in place, while in receipt of only 1/7th of the initially intended funding.

✓ Present CHA project staff, and members of the VWHC collective interviewed for the final report expressed concern that in their view the administration of the CHA project by the former Project Coordinator *"was not an open collective approach or process."* By this they meant that their observation was that she ran the project and made decisions about how it would run, largely at a very small committee level, *"without funnelling decisions back to the Steering Committee."* Staff interviewed for the evaluation now state that discussions of proposed CHA names should have come back to the collective for discussion before their fall/98 confirmation.

The impacts related to Objective A up to October 31/99 are:

✓ The CHA project did reach out and make connections with community partners in areas where the Health Collective wanted to become more active and visible. These community partners are now being called upon to participate in the workshop format the CHA project is moving towards. [7]

✓ The CHA project, despite challenges related to big plans, little money and some internal dissent, is still trying to find a way to make a good concept work.

[7]For example, the Project Coordinator is, as of fall 1999, working with South Vancouver Neighbourhood House and the CHA based there, to develop a November workshop with women attending groups at that facility. A focus group with seven Downtown Eastside agencies, planned for January 2000, is intended to discuss planning for a February workshop at the Downtown Eastside Women's Centre.

OBJECTIVE	SUCCESS INDICATOR	EVALUATION TOOL	ACHIEVED
B. We will provide CHAs with tools and guidelines to carry out their work.	*initial training of 12 CHAs is completed by November 30, 1998 *CHAs state their knowledge and skill level has increased after each training *learning objectives of training are consistently met by CHAs *training takes place on an ongoing basis as needs emerge or are identified by CHAs	-training feedback forms -focus group with CHAs -Interview with Project Coordinator	Yes.

Commentary on activities for Objective B to April 1999, for Interim Report

✓ The first training for CHAs took place over three sessions totalling 16 hours in November 1998. The material was presented by the CHA Coordinator, a co-trainer working on short-term contract, and several guest speakers.

✓ Immediate feedback on the training (via post session feedback forms) was received from six of 12 participants. Comments were generally satisfactory, including:
-participants liked the exchange of ideas, networking and meeting other women most;
-participants would have liked more time to share expertise and making connections;
-participants wanted more detailed information on lobbying, advocacy, the BC and Canadian health care system.

✓ In April 1998, five months after the initial training, CHA focus group participants reflected back on the training and commented:

-the initial training in November 1998 was good;
-more training is needed soon;
-the initial training did not prepare them for the broad range of issues women are bringing to them as "health issues"- issues that fit with Health Canada's larger determinants of health and include poverty, housing, income, etc.;
-more training is needed on BC Benefits;
-CHAs need to know how to be an advocate for all issue areas;
-women are coming to the advocates to talk about issues going beyond a narrow definition of health - beyond "bodily health issues";
-CHAs suggest that ongoing training could be partly delivered by CHAs themselves, who have a wide range of expertise in various issue areas.

✓ During her interview the initial CHA Coordinator reflected back on the training made the following observations:

-the initial training designed by herself and a the project's short term contract trainer and delivered in November 1998 was too short and rushed - ideal would be three full days, one after the other, rather than 3 separate sessions;
-longer continuous training at the beginning would encourage stronger immediate bonding and information sharing between advocates;
-the training should strive to more effectively integrate CHAs into the Health Collective, i.e. have each CHA do a shift at the Health Centre with a Collective volunteer;
-the content of guest speaker presentations in the training should be more closely monitored to ensure what is actually delivered is what the training session requested and needs.

Interim report summary for Objective B

While the training met the basic initial training needs, comments from participants, and experience "on the job", provide the project with valuable perspectives and should lead to a re-working of the training curriculum. CHAs say that they do learn from one another during their monthly meetings, and want to develop ways to consistently share their experiences and their expertise. Further training may be designed and enacted after receipt and discussion of the interim report.

Commentary on activities for Objective B - May 1 to October 31/99 - for Final Report

✓ Two additional training sessions were delivered between May and October 1999. The first, on advocacy and disability, was held in June, with three CHAs attending. The second, on diversity, took place October 31, with one CHA attending. One CHA facilitated the training on diversity as she has extensive expertise in this area.

✓ As of May 1999, the second Project Coordinator has made it a priority to integrate the CHA project into the VWHC. For example, each CHA training session was open to VWHC members and a CHA project support committee, with attendance ranging from 4 - 6 volunteers, has formed within the VWHC.

✓ Between May 1 and August 15/99 a Social Work Practicum student did a 420 hour placement with the VWHC, and 336 of those hours were spent working with the CHA Project Coordinator. She assisted with research and facilitation of the training sessions as part of this work.

The learnings related to Objective A up to October 31/99 are:

✓ Low CHA attendance at the summer and fall/99 training sessions is an indicator of CHA

attrition, and ongoing issues with expectations of each CHA's volunteer capability. Reasons for this attrition include illness, stress, family commitments, job changes, lack of time, and for some, a sense of inadequacy around doing the actual advocacy work.

The impacts related to Objective B up to October 31/99 are:

✓ A review of evaluation feedback from the June and October training sessions shows that participants did learn what they believed they needed to know.

OBJECTIVE	SUCCESS INDICATORS	EVALUATION TOOLS	ACHIEVED
C. CHAs will develop their advocacy plans and take action on those plans in a way that works best for them.	*when advocacy plans are set up in each CHA community by Mar 1999 *when priorities for each advocacy plan re set *when there is input to the advocacy plan from community women *in the long term, community women are empowered through the advocacy work *in the long term, the CHAs and women take action on women's health needs in the community	-CHA focus group *project records *use of a range of evaluation tools that work best for women and their community	Partially done initially, not followed through.

Commentary on activities for Objective C to April 1999, for Interim Report

✓ All CHAs have an initial advocacy plan in place to start their work.

✓ The initial advocacy plans were developed by the CHAs themselves. At this early point in the work, specific priorities have not been set, but likely will as the work emerges and takes shape.

✓ The advocacy plans list:

-type of advocacy the CHA will do (see the appendix for a sample advocacy plan);
-where and when CHA can be reached;
-community partners;
-promotion plans.

✓ Types of advocacy listed for each CHA are:

-lesbian, bisexual, Aboriginal women, women of colour, poor women: individual advocacy;
-UBC women and Farsi-speaking women: individual advocacy, workshops, interpreting
-disabled women: individual advocacy, presentations;
-Downtown Eastside women: individual advocacy;
-Latin-American women: individual advocacy, presentations, interpreting;
-Somali women: individual advocacy, interpreting;

-South Asian women: individual advocacy, media presentations;
-Chinese-speaking women, mental health: individual advocacy, presentations, interpreting.

✓ Five CHAs consider themselves as "doing" advocacy in April/99. Four of those five CHAs report putting in 10 or more hours a week on health advocacy. The other four CHAs do not put in five hours a week (the amount suggested/recommended by the project) due to several reasons. Some do not get enough calls or visits to make up five hours a week, another believes that it is unreasonable to expect volunteers to put in that much time, others are busy doing other things. It should be noted that all CHAs hold other jobs or responsibilities and the CHA work is an "add-on" to their schedule.

✓ CHAs discussed advocacy during their focus group, and raised a number of issues including:

-some find themselves being used as a resource more than an advocate;
-some are being asked for "cures" or medical advice, which of course they do not give;
-some of their women's communities require education on what an advocate actually is. In the South Asian community, for example, one of the advocates is spending her time doing public relations and education on women's health rights and information through a local ethnic radio station.

✓ CHAs have differing opinions as to what they should and can advocate for. One advocate working with a particular ethnic group commented: *"we can't be experts in everything. If I had a lady with a disability, I would contact the disability advocate."* Another noted, *"how do we expand our area of expertise so we can cover all areas"*, and went to note that this led to *"the issue of resources and money, and in some cases there are no resources."* The disability advocate noted that *"I wasn't prepared for BC Benefits questions, requests for doctors who deal with disability issues, someone requesting that I accompany them to a BC Benefits appeal."*

✓ CHAs report that health issues brought to them are *"all over the place"*, including what they describe as narrow health issues, and larger health issues such as housing. Some women want to be driven to their medical appointments, or need interpretation with medical personnel.

✓ A review of the 21 tracking forms returned to the CHA Coordinator between January and April/99 show that:

-seven women requested information on finding a suitable Doctor or Dentist;
-two women asked for assistance or information about Tribunals;
-two women came with specific medical issues (pain) they wanted help with;
-one woman each came needing information about BC Housing, weight reduction, and help with the cost of delivering a baby (refugee).

✓ The Project Coordinator developed a tracking form for each CHA to use with each woman she speaks or works with. CHAs are to return these forms to the Coordinator, who in turn shares these with the Evaluator. A copy of the tracking form is in the appendix.

✓ The CHAs raised the following issues about the tracking form during the focus group discussion:

-form is not long enough, would prefer more options and tick boxes to allow for less writing;
-one CHA has put a variation of the tracking form on her computer, and is not using the one provided;
-there should be a common program on disc, however, only one CHA has access to a computer for this purpose;
-another CHA says she gets and fills out the tracking form as soon as she starts work with a client as it helps her keep on track.

