

Canadian Women's Health the network

winter 2006/07

volume 9

number 1/2

**Women and
Mental Health
in Canada –
Breaking
the Silence**

**Update on
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Advertising Charter
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Research Policy on
Gender and Sex-
Based Analysis**



editor's note:

A lot has transpired since our last issue. One thing in particular that caught our attention was the release last May of a long-awaited report on mental health, mental illness and addiction in Canada by the Senate Committee on Social Affairs, Science and Technology, chaired by Senator Kirby. *Out of the Shadows At Last* revealed significant gaps in Canadian mental health care, and pointed a few ways forward toward filling them. More disappointing, however, was the Report's silence on the differences between men and women's and boys and girls' mental health, mental illness and addiction. Given the diverse abundance of gender-based mental health research in progress around the country (for a sampling, see *Women, Mental Health, Mental Illness and Addictions in Canada: An Overview* at www.cwhn.ca/PDF/womenMentalHealth.pdf), the omission is stark.

As we go to print, Health Canada is holding online consultations to hear Canadians' opinions on the proposed mental health commission to better guide the Government in addressing mental health and mental illness in Canada. Let's hope the consultations mark the beginning of a more robust and directed effort to hear the voices of historically marginalized groups, and of women and girls in particular.

But if recent Federal ambivalence over renewing funding for Insite, Vancouver's innovative harm reduction facility, and the severe Status of Women Canada budget slashes and closures announced last fall are any indication, the road ahead may be rocky. In this issue, Marie Claire MacPhee and Kathleen O'Grady respectively look at those two developments, and what they mean for women in Canada.

What we need more of are victories like Women and Health Protection's (WHP) achievement of intervenor status as part of a coalition in the CanWest Mediaworks Charter Challenge on Direct to Consumer Advertising (DTCA), groundbreaking analysis on gender and wait times from Women and Health Care Reform (WHCR), and grassroots initiatives like the Prairie Women's Health Centre of Excellence (PWHCE) Photovoice project for low income women – all of which you can also read more about here.

Finally, my sincere apologies to those of you who have been anxiously awaiting this somewhat delayed issue of our magazine. If there's one thing we here at *Network* can know to expect, it's that health is a tricky thing. An unexpected turn in my own health significantly slowed down the production of this issue, originally scheduled for release last fall. The good news is that you can expect another issue close on the heels of this one, jam-packed with more Canadian women's health news and analysis, and with Kathleen O'Grady back at the editorial helm.

Thanks to CWHN staff, Board, members, contributors and readers for your support during my tenure. As always, your feedback is much appreciated, and I look forward to continuing this work with you all through other avenues.

Sincerely,
Laila Malik
Editor

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Network/Le Réseau is published in English and French twice a year by the Canadian Women's Health Network (CWHN). Parts of Network/Le Réseau are also available on the CWHN web site: www.cwhn.ca

To subscribe to **Network** magazine, call 1-888-818-9172 or email cwhn@cwhn.ca for details and payment options. Individuals receive two issues of **Network** for \$15, four issues for only \$25.

Organizations – two issues for \$35. Back issues are also available at \$5 each. We welcome your ideas, contributions and letters. All requests for information and resources, as well as correspondence related to subscriptions and undeliverable copies, should be sent to the address below.

PUBLICATIONS MAIL AGREEMENT NO. 40036219
RETURN UNDELIVERABLE CANADIAN ADDRESSES TO

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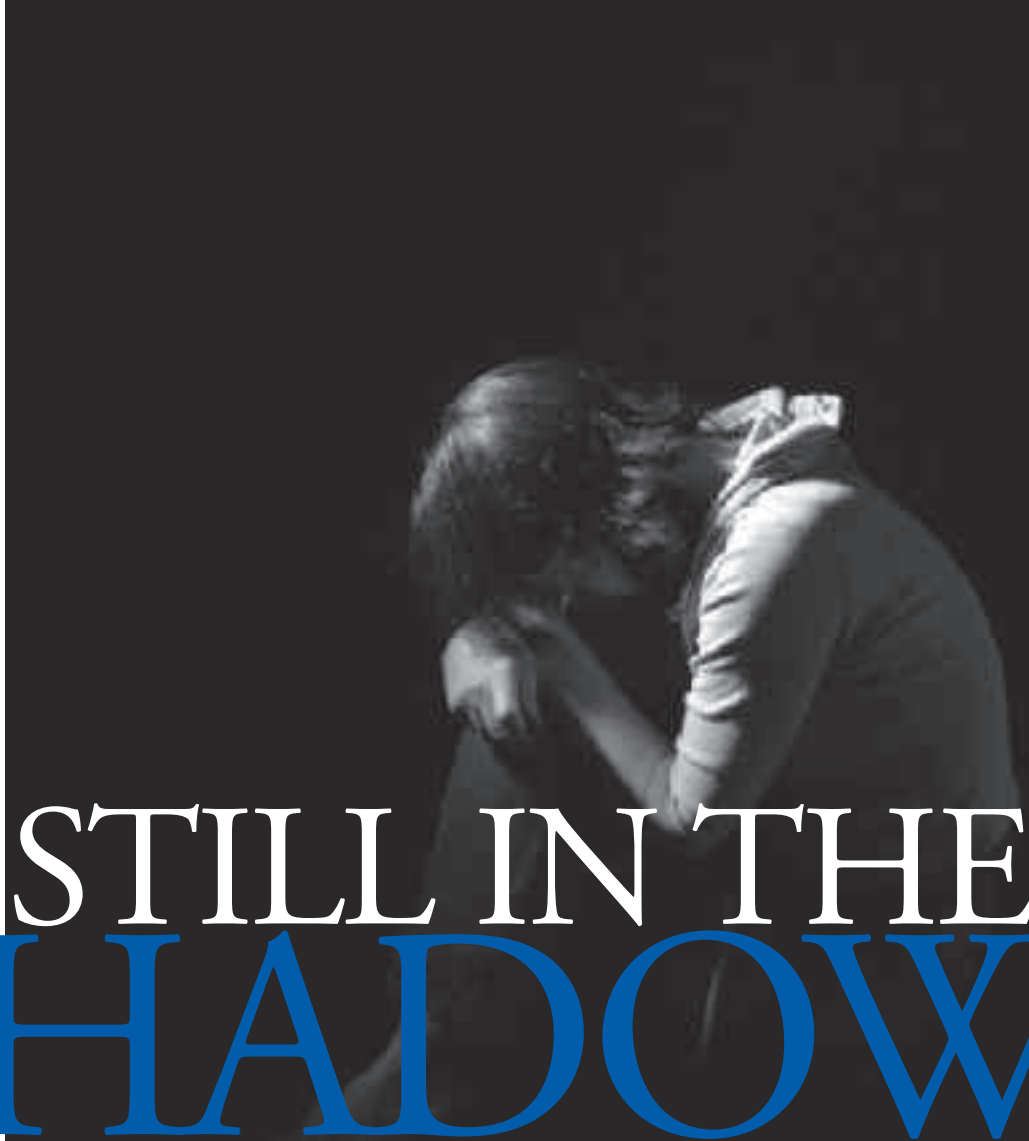
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The opinions expressed by contributors are their own and do not necessarily represent the views of the Canadian Women's Health Network, its funders or its members. Articles are intended to provide helpful information and are not meant to replace the advice of your personal health practitioner.