✓ In reviewing the 21 completed tracking forms the Evaluator found the forms completed differently by various CHAs, or they were not filled out completely.

Interim report summary for Objective C

The initial advocacy plans are basic statements of where the CHAs will work, and what areas they hope to focus on. There has not been input from community women at this stage. The amount of time spent in advocacy work varies from very little, to 10 or more hours by four of the CHAs. All CHAs lead busy lives, and there is some concern about being expected to do this work as volunteers. They are receiving a range of requests for information and assistance, some women simply want a ride to their medical appointment, others are asking for help with housing etc. The advocacy or information requests are not yet falling into a pattern, although CHAs believe that the boundaries of their work should be defined more by the larger issue determinants of health rather than "bodily" health issues. The tracking form used to document the work with women is not being used by some CHAs, nor are they being completed consistently by those who do. The design of the tracking form is not working well for some CHAs.

Commentary on activities for Objective C, May 1/99 to October 31/99 for Final Report

✓ No new activities took place related to advocacy plans. The CHAs did not do advocacy work over the summer and tracking forms have not been received by the Project Coordinator since May/99.

The learnings related to Objective C up to October 31/99 are:

- ✓ The kinds of requests received for assistance and resources by CHAs reflect the reality of community development work, i.e. that many requests for what might be called "ordinary" assistance have to be dealt with before it is possible to see a community trend or theme that then could be identified as an issue for further development. The CHAs did not work long enough at advocacy for such issues to be identified.

- ✓ A hope (not a learning) is that the remaining CHAs will connect with women in the community groups receiving the workshops and in turn, that these women will recognize both the CHAs faces and the potential assistance that CHAs can offer. As the women access the CHAs, and use their services, it is hoped that issues and further advocacy plans will emerge.

OBJECTIVE	SUCCESS INDICATOR	EVALUATION TOOLS	ACHIEVED
D. The CHAs and the project will create partnerships that support and provide input to the project.	*when community partners/facilities provide space for CHAs to work out of on an ongoing basis *when each CHA has a range of partners who do provide her with support and information that is useful *when CHAs can describe the support and input received from her partners *when partners describe ways in which they are able to support and provide input to the project	*project records *CHA focus group	Yes.

Commentary on activities for Objective D to April/99, for Interim Report

✓ Seven of nine CHAs are working in or through specific community partner facilities and as of April/99, feel well settled into that relationship.

✓ The CHA working with disabled women is using her own home/phone as a base.

✓ Another CHA working with lesbian & bisexual women, Aboriginal women, women of colour and poor women is also working through her own phone line at her home office

✓ All CHAs have identified potential community partners (see the list below). Some linkages have been made. Asterisks on the list below note organizations that are offering specific support and/or a physical space.

-Pacific Dawn Women's Health Action Group*
-Coalition of People with Disabilities
-Voices of Cerebral Palsied of Greater Vancouver
-Positive Women's Network
-SPARC
-Vancouver Second Mile Society*
-Aboriginal Friendship Centre
-Vancouver Status of Women
-DAMS (Drug and Alcohol Meeting Support for Women)
-Carnegie Centre
-Multicultural Family Centre*
-South Vancouver Neighbourhood House* - Latin American Group

-South Vancouver Neighbourhood House - Seniors and Family & Children's Worker
-East Health Unit
-Seniors Arts and Crafts Group - Multicultural Family Centre
-North Health Unit
-South Asian Women's Centre*
-South Health Unit
-West main Health Unit
-Rainbow Community Health Co-op (Surrey)
-RimJhim Ethnic Radio Station
-Richmond Mental Health Advisory Board
-Richmond Women's Centre*
-Richmond Health Unit
-Monday Health Project
-Asia-Asian Society for the Intervention of Aids
-Immigrant Service Society
-AMSSA
-Africa Canada Development Information Services Association
-UBC Women's Student Office*
-Colour-connected resource group at UBC

✓ During the CHA focus group, the following points were made about community partners:

-community partners are also working with limited resources;
-CHAs working from their own space, using their own lines, have had to return some long distance calls which is an added expense;
-one CHA can only access her community partner in the evening when copying machines, etc, are not available to her;
-another CHA is reluctant to begin a connection with the local Health Unit as she does not think she has the time (in five hours a week) to handle the calls that might result;
-some CHAs working out of a specific centre report that transportation problems hinder women's direct access to them.

✓ The CHA Coordinator also noted in her interview that more connection needs to be built between the Vancouver Women's Health Collective and the Community Partners. She observed that one media article on a CHA did not mention the Health Collective as the sponsoring organization with oversight responsibilities. Due to a lack of time, and a need to spend her limited hours on more immediately pressing issues (such as preparing posters and brochures) the CHA Coordinator had not been able to visit the Community Partners, or the CHAs in their sites, since their placement in January.

Interim report summary for Objective D

CHAs have set up relationships with their direct community partners - the organization that is housing them or from which they come. Outreach work to other community partners has yet to begin.

Commentary on activities for Objective D, May 1 to October 31/99 - for Final Report

✓ With CHA attrition, there has been less connection with site partnerships, although they remain as a base.

✓ The summer Practicum Student made telephone and in-person connections with community partners.

✓ The Project Coordinator plans to use the community partners as a base to build workshops from. As of October 31/99, she reports the potential of five workshops in the South Vancouver and Mount Pleasant areas. The Coordinator is convening a focus group of seven Downtown Eastside agencies in January of 2000 to plan for a workshop at the Downtown Eastside Women's Centre in February.

The learnings related to Objective D up to October 31/99 are:

✓ Cultivating a regular connection with community partners does require ongoing support and work from the Project Coordinator. She hopes that the internal VWHC volunteer CHA support committee will be able to take on some of her administrative work, giving her time to connect with community partners as well as continuing to attend other community meetings relevant to the CHA project.

The impacts related to Objective D up to October 31/99

✓ VWHC, after a year and a half of connecting with community partners and doing public relations for the CHA project, is starting to be more visible "out there" in the community.

✓ The partnerships developed by the first Project Coordinator, enhanced by the second Coordinator and animated by the CHAs, provides the VWHC with a base in diverse communities from which they can build ongoing relationships related to women's health issues.

OBJECTIVE	SUCCESS INDICATORS	EVALUATION TOOL	ACHIEVED
E. We will develop, maintain and change as needed, a manual to support the advocates in their work.	*when CHAs actively use the manual *when CHAs can describe how the manual supports their work *when CHAs make contributions to the manual and see that reflected in manual revisions *when the manual changes, in a timely way, to meet needs, as informed by the CHAs work in specific communities	-CHA focus group -interview with Project Coordinator	Yes, in that original manual was completed. Partially, in that needed changes have yet to be made.

Commentary on activities for Objective E to April/99, for Interim Report

✓ The Community Health Advocate Manual was written by the CHA Project Coordinator. It was introduced to CHAs during the initial training, and part of one of the training sessions was used to walk participants through it.

✓ The CHA Coordinator had these things to say about the manual during her interview:

-more work is needed on developing information about how to help people make complaints about the health system;
-more information is needed on disability benefits, housing, legal advocacy and child apprehension;
-more information is needed on the BC health system and how it works.

✓ the CHA Coordinator also noted that *"we built this manual around health, but the project is going off in so many ways into larger issues related to health"*. She wasn't sure how the project would or could deal with being broadened this way and felt this was something the new Coordinator would have to address. The issue of project direction is discussed in the "other issues" section of the interim report.

✓ The CHAs had these things to say about the manual during their focus group:

-manual does not deal with larger determinants of health, including housing, income, BC Benefits, courts;
-"*other CHAs have been more useful to me than the manual*";
-don't need a large manual for training, the process of training should be more interactive as there is much to learn from one another;
-some have used the manual with other advocacy groups requesting information about health issues and found it worked well;

-the resource all CHAs want to have and feel they need, is the Red Book. This resource costs $70 which none of them have or are prepared to spend. Most do not have any way to access to the Red Book other than owning their own copy.

Interim report summary for Objective E

The manual is being used in varying ways by CHAs, but is only one of the tools that they need in their repertoire. All CHAs would like to have the Red Book, and to have the manual deal with issues such as the determinants of health, disability issues, how to make complaints and the BC health system.

Commentary on activities for Objective E, May 1/99 to October 31/99 - for Final Report

✓ Several pages of definitions for the manual, requested by CHAs, were written by the summer practicum student. These are now being reviewed by the VWHC before insertion into the manual.

✓ Further revisions to the manual are low on the Project Coordinator's priority list due to her limited hours of work and other priorities such as maintaining the remaining CHAs and adapting the project to work more effectively.

The learnings related to Objective E up to October 31/99 are:

✓ The VWHC staff now believe that an effective resource tool would be a pamphlet on advocacy that can be given to women at the community workshops.

✓ In retrospect, the present CHA Project Coordinator and VWHC staff believe that it may have been more useful to have developed a tool for consumers rather than a manual - which was a tool for CHAs themselves. As one staff person said in her interview *"maybe the project didn't need a manual at the beginning - was that jumping the gun?"*

The impacts related to Objective E up to October 31/99 are:

✓ The advocacy manual is still being used by the remaining CHAs.

OBJECTIVE	SUCCESS INDICATOR	EVALUATION TOOL	ACHIEVED
F. We will provide information and support to the CHAs while they are doing their work in the community.	*regular communication takes place between CHA coordinator and CHAs *when communication methods are open and clear to all *CHAs state they can get the support they need, when they need it, from other CHAs and Project Coordinator	-CHA focus group -interview with Project Coordinator -project records	Yes, although not to the degree ideally required to support volunteers working out in the field.

Commentary on activities for Objective F up to April 1999, for Interim Report

✓ The CHA Coordinator (or other staff, such as a nursing practicum student at the Health Collective, or the term contract trainer) connected with the CHAs in the following ways:

-two hour monthly meeting with CHAs (attendance: January, 9 of 12 CHAs, February , 3 of 10 CHAs, March , 8 of 10 CHAs, April, 8 of 9 CHAs);
-telephone call approximately once every two weeks;
-regular mailings of minutes, memos, Health Collective information.

✓ CHAs have been made members of the Vancouver Women's Health Collective and receive mailings from the organization.

✓ CHAs report that they feel well-linked with the Health Collective and Coordinator, noting that *"each time I've called, someone has gotten back to me"*. Some said that they didn't know much about the Health Collective before starting on the project but do now.

✓ CHAs also observed that the CHA Coordinator and term contract co-trainer put in more hours than they were paid for, and expressed concern and shock that the V/RHB put so little money into the project *"given the needs out there"*. [8]

✓ In turn, the CHA Coordinator noted that her hours with the project had begun in July/98 at 20 hours per week. The project actually received the 1997/98 fiscal year funding in a lump sum in March 1998, and began receiving a monthly disbursement of $1,400 for the 1998/99 fiscal year as of April 1, 1998. Those funds were used to cover the costs of the Coordinator and a trainer (and the production of the manual) in the first six months of project start-up.

[8] In fact, up to the end of September 1999, the V/RHB provided the VWHC's CHA project with the funds requested. However, the VWHC did not request the September 1999 - September 2000 funding extension, which they first heard of in June 1999. This extension was given without consultation with the VWHC as to whether or not they wished to continue the project, and without consultation about the amount of funds actually needed to continue the project effectively.

In order to cover off the overtime she also put in during the first six months of the project, her working hours from January 1 to March 31/99 were reduced, by choice, to 16 hours a week from January 1 to March 31, 1999. (Approximately one month's worth of overtime was accumulated and the Health Collective policy is that overtime be taken in time off. Rather than take a month off the Coordinator reduced her time by 4 hours a week.) The project was initially due to be either over, or renewed at the end of March/99. However, many of the CHIF projects, including this one, had their funding extended from April 1 to September 30/99. As of March 1999, the Health Collective finds that project funds of $1,400 per month will cover one staff person at 10 hours per week, plus other project costs. (Please see budget for 1999/2000 in the appendix.)

✓ The CHA Coordinator put her experience with project work hours this way: *"20 hours a week is what is needed to maintain the project and do the networking/visiting. 16 hours a week means just the maintenance gets done".*

✓ The CHA Coordinator also noted that over the course of the project her designated work hours were not focussed only on the CHA project as she was considered a staff person at the Health Collective and had other duties and issues to attend to as a result.

Interim report summary for Objective F

The CHAs feel supported by the CHA project coordinator in their work. The outgoing Coordinator has some concerns about a new staff person being able to maintain the project while working only 10 hours a week.

Commentary on activities for Objective F, May 1/99 to October 31/99 - for Final Report

✓ The new CHA Project Coordinator began her work, also at 10 hours a week, on May 1- a month after the previous Coordinator had finished. As of mid November/99, the Coordinator's hours were increased to 12 per week. The Coordinator's work is more fully described in the Executive Summary of this report.

✓ From May 1 to August 15 a social work student served her practicum at the VWHC and contributed approximately 80% of her 420 hours (336 hours or about 24 hours a week) to the CHA project. She worked with the Project Coordinator to:

-respond to telephone requests for information about the CHA project, mostly from people who had read about it on the Volunteer Vancouver website;
-complete CHA mail-outs and word processing;
-research and compile a data base of potential community partnerships;
-liaise with CHAs and community partners;

-participate in community meetings related to the CHA project;
-work to re-establish a connection with the VWHC and CHA committee;
-research and co-facilitate CHA training.

✓ The CHA Project Coordinator worked to integrate the CHA project into the VWHC by bringing all CHA project issues to collective meetings for discussion. As well, CHAs were invited to the VWHC annual general meeting in the late spring of 1999, (two attended), to the August VWHC Volunteer Appreciation Night (none were able to attend), and another CHA social evening in October (two attended). The CHA Project Coordinator made all arrangements for these events.

✓ Regular VWHC mailings continued to CHAs.

✓ The practicum student, and when possible, the CHA Project Coordinator, met with four of the CHAs over the summer. They had hoped to meet with every CHA, but this was not possible due to summer holidays and the fact that some CHAs had moved on and it was not possible to get in touch with them.

✓ A new project Advisory Committee is being formed and is scheduled to meet November 15/99.

The learnings related to this objective up to October 31/99 are:

✓ The Project Coordinator is following through on a suggestion made by several CHAs to adapt the project in order to reach more women and use the CHA volunteer time more effectively. Specifically, the project is now working with community partners to co-sponsor community-based workshops on women's health and advocacy. These workshops, to be facilitated by the Project Coordinator and different CHAs, will take place at a community partner site with women who belong to already formed groups (such as a Mothers's Group etc) at that site. It is hoped that this format will:

-efficiently make use of the CHA's expertise;
-reduce the number of volunteer hours per month for each CHA;
-more effectively reach groups of non-English speaking women;
-help build stronger community partnerships;
-increase the visibility of the project and the VWHC in the community.

✓ Although CHAs always told the Project Coordinator they would like to attend VWHC activities when she contacted them about events, the low attendance rate shows that even a social evening is another piece of volunteer "work" for them, involving travel, finding childcare etc.

- ✓ A few CHAs lived in Surrey and North Vancouver. Although they were situated with community partners within the V/RHB region, the fact that they lived further away from Vancouver exacerbated problems of getting to monthly meetings and other social events.

- ✓ Volunteers who conduct their voluntary work outside of the home organization require consistent staff support or they lose momentum, feel left out and eventually find it easier to "disconnect" from the project. Fully supporting each CHA in this project required more than mailing notices and making phone calls every few weeks. The initial project budget called for a full time coordinator (hopefully to be funded by a provincial government ministry) to do this work but as funds were not received from this source, the VWHC used the V/RHB funds (originally intended for two part time contract trainers and volunteer training honorarium) to also fund project coordination. There was not enough time to do all the support necessary for the CHAs as well as complete the other project work.

- ✓ The overall lower level of funding received for this project should have alerted the VWHC to revise the project plans to be less ambitious. At the very least, the project could have started with fewer CHAs.

- ✓ The CHA project should have had greater advice, support and oversight from the VWHC and an advisory committee from the start. Present VWHC staff believe that this support was not available because the organization was recovering from a period of internal instability at the time the funding was received.

The impacts of Objective F on the project up to October 31/99 are:

- ✓ The initial selection of 12 CHAs for the project was too much for the resources at hand. Although there was a plethora of written letters and notices sent, the CHAs were not supported, in-person, to the degree needed due to lack of staff time.

- ✓ Ongoing project CHAs will be made up of the 3 - 4 CHAs who, since May of 1999, have consistently attended VWHC events and responded to phone calls

- ✓ CHA attrition and staff turnover led to a marked transition period for the CHA project, lasting from April 1/99 until approximately September 1/99, when the workshop format was put in place and fall meetings were planned. During the transition period the new Project Coordinator and the summer practicum student worked to familiarize themselves with all aspects of the project, and set a new direction for the work. There was minimal advocacy work carried out by CHAs during this time.

OBJECTIVE	SUCCESS INDICATORS	EVALUATIO N TOOLS	ACHIEVED
G. The project will identify health care issues for women that are not being met. (Outcome)	*an initial list of "needs" re health care issues in each specific CHA community will be produced by the CHA and women from that community by March 31/99 and reviewed semi-annually *the list of "needs" is based on women's actual experience and analysis *when community women are involved in the needs identification process	*CHA focus group *interviews with Project Coordinator	Partly.

Commentary on activities up to April 31, 1999 - for Interim Report

✓ The list of "needs" was not developed by the end of March, 1999 as the CHAs and the CHA Coordinator felt it was still much too early in the project to be able to identify any pattern of needs, nor were they doing enough advocacy or meeting with women to be able to develop a sense of the range of needs.

Commentary on activities - May 1 - October 31/99 - for Final Report

✓ Four CHAs continued to work directly with women as advocates and maintain contact with the VWHC. One of these CHAs already works with Somali women through the South Vancouver Neighbourhood House and combines that with her CHA role. The second advocate works with lesbian, gay, bisexual and transgendered women, Aboriginal women, women of colour and poor women. She too already does advocacy work in this area, on her own and is available for appointments at various times and locations. A third CHA does the advocacy work with Farsi-speaking students through her voluntary commitment at the UBC Women's Centre.

✓ A fourth advocate does the work but due to her time constraints, and the time constraints of the Project Coordinator, does not connect regularly with the project. She combines the CHA advocacy in her existing job with Chinese women and mental health consumers, working out of her home and various centres in Richmond.

✓ Another advocate wants to work but has not received calls at her site and plans are being

made to find her another partnership. This advocate was working out of the Downtown Eastside Seniors Centre.

The learnings related to Objective G up to October 31/99 are:

✓ Advocates who came to this project already involved in advocacy were able to incorporate the VWHC advocacy job into their existing work. These advocates are the ones who continue to work with the VWHC CHA project.

✓ Successful advocacy requires time, knowledge, resources, commitment and, like any job, monetary support. The four women still working on a voluntary basis with the VWHC CHA project, because of their pre-existing work as advocates in similar fields, are able to access and use the time, resources and monetary support from that other work to help support their voluntary commitment to the CHA work. These women also had a base of experience and knowledge to call upon.

✓ The level of support required even by advocates already working in the field shows the importance of focussing project energies on working with the remaining CHAs rather than replacing those who have left.

✓ From the 4-5 months of active advocacy work in 1999, CHAs noted that the most common health related issues not being met for the women they saw as:

-the need for interpretation;
-the difficulty in finding female health practitioners;
-the need for help in accessing welfare, housing and other resources;
-the need for assistance in getting to medical appointments.

The impacts related to Objective G up to October 31/99 are:

✓ The women who did receive advocacy assistance got a range of support to meet their varying needs.

✓ The remaining advocates were already working in the advocacy field, which will impact on ongoing project design and training in that they already have some advocacy expertise.

OBJECTIVE	SUCCESS INDICATORS	EVALUATION TOOLS	ACHIEVED
H. The project will develop ways that women's health care issues can be met through the CHAs, Vancouver Women's Health Collective, CHA's community partners and beyond, such as the Centre for Excellence in Women's Health, Women's Population Health Advisory Committee, etc.	*when problematic health care policies and practices are identified by women in each CHA community *when specific strategies are developed in each CHA's community area to change problematic health care policies for community women (such as awareness-raising for physicians or others, media promotions, etc.) *when health care policies that have been identified as problematic are changed *when a range of appropriate partners are involved in changing problematic health care policies and practices.	-CHA focus group -project records -interviews with CHA Project Coordinator	No. However, a foundation for continuing to meet this objective has been built.

Commentary on activities for Objective H to April 31/99 - for Interim Report

✓ There is not enough data to be able to make any comment on this part of the work yet. This community development project will need several more months, at minimum, before any findings will be revealed.

Commentary on activities for Objective H from May 1/99 to October 31/99 - for Final Report

✓ The project is now adapting to challenges with 1-1 CHA work by designing community-based women's health workshops that will be offered through community partners. The first is planned for November/99, from which a template will be built for others to take place in the new year.

✓ Community partnerships are being kept up through regular communication from the Project Coordinator.

✓ VWHC is maintaining its visibility in the community by attending other relevant community meetings and planning the workshops

The learnings related to Objective H up to October 31/99 are:

- ✓ Learning about issues through direct work with women (hearing their stories) is still an valuable way to work at the grassroots level, and an effective way to do community development.

- ✓ The size of project work should match the organizational capacity to supervise, oversee and manage the work effectively.

- ✓ The project's expectations of volunteers was too high.

The impacts related to Objective H up to October 31/99 are:

- ✓ The project is using the learnings to now try another model in order to more effectively work with volunteer advocates and reach community women. At least six workshops will need to be completed and further advocacy undertaken by the CHAs before consistent impacts can be described identified and described.

OBJECTIVE	SUCCESS INDICATORS	EVALUATION TOOLS	ACHIEVED
I. The project will, in all aspects of its work, provide the opportunity and milieu for community women to empower themselves regarding health care issues.	*when women can state the various ways in which they have empowered themselves, including any of the following: -increased self-reliance -increased confidence -improved competence -comfort with what they are doing -assertiveness -increased knowledge -ability to use information and knowledge -feel positive about choices they can make	-(long term)case studies of specific community women -interviews with a range of women working with CHAs -CHA focus group	Minimally. Some women did seek and receive empowering information from CHAs. There were not enough women seen over the project time period for the evaluation to assess the degree of empowerment.

Commentary on activities for Objective I up to April 31/99 - for Interim Report

✓ It is too soon to be able to comment on this objective.

Commentary on activities for Objective I from May 1/99 to October 31/99 - for Final Report

✓ The remaining four advocates continue to work using an empowerment model.

✓ The community workshops planned for the rest of the project are intended to provide opportunities to impart information and analysis that community women can use to empower themselves .

The learnings related to Objective I up to October 31/99 are:

✓ Over the project time period the following "stories" were told to the advocates by women they saw. These illustrate the value of working in this way with community women.

"One woman was concerned with the general health of her children, who had asthma. I accompanied she and her children to the doctor and translated for them. The doctor recommended that they change the carpet in the apartment because it was too old, and the previous tenants had cats. I then accompanied them to BC Housing to explain the situation. Eventually the family found a new home and now the children feel much better."

"I went with one older lady to the doctor for several times. She was complaining about joint paints that were bad enough so that sometimes she could not walk. Her doctor did a test and could not find cause. I finally took her to a different doctor and in one x-ray they found out that she has arthritis. This doctor referred her to a specialist and physiotherapy. Now the lady feels much better."

"A Venezuelan woman emigrated to Canada in early 1998 married to a Canadian citizen who initiated her sponsorship process around September 1998. He died of ALS in December of 1998 leaving the woman pregnant with no legal status in Canada,hence with no access to income assistance nor medicare. Her baby was born a couple of days after her husband passed away, and does have a medical card. The Hispanic workers at a number of agencies, myself included, have been in close contact with this woman providing financial and emotional support. The cost of delivering the baby was waived."

"One advocate received a phone call from a woman who had just had her baby and was experiencing abnormal pain in her wound area (caesarian). Her Doctor had examined her and had told her that a piece of the placenta was still inside and that she would have to have a hysterectomy. The woman, upset about this, had come to the Multicultural Centre for help and advice because she knew of the services there. She had in turn been referred to the Community Health Advocate working out of the Centre. The CHA said that she reassured the woman that it was OK to seek a second opinion about this and referred her to another physician."

The impact of Objective I up to October 31/99 are:

✓ Some of the women who received information and support from the CHAs were able to take empowering action regarding their health care issues.

SECTION 7: REVIEW OF CHA OBJECTIVES WITH V/RHB WOMEN'S PHAC GOALS

This part of the report offers a description of how various CHA project objectives fit with the five priority health issues identified by the V/RHB Women's Advisory Committee. Again, the CHA project activities, learnings and impacts are noted. Notations are made of any implications that the CHA work to date might have for V/RHB policy.

Women's PHAC priority health issue: Poverty
Relates to these CHA project objectives: G: To identify women's health care issues that are not being met in the specific communities CHAs are working in. H: To develop ways that women's health care issues can be met through the CHAs, VWHC, community partners, and, when appropriate, by reaching out to the Centre for Excellence in Women's Health, Women's PHAC, etc. I: To provide, in all aspects of the project work, the opportunity and atmosphere for community women to empower themselves regarding their health care issues.

CHA project activities	CHA project learnings	CHA project impacts
-advocates provide information about GAIN, financial resources, social housing etc -women are given support to go to BC Housing	-poverty and housing issues affect health. For example, the deteriorating carpet in one woman's apartment was affecting her child's asthma. The CHA was able to help her approach BC Housing to have the carpeting replaced. -social workers are often able only to work from a crisis mode, thus giving information related only to the most pressing and isolated problem. However, for some women, the issues are linked and complex, requiring assistance from someone such as a CHA who can fit them into the broader picture and offer a range of supports and guidance.	-women are empowered to advocate for themselves and their children -holistic information is given by the CHA in one place (one-stop shopping)

Implications of this work for V/RHB policy

✓ Being able to access interpretation is a health issue for many women new to Canada.

✓ Marginalized women will use "one stop shopping" that provides holistic information when that information is provided in a safe, non-judgmental, accessible manner.

Women's PHAC priority health issue: Violence Against Women
Relates to CHA project goals: G: To identify women's health care issues that are not being met in the specific communities CHAs are working in. H: To develop ways that women's health care issues can be met through the CHAs, VWHC, community partners, and, when appropriate, by reaching out to the Centre for Excellence in Women's Health, Women's PHAC, etc. I: To provide, in all aspects of the project work, the opportunity and atmosphere for community women to empower themselves regarding their health care issues.

CHA project activities	CHA project learnings	CHA project impacts
-none to this point	-talking about violence issues with a CHA requires a level of trust between women and the CHA, and this takes time to develop.	-none to this point

Implications of this work for V/RHB policy

✓ None at this time.

Women's PHAC priority health issue: Accessibility to health services and health information for women of diverse backgrounds
Relates to CHA project objectives: G: To identify women's health care issues that are not being met in the specific communities CHAs are working in. H: To develop ways that women's health care issues can be met through the CHAs, VWHC, community partners, and, when appropriate, by reaching out to the Centre for Excellence in Women's Health, Women's PHAC, etc. I: To provide, in all aspects of the project work, the opportunity and atmosphere for community women to empower themselves regarding their health care issues.

CHA project activities	**CHA project learnings**	**CHA project impacts**
-women are supported to seek female health practitioners as desired	-(Somali) women were not comfortable with male physicians and were not aware they had a choice of women physicians	-women receive care for physicians they feel more comfortable with
-CHA project materials are translated into Spanish	-some women don't know the English words for specific body parts	-learning the "right" words empowers women to self advocate for their needs
-one advocate provides a safe place for lesbian, bisexual, gay and transgendered women to seek health information	-in some cultures, women are not permitted to view unclothed bodies, or parts of bodies, in person or through pictures	-cultural considerations have to be taken into account in developing or revising resource materials
	-safety for LBGT women means acceptance, respect, being non-judgmental and the ability to see LBGT issues in the larger context of poverty, race and class	-Lesbian, bisexual, gay and transgendered women are provided with the information they need in a way that is respectful and useful to them

Implications of this work for V/RHB policy

✓ Literacy and visual imagery are issues that need to be taken into account in providing health-related resource materials. It may be appropriate to develop handout tools such as pamphlets or flyers with a picture of a woman's body on it for women to use when they have are speaking with a health professional who cannot speak their language. The woman could point to various body parts or areas.

✓ Cultural concerns also need to taken into account regarding visual imagery used in resource materials. In some cultures, women are not permitted to view pictures of unclothed women's bodies, in whole or in part.

✓ The components of providing a safe place for lesbian, bisexual, gay and transgendered women to access health information are already contained in the document entitled "*Your Everyday Health Guide: A Resource from the LBGT Community*"[9] which was launched in December 98. This guide has been distributed to schools, libraries, hospitals and health units as well as to the V/RHB.

[9]McInnis, Anne Marie, Sook, C. Kong, Everyday Health Guide: A Resource from the LBGT Community, LBGT Health Association, Vancouver, BC. December 1998.

VRHB Women's PHAC priority health issue: Participation and the empowerment of women
Relates to CHA project objectives: G: To identify women's health care issues that are not being met in the specific communities CHAs are working in. H: To develop ways that women's health care issues can be met through the CHAs, VWHC, community partners, and, when appropriate, by reaching out to the Centre for Excellence in Women's Health, Women's PHAC, etc. I: To provide, in all aspects of the project work, the opportunity and atmosphere for community women to empower themselves regarding their health care issues.

CHA project activities	CHA project learnings	CHA project impacts
-advocates provided a broad range of information, using a holistic approach	-advocates observe that social workers often work from a crisis mode, thus giving women specific and immediate information rather than the range of information women need to meet a context of needs -difficulties women experience in accessing a CHA on a 1-1 basis include transportation costs, finding and paying for child care, getting the time away from family, language barriers, knowing when the CHA is available, etc.	-women working with a CHA receive the breadth of information they require to take action on their issues -project decided to make the CHAs accessible through community based workshops, i.e. meeting with women who are coming together already for other reasons. Hopefully links with community partners will be helpful in reducing barriers for women.

Implications of this work for V/RHB policy

✓ Confirms that women require information before being able to make choices and take responsibility and action vis a vis their health, and will use support to help them take that responsibility and action.

V/RHB Women's PHAC priority health issue: Medicalization of women's lives
Relates to CHA objectives: G: To identify women's health care issues that are not being met in the specific communities CHAs are working in. H: To develop ways that women's health care issues can be met through the CHAs, VWHC, community partners, and, when appropriate, by reaching out to the Centre for Excellence in Women's Health, Women's PHAC, etc. I: To provide, in all aspects of the project work, the opportunity and atmosphere for community women to empower themselves regarding their health care issues.

CHA project activities	CHA project learnings	CHA project impacts
- nothing specific to this time	-nothing specific to this time	-nothing specific to this time.

Implications of this work for V/RHB policy

✓ None to report at this time.

SECTION 8: REVIEW OF CHA PROJECT AND V/RHB 1998/99 PRIORITY GOALS

This section also reviews each V/RHB priority goal and how it relates to any specific CHA project objectives. Where relevant, CHA project activities, learnings and impacts are described and implications of this work for V/RHB policy are stated.

V/RHB 1998/99 priority goal <u>one:</u> Promote and advocate with other sectors for improvements in the determinants of health
Relates to CHA project overall goal: to empower and support women to know their rights in the health care system and support them in overcoming barriers that prevent them from receiving safe health care.

CHA project activities	CHA project learnings	CHA project impacts
-the project's eventual intent was also to take health issues identified by women and work, as appropriate, with those women and the other sectors, to promote and advocate for improvement.	-none to this time	-none to this time

Implications for V/RHB policy

✓ None to report to this time.

V/RHB 1998/99 priority goal <u>two:</u> **Foster and develop health promotion and disease, disability and injury-prevention programs**
Relates to CHA project objective <u>H</u>: To develop ways that women's health care issues can be met through the CHAs, VWHC, community partners, and when appropriate, by reaching out to the Centre for Excellence in Women's Health, Women's PHAC, etc.

CHA project activities	CHA project learnings	CHA project impacts
-the advocacy work was meant to do this, and is now shifting to a community workshop model	-nothing significant to this time	-none to this time

Implications for V/RHB policy

✓ None to report at this time.

V/RHB 98/99 priority goal <u>three</u>: **Assess trends and disparities in health status, groups at risk and factors contributing to health problems.**
Relates to CHA project objective <u>G:</u> To identify women's health care issues that are not being met in the specific communities CHAs are working in.

CHA project activities	CHA project learnings	CHA project impacts
-CHAs track women's experiences and stories -CHA project will gather information on women's health issues through the community-based workshops	-to date, that language, economic status and degree of marginalization affects women's health	-not enough to say yet

Implications of this work for V/RHB policy

✓ None to report at this time.

✓

VRHB 98/99 priority goal four: Seek to continually improve the quality of health services.
Relates to CHA project objectives C and H: Assist CHAs to take action on advocacy plans, and develop ways that women's health issues can be met.

CHA project activities	CHA project learnings	CHA project impacts
-project is now focussing down to work with several CHAs instead of many -project is moving to incorporate a community workshop format in order to better reach women and develop ways to meet their health issues	-the CHA project will still need time to gather enough information from women to take action	-none to this time

Implications of this work for V/RHB policy

✓ None to report at this time.

V/RHB 1998/99 priority goal five: Develop integrated and coordinated health services in a seamless continuum of care.
Relates to CHA project objective G: To identify women's health care issues that are not being met in the specific communities CHAs are working in.

CHA project activities	CHA project learnings	CHA project impact
-CHAs share holistic information	-nothing definitive yet	-nothing definitive yet

Implications of this work for V/RHB policy

✓ None to report at this time.

V/RHB 1998/99 priority goal six: Facilitate significant public participation in and responsibility for the planning, monitoring and evaluation of health services.
Relates to CHA projective objective H: To develop ways that women's health care issues can be met through the CHAs, VWHC, community partners, and when appropriate, by reaching out to the Centre for Excellence, Women's PHAC, etc.

CHA project activities	CHA project learnings	CHA project impacts
CHA project and the Vancouver Women's Health Collective do monitor health services through listening to women's experiences.	-not definitive to date	-not definitive to date

Implications of this work for V/RHB policy

✓ None to report at this time.

V/RHB 1998/99 priority goal seven: Promote individual choice, control and sense of responsibility among users of the health care system.
Relates to CHA project objective I: To provide, in all aspects of the project's work, the opportunity and atmosphere for community women to empower themselves regarding their health care issues.

CHA project activities	CHA project learnings	CHA project impacts
-CHAs provide women with information that empowers them to make their own choices	-women require information before being able to make choices and take responsibility for their own health	-not overly definitive yet, but a few women who spoke with CHAs have used that information and support to make changes related to health issues

Implications of this work for V/RHB policy

-Not enough definitive and consistent data yet.

V/RHB 1998/99 priority goal eight: Respect, recognize and support those who work in the health care system as a vital force in contributing to improvements in the health system.
This V/RHB goal does not relates to any specific CHA project objective, however it does relate to some of the general policies of the Vancouver Women's Health Collective which exist to respect, recognize and support volunteers and staff. Although a review of VWHC policies was not the purview of this evaluation, it was the request of the CHIF staff that VWHC worker, family and child-friendly policies or practices be briefly noted here. Further and more complete information should be sought directly from the VWHC.

VWHC practice activities	VWHC practice learnings	VWHC practice impacts
-VWHC works with a flat collective structure. Although this structure brings challenges, it does encourage involvement in all aspects of the organization by paid and unpaid staff.	-An oversight mechanism was required to deal with difficulties and issues between staff and volunteers that would, in a hierarchical organization, be handled by an Executive Director or Human Resources Manager. The VWHC chose to develop a Solidarity Committee to do this work.	-the organization reports that the Solidarity Committee is working as a method of dealing with difficulties and issues between staff and volunteers.
-the practices of VWHC also promote involvement of paid and unpaid staff and volunteers, for example: -the child care & bus fare needs of volunteers are paid -VWHC provides volunteers or workshop participants with meals, snacks, as appropriate -staff and volunteer working schedules are flexible -infants are brought to work by staff or volunteers if necessary, although child care is not provided on site and off-site child care costs of staff are not covered. -the workplace, which contains the Resource Centre, is open to the public, provides comfortable seating, and an overall homelike atmosphere.	-practical matters such as child care, bus fare, and family friendly policies/practices are important to have in place to encourage women's participation in the organization as paid workers and unpaid workers (volunteers).	-VWHC staff and volunteers are supported in their work with the organization. It is a women-friendly workplace. -The family related needs of any staff and volunteers who are mothers with infants are considered. -The homelike atmosphere welcomes the range of women, with and without children, who use the resource centre.

Implications of Vancouver Women's Health Collective practices for V/RHB policy

✓ This evaluation of the CHA project was not intended in any way to be a review of VWHC policies and practices so depthful comment or analysis of how the VWHC policies and practices respect, recognize and support those who work within its organization cannot properly be made by this report.

✓ However, it is common knowledge that women's participation in the work force (as a paid member or volunteer) is hindered by lack of access to child care, and lack of family-friendly policies or practices generally.

✓ The historical practice of the Vancouver Women's Health Collective has always aimed to de-mystify and de-institutionalize women's health issues. This is shown by their purpose statement, which reads:

> *"We have all been taught that only medical experts know about good health care. In fact, health information has been passed down from one generation of women to the next for centuries. Since our founding in 1972, the Vancouver Women's Health Collective has promoted and supported women helping women to help themselves."*

✓ The structure and practices of the VWHC, as described briefly on the previous page, and their open, non-hierarchical method of delivering service reflects its purpose of women helping women to help themselves.

V/RHB 1998/99 priority goal nine: Foster the creation, dissemination and application of knowledge, improving health services and population health.
Relates to CHA project objective: none specifically relate.

Implications of this work for V/RHB policy

✓ None.

Please note: all evaluation conclusions are found in Section 1: Executive Summary and Conclusions.

APPENDICES

INTERVIEW GUIDE
PROJECT COORDINATOR - VWHC COMMUNITY HEALTH ADVOCATE PROJECT
January 1999

A. Training

(Review comments on training from focus group and training feedback forms)

What did you learn from delivering the training to the CHA's?
- -about the CHA's
- -about timing
- -about content

What, from your perspective, went exceptionally well in the training?

What would you change in the training for next time? Why?

How have you observed that the CHA's use their training as they start/continue their work out there?
- -strengths/gaps in training revealed by this are?

B. Manual

What have you learned about the manual as a tool for the CHA's?
- -from observing CHA's use of it
- -from your teaching of it, reference to it
- -what's working well, especially useful, gaps

What are your thoughts about what else should be included in the manual–changed–removed?

C. Project structure (communication, support, base of operations, staffing, community partners)

Tell me about the communication set up between the CHA's and yourself?
- -formal and informal, when & what for
- -what does it look like, how is it working?
- -helps, hindrances, how can it be enhanced?

How do you communicate with others in this project (other staff, community partners, funders etc)
- -when, what for
- -what does it look like, how is it working?
- -helps, hindrances, how can it be enhanced?

What do you observe that the CHA's need re support to get their job done?

-can you provide it, or arrange for others to? How? If not, what's the barrier?
-suggestions and advice about structure that could help?

How would you rate the sense of linkage/belonging felt by the CHA's within the VWHC?

-is it possible...necessary? What works to help this? What would make it stronger?

What has the process of getting the CHA's "settled into" their specific communities been like for you?

-locating, linking with, problem-solving, communication
-strengths, weaknesses, helps, hindrances in this process

What has been your role, if any, in finding & working with potential/actual community partners at the CHA and project administration level?

-what helped, hindered this work?

D. The work of the CHA's

What do you observe re CHA's understanding of their role as CHA's?

-boundaries, limitations, what they CAN do?
-what has been your role in helping them with this?

Is the CHA work evolving as the VWHC thought it might?

-content
-time
-surprises? What, why?
-what is VWHC learning from this about what to change, keep etc?

How do CHA's link their work with VWHC?

What is VWHC learning about women's specific and general health needs, (and systemic responses) from this project so far?

-any emerging patterns between CHA's work, problems, types of issues, kind of women?
-amount of work the project has taken/is taking?

E. Your work as project coordinator

Describe what the actual work is - compare with what the job description was/is.

-what changed, when, why?

What time does doing this project actually take?

-what's your assessment of this...enough, too much?
-where's the greatest need for your time?

INTERVIEW GUIDE
PROJECT COORDINATOR - VWHC COMMUNITY HEALTH ADVOCATE PROJECT
August 1999

A. Update

Describe your understanding of the job of Project Coordinator now?
- -when started, # hours per week
- -what the job description is, how has it changed from first Coordinator?

Tell me about the work you have been doing since you started.
- -list and describe

What is going on with the CHAs?
- -your relationship with them
- -number of CHAs remaining, who has left & why, who has stayed & why, replacements?
- -training
- -tracking form
- -issues raised by CHA's
- -CHA's relationship with community partners

B. New work

What shifts are being made in the project?
- -what, why, when, where, how
- -how does this impact on the project overall?

What about the manual?
- -revisions made, by whom, deadline for completion

What work has the practicum student done this summer?
- -impact of her work
- -what did she learn about the project

Describe the training sessions that have been run
- -content, who came, evaluations

C. Overall vision

What is your sense of the project at this time?
- -relationship with CHAs
- -relationship of project to VWHC
- -shift in focus & how that will impact on your work, work of CHAs
- -did CHAs continue to use the manual?

FOCUS GROUP GUIDE
COMMUNITY HEALTH ADVOCATES - VWHC
1999

A. Training

Now that a number of months have gone by since your first training, tell me how you've been able to take that training and apply it to your work as a CHA.

-what, if any, specific situations have come up, what did you do about it, where did you learn what to do about it...the training, contact with other CHA's, contact with Brenda?

- from that experience, what comments do you have for change/additional/same training?

B. Manual

How are you using the manual in your work?

What's been especially useful - how?

Any thoughts yet about what ELSE should go in to it?

C. Project structure (communication, support, base of operations, staffing, community partners)

How do you communicate with others in this project (Brenda, office, ctty partner, facility, CHA's) (phone, fax, e-mail, meetings?)

-when, what for - give me some examples
-what happens to the work or situation when you can't get through to someone
-how is the communication working...in specific instances and overall
-how would you rate your own sense of linkage/feeling of belonging, with the Health Collective. Is it possible..necessary? What works to help this? What would make it stronger?

As an advocate working as a volunteer out in the community, what kind of support are you finding that you need/want in order to do your job?

-can you get it? How? If not, what's the barrier? Suggestions/advice about project structure that could help...

What's it like working in the specific communities that you are each in?

-how are each of you working with the community/organization you are part of?

What role has VWHC played in your work and this project?
-support, vision, helps, hindrances?

What other external and internal impacts have influenced your work?

F. The Big Picture

What is going on in the communities that VWHC hasn't known about before?
-issues

What have you learned so far, through this project, about ways to make the VWHC visible and accessible?

What is the impact, if any, of the CHA project on other parts of VWHC to date?

G. Review of project goals, objectives

(Go over chart of goals, objectives)

Will you rate results of process and outcome objectives.
-(rate and discuss why each rating given)

What does this tell you and VWHC about this project to date?
-about what worked and why
-about what didn't work, and why
-about what should stay the same, what should change for the project to continue

-how do you rate yourselves in terms of being "in and settled" (give me some examples)
-how did that happen, or why do you think it is not happening - is it necessary to the success of working with the women?
-what would make it work/feel better/more effective?

How are community partners emerging?
-who - give some examples
-what does the work/linkage with community partners look like?

D. The advocacy work

What is the advocacy work looking like in terms of content. Give some examples.
-any surprises in this for you? Why, why? How are you dealing with those?

What is the advocacy work looking like in terms of your time. Give some examples.
-any surprises in this for you? What, why? How are you dealing with those?

How do you make the decision to take a women's health issue on as a CHA?...or not?
-what about criteria, boundaries, roles, limitations, ability to refer women elsewhere...and the time that takes?

How did the women you've worked with so far actually find you?
-referred, read a poster, via health collective, via supporting agency, word of mouth...?

How were community women involved in helping to develop your advocacy plan...list of health care needs?
-describe, helps, barriers, time it took

Overall, what, if any patterns are you seeing so far in the issues being brought forward?

HANA HUSSEIN. 325-4913

Hana was trained as a registered nurse in Somalia. She had just completed her practicum in Somalia when her family immigrated to Canada. For the past year, She does volunteer work with Somalian women at South Vancouver Neighbourhood House. In addition, Hana was a member of Barriers to Bridges committee. She assisted in planning, coordinating and overseeing monthly multicultural, intergenerational events. She also works with Somalian women at Mount Pleasant Neighbourhood House.

TYPE OF ADVOCACY:

Individual advocacy, assisting Somalian women who are going to medical appointments, finding women doctors, assisting the women in finding the resources they require.

WHERE & WHEN:

South Vancouver Neighbourhood House, Saturdays 1:00-4:00pm, Mondays, 9:00-2:00pm
Hana will also start doing workshops on various health issues in February. Details to be confirmed. She wants to do them at Mount Pleasant Neighbourhood House.

COMMUNITY PARTNERS:

South Vancouver Neighbourhood House-Paula Khan, Seniors Worker & Marilyn Gutierrez-Diez, Family & Children's Worker, 6470 Victoria Drive, Vancouver, BC, V5P 3X7, Phone: 324-6212

Other:

Hana will use the tracking form for each contact or workshop and will keep track of important information in her journal.

ADVOCACY PLAN
EARLY 1999

SADIE KUEHN: 684-5307 or 266-5414, cell: 729-7815

COMMUNITY HEALTH ADVOCATE BIOGRAPHY:

Sadie Kuehn is the Community Development Worker for The Centre. A community centre for the Lesbian, gay, bisexual & transgendered communities. She will work with Lesbian, Bisexual, aboriginal woman, women of colour and poor women.

TYPE OF ADVOCACY:

Sadie will do individual and organizational advocacy. She will work on the provincial level with AMSSA. (a province wide multicultural organization). Community Discussion Groups, Kitchen Table Discussions, Complaints, Letter Writing, Education, Direct Contact.

WHERE & WHEN:

Sadie can be reached on her cell, 729-7815 or home office, 266-5414.
Sadie has not set out specific work times for herself. She is willing to be contacted as needed

COMMUNITY PARTNERS:

Monday Health Project -1065 Seymour Street, Blood Services, Rob Kolan, 659-1144, fax: 659-1155

Positive Women's Network-promote work of CHA, Coordinator: Susanna Pan, 1107 Seymour Street, Vancouver, BC V6B 5S8, 681-2122 local 200, fax: 893-2256

Asia-Asian Society for the Intervention of Aids, Contact: Susanna Pan, #507-1033 Davie Street, Vancouver, BC, 669-5567

Immigrant Services Society-help with organizing focus groups, Contact: Chris Freisen, #501-333 Terminal Ave, Vancouver, BC V6A 2L7, phone: 684-2561

AMSSA(affiliation of Multicultural Societies & Services Agencies of BC)-use of name & support for organizational advocacy, Contact: Vera Raydo, 385 S.Boundary Road, Vancouver, BC V5K 4S1, phone: 718-2777

Africa Canada Development Information Services Assn-help with promotion, word of mouth, newsletter (every 4 months), help identify key area of work, Contact: Sadie Kuehn

PROMOTION:

Queer FM, Obaa-Women of Colour, Coming out radio programs on Van Co-op Radio, Extra-West, Gay TV, Women in Print Newsletter, Centre of Excellence in women's Health.

TRACKING FORM:

Sadie liked the form her only suggestion was to have larger print. She feels that whether or not women come back to her or not is a real show of her effectiveness. Also, through word of mouth feedback she feels is a good way to show one's effectiveness.

Other: Sadie talked about the results of the surveys that were done by the LGBT health project copies are in her file folder.

ADVOCACY PLAN
EARLY 1999

Vancouver ECHO Wednesday, March 3, 1999

Tom Bertrand photo

Sonia Bilkhu volunteers as a community health advocate at South Asian Women's Centre.

Health advocates help women

Volunteers try to get rid of confusion that arises from cultural differences.

By BRENDA JONES
Staff writer

Vancouver Women's Health Collective originated two decades ago after women complained about sexual harassment and abuse by doctors. Today, women still feel they aren't taken seriously or treated with respect by their physicians, says women's heath advocate Brenda Kent.

Serious health problems are sometimes dismissed as hormonal fluctuations or premenstrual syndrome - a.k.a. "woman problems."

"They're sent away with a bunch of pills but no answers," said Kent, who coordinates a Community Health Advocate program through the collective. Late last year she recruited advocates from various ethnic groups and the gay and lesbian community, and they've been helping women since January.

In some cases, doctors have told lesbians they didn't need pap smears (which test for cervical cancer) because they don't have sex with men, Kent said. Women in wheelchairs didn't receive sexual information because doctors assumed they didn't have sex. Kent has also heard from overweight women whose doctors discounted their symptoms as being products of their weight problems.

Cultural differences make delivering health care particularly sensitive in the South Asian community, says advocate Sonia Bilkhu, coordinator of the South Asian Women's Centre on Main Street. These patients can find general practitioners who speak Punjabi, Hindu or Urdu, but language barriers become a problem in hospital. Hospitals also serve food they aren't used to eating.

"They may never have eaten bread and soup in their lives, then have to eat that for a week," Bilkhu said. "It's torture."

The Main Street centre helps women access community resources such as shelters for abused women. In a couple of cases, women approached Bilkhu because their husbands wouldn't allow them to see a doctor. Other women don't know they can switch physicians or ask for second opinions from doctors free of charge, she said. Some don't feel comfortable talking about gynecological problems with doctors who share the same social circle.

Depression is a common problem among newly immigrated South Asian women because they're homesick and lonely if they don't work outside the home, Bilkhu says. Mental health problems are taboo in certain South Asian cultures.

Bilkhu and nine other volunteer advocates trained for three days last November. They learned how to navigate the health care system and find community resources that help women. They started working a minimum five hours a week in January.

"The volunteers are speaking out for women who can't speak for themselves," Kent said.

The CHA program has funding from the Vancouver/Richmond Health Board until September, through the 1997 community health initiative fund. It finances programs focused on health promotion and disease prevention.

Vancouver Women's Health Collective also keeps files of women's complaints against doctors and other comments about care they've received. It has information on general practitioners, gynecologists, chiropractors and other specialists.

Call Vancouver Women's Health Collective at 736-5262 or 736-4234 to be referred to a community health advocate.

COMMUNITY HEALTH ADVOCATES

The Community Health Advocate Project, operated by the Vancouver Women's Health Collective, is founded on the need for safe, respectful, and appropriate health care for women. Fully-trained volunteer advocates will work within a grassroots community setting to help women empower themselves about their own health care. The Advocates will provide health information, resources, and support, as well as raising awareness about the needs that are not being met for women in their communities. Recognizing that women have the right to a health care system that meets their needs, Community Health Advocates not only provide information, they also speak out for women who feel they do not have a voice of their own that is loud enough to be heard. "I love the philosophy of women helping women help themselves."

Brenda Kent, Coordinator, has been involved with this project since its inception 9 months ago. She is fully committed to the vision of the project. Currently there are 10 Community Health Advocates working in various communities.

Hana Hussein
Somali Women Health Advocate
Brenda Kent
Project Coordinator
Suite 219 - 1675 West 8th
Vancouver
Ph. 736-4234, Fax 736-2152

VANCOUVER WOMEN'S HEALTH COLLECTIVE

The Vancouver Women's Health Collective is a non-profit, volunteer organization, which has for 27 years been providing women with resources to make their own, informed, health care choices. In the fall of 1971, a woman angry and dissatisfied with the health care she had received from her doctor ran an ad in a local woman's paper hoping to meet other women who shared a similar experience. Today, women gather at the VWHC to share information, knowledge and experience. At the VWHC you will find a multi-faceted information centre complete with health/holistic/therapist files, resource library and supportive volunteers who are available to help you research your own health issues. Virtually every volunteer involved with the Collective would agree, the most rewarding aspect of what we do gives us not only a strong sense of purpose, but also that the work being done is rewarding and meaningful not only for today, but well into the future.

SUITE 219-1675 WEST 8TH
VANCOUVER
INFO LINE: 736-5262
ADMIN LINE: 736-4234
FAX LINE: 736-2152

Community Health Advocates

Your **Community Health Advocate** will listen to you and offer support and information. She will help you find resources to get the best health care possible.

SOMALI WOMEN health advocate, Hana Hussein. Drop-in at the South Vancouver Neighbourhood House on Mondays from 9am-2pm and Saturdays from 1pm - 4pm or leave a message 324-6212.

LESBIANS, BISEXUAL WOMEN, ABORIGINAL WOMEN, WOMEN OF COLOUR & POOR WOMEN health advocate, Sadie Kuehn. Call 266-5414 or 729-7815.

UBC WOMEN & FARSI-SPEAKING WOMEN health advocate, Fatma Acktary. Drop-in at the UBC Women's Centre Mondays & Fridays from 10:30am - 1:30pm, or phone 822-2163 to leave a message.

SOUTH ASIAN WOMEN health advocates, Sonia Bilku and Gaitry Kaul. Drop-in advocacy at the South Asian Women's Centre on Mondays and Tuesdays from 1pm - 5pm or phone 325-6637.

ANY WOMAN of the DOWNTOWN EAST SIDE health advocate, Diane LeClaire. Drop-in at the Downtown Eastside Seniors Centre (509 E Hastings) Thursdays 4pm - 8pm or leave a message at 258-4109.

WOMEN WITH DISABILITIES Health Advocates. Call 878-3211 to leave a message and an advocate will return your call.

LATIN AMERICAN WOMEN health advocate, Elena St.John. Appointments at the Multi-Cultural Family Centre - call 254-6468.

CHINESE WOMEN and **MENTAL HEALTH CONSUMERS** health advocate, Ahlay Chin. Leave a message for Ahlay at the Richmond Women's Resource Centre at 279-7060 or at 273-1989.

TALK TO YOUR COMMUNITY HEALTH ADVOCATE

A Project of the
Vancouver Women's Health Collective
#219-1675 West 8th Ave Vancouver, BC V6J 1V2 Health Information: (604)736-5262 Administration: (604)736-4234 Fax: (604)736-2152 vwhc@axionet.com

Why do women need Community Health Advocates?

Here are some stories from women about their treatment in the health care system.

"I complained about pain during menstruation and was told it was normal. 2 years later, I found out that I had endometriosis."

"My doctor wouldn't treat me for my migraines. He said all I need to do is lose weight."

"Women with disabilities are considered asexual in our society. They do not get the same information about sexuality as able-bodied women."

English was her second language and her practitioner didn't have enough patience to understand her problem. She was treated like a child and left the office with no help.

"When I told my doctor I am a lesbian, she became very uncomfortable. Then she told me I did not need a PAP smear because I am not sexually active [with men]."

[January 1999]

A Project of the
Vancouver Women's Health Collective

#219 - 1675 West 8th Ave
Vancouver, BC V6J 1V2
Health Information : (604)736-5262
Administration Office : (604)736-4234
Fax : (604)736-2152
vwhc@axionet.com

With funding from the
Vancouver/Richmond Health Board

Community Health Advocates

Women speaking-out for safe, respectful and appropriate health care for women!

The Health Advocate in <u>your</u> community wants to help you get your health care needs met.

ABOUT THE PROJECT

The Community Health Advocate Project was developed because many women are not getting their health care needs met. There are many barriers women face accessing *safe*, *respectful* and *appropriate* health care. This project seeks to address these issues by training and supporting advocates who will speak-out for women in their communities. They will *raise awareness* of the needs of the women in their communities, *educate* women on their rights, and help women *develop tools* to access safe health care.

WHO ARE THE ADVOCATES?

Community Health Advocates are **volunteers** trained and supported by the Vancouver Women's Health Collective, and other community groups. Our goal is to keep training and supporting more advocates to represent a greater number of women. Currently, the following groups of women in Vancouver and/or Richmond have access to a trained volunteer advocate:

African Women
Somali Women
Women with Disabilities
Mental Health Consumers
South Asian Women
Latin American Women
Lesbians and Bisexual Women
UBC Students
Chinese Women
Low-Income Women
Aboriginal Women

WHAT IS ADVOCACY?

In this project, the advocate may work in a variety of ways, depending on the needs of the community. The advocate may accompany women to their doctor for support and help overcome language barriers. She may be available to listen to women's experiences and help find further resources within the community. She may coordinate workshops for women on health issues. She may raise awareness in the community about what women need from the health care system, and lobby for change.

YOU HAVE THE RIGHT TO A HEALTH CARE SYSTEM THAT MEETS YOUR NEEDS

Have you ever been treated poorly by your health care provider?

Have you tried to complain about your treatment and been frustrated?

Have you been told that your illness is "all in your head"?

- Do you feel that you know your body better than anyone else, but no one believes you?
- Have you been frustrated because you can not find a health care provider who speaks your language?
- Do you feel like you are not being heard by your health care provider?
- Do you want to learn more about alternative medicine, but are afraid to talk to your doctor about options?

Your Community Health Advocate will listen to you and offer support and information. She will encourage you to find resources in your community that can help you get the best health care possible.

What are my <u>rights</u> as a woman in the health care system?

- ☑ You have the right to be treated with dignity and respect
- ☑ You have the right to make decisions about your health care needs
- ☑ You have the right to access information in a way that makes sense to you
- ☑ You have the right to be heard
- ☑ You have the right to chose your own health care provider and to have a second opinion
- ☑ You have the right to bring a friend, husband or partner to the doctor for support
- ☑ You have the right to access your medical files
- ☑ Many more....

How can I make a <u>complaint</u> about my treatment in the health care system?

Some women who want tomake formal complaints about their experience with their health care provider do not know where to go. Talk to your Community Health Advocate about ways to tell your story.

How do I find more resources in my community about my health issues?

Your Community Health Advocate will help you find support, information, and resources in your neighbourhood.

I just want to share my experiences with someone who will understand!

Your Community Health Advocate will listen to your story and work to make changes in the health care system to respond to your issues.

Community Health Advocates

Speaking-out For Safe and Respectful Health Care For Women

- ☑ What are my rights as a woman in the health care system?
- ☑ How can I make a complaint about my treatment in the health care system?
- ☑ How do I find more resources in my community about my health issues?

Your **Community Health Advocate** will listen to you and offer support and information. She will help you find resources to get the best health care possible.

You have the right to a ***Health Care System*** *that meets your needs!*

TALK TO YOUR COMMUNITY HEALTH ADVOCATE

A Project of the
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Appendix A

Project Budget

1997-98
Community Health Advocates

Community Health Advocate workshop development, production & evaluation 1contract curriculum designer @ 100 hrs x $25/hr manual design & production	 2,500 3,500	Vancouver/Richmond Health Board
Community Health Advocate training **2 contract trainers @ 300 hrs x $18/hr** **honorariums for Community Health** Advocate2 @ 250/training x 9	10,800 2,250	Vancouver/Richmond Health Board
salary & benefits for full time Community Health Advocate Program Coordinator @ 38,500	38,500	Ministry of Women's Equality
working with selected women's centres to educate community health councils and regional health councils about need for the Community Health Advocate Program	10,000	Ministry of Women's Equality – Speaking Up and Speaking Out
development of 5-year business plan	3,000	United Way TAP Grant
soft ware development program evaluations	15,000	Centre of Excellence for Women's Health
rent for workshop & training	2,400	**Gaming Funds** - Vancouver Women's Health Collective
Materials & Supplies	4,000	VWHC
volunteer hours provided by: VWHC members ~1728; steering committees ~400; community health advocates (9) training ~1440; delivery of advocacy in community ~4680		we have both internal and community support for all of these positions in place already
total request from Vancouver/Richmond Health Board	19,050	

AS SUBMITTED TO V/RHB CHF OCT/97

for 97/98

1998/99 Community Health Advocate Budget $35,850		
Workshop Design	2500	Acct #/Dept
Salary 1750		WHN 5288
Production 750		WHN 5263
Manual Design	3500	
Salary 2750		WHN 5289
Production 750		WHN 5264
Promotion	1500	WHN 5265
Trainers Salaries	13500	WHN 5287
Trainers Benefits	1450	WHN 5047
Honoraria for CC Participants	4725	WHN 5151
Training Expenses		WHN 5297
Fixed Costs:		
Equip Rent & Service	1000	
Fax	160	
Materials & Supplies	750	
Telephone	600	
Utilities & Garbage	280	
Rent & Parking	4185	
Variable Costs:		
Equip & Furniture	700	
Hospitality	500	
Postage	500	
Total Expenditures	35,850	

AMOUNT INCLUDES
97/98 #19,050
(rec'd 3/98)
98/99 #16,800
(rec'd in monthly amounts)

File: Admin/Budget/CHA.doc

CHA Budget 1999/2000			
Expenditure	**Account #**	**Department**	**$**
Benefits	5047	cha	954
Honoraria	5151	cha	480
Hospitality	5155	cha	564
Program Promo	5265	cha	1020
Salaries & Contracts	5287	cha	9540
Training	5296	cha	1020
Admin. Overhead	5297	cha	670
Communications	5298	cha	1690
Outreach	5299	cha	1000
Travel	5301	cha	324
Total CHA			**17262**
Total V/RHB Grant			**16800**
Deficit			**(462)**

file: admin/budget99/chabud.doc

Most recent revision, rec'd by Consultant 11/01/99