The Canadian Women's Health Network gratefully acknowledges the funding support provided by the Women's Health Contribution Program of the Bureau of Women's Health and Gender Analysis, Health Canada, as well as the support and donations of the individuals and groups whose work strengthens the Network.

Printed by union labour on 50% recycled, 25% post-consumer paper by Winnipeg Sun Commercial Print Division.





STILL IN THE SHADOWS

Kirby report turns a blind eye to women

BY LAILA MALIK

ALMOST TWENTY YEARS AGO, THE CANADIAN MENTAL HEALTH ASSOCIATION (CMHA) ISSUED AN IN-DEPTH REPORT CALLING FOR ACTION TO ADDRESS MENTAL HEALTH CONCERNS FACING WOMEN IN CANADA. *Women and Mental Health in Canada: Strategies for Change* WARNED OF THE DIRE MENTAL HEALTH EFFECTS OF THE FEMINIZATION OF POVERTY AND VIOLENCE AGAINST WOMEN AND DREW ATTENTION TO THE DISPROPORTIONATE NUMBER OF WOMEN ASSIGNED WITH THE DIAGNOSTIC CATEGORIES OF DEPRESSION AND ANXIETY.

It outlined 25 recommendations for improvement, including the development of affordable, high quality child care services, the establishment of pay equity policies, recognition of unpaid caregiving, and the creation of a national clearinghouse of research and programs on women's mental health.

The report was promptly buried, its recommendations consigned to oblivion.

In May 2006, the Senate Committee on Social Affairs,

Science and Technology, chaired by Senator Kirby, released a new three-year study on mental health, mental illness and addiction in Canada. *Out of the Shadows at Last* reveals massive gaps in Canadian mental health care which aggravate illness and offload care to families—particularly women, and highlights social factors, like the housing crisis, that are crucial for integration and healing. Its recommendations to expand care and increase supportive housing are good news for women, who make up the

majority of unpaid care-givers in Canada.

Given these welcome interventions, the Kirby Report's silence on significant differences between men and women's mental health, mental illness and addiction is distressing.

Canadian figures bear out those differences. Health service utilization data from Manitoba and Quebec over the past ten years shows that substantially more women than men received a diagnosis of a mental health problem and of an anxiety/ depressive disorder and that more women than men received a psychotropic or an anti-anxiety drug or antidepressant. In Canada, 13% of women versus 9% of men consume sedative-hypnotic drugs. Data from the Canadian National Population Health Survey indicate that women are more likely to experience a major depressive episode, with annual incidence rates of depression twice as high as those of men. Women are more than twice as likely as men to walk out of the doctor's office with an anti-anxiety or antidepressant prescription.

The pattern continues with addictions. Women's bodies are more susceptible to the effects of alcohol, tobacco, and other drugs, and women develop many substance-related health problems, such as alcohol-related liver disease, earlier than men. Substance use and mental health problems also frequently co-occur among women who are survivors of violence, trauma, and abuse, often in complex, indirect, mutually reinforcing ways—as many as two-thirds of women with substance use problems report a concurrent mental health problem such as post-traumatic stress disorder, anxiety, and depression.

International mental health authorities are increasingly mindful of these differences and their causes. Organizations like the World Health Organization

(WHO) have recognized that certain common mental disorders affect women disproportionately and in unique ways, often triggered by risk factors like gender-based violence, socioeconomic disadvantage, low income and income inequality, and primary responsibility for care-giving. In September 2005, the World Psychiatric Association (WPA) passed the International Women's Mental Health Consensus Statement,

We need a balance of women and men within the Kirby Report's proposed Mental Health Commission, a systematic gender review of mental health, mental illness and substance use in Canada, and greater support for women-centred models of care.

signed by 140 of its member associations. The statement, which calls for mental health policy to address women's unique roles in reproduction, family and society, and their often lower socioeconomic status, has been endorsed by several other international organizations, including the World Federation of Mental Health.

Yet despite the mounting evidence—as well as Canada's many commitments to using Gender-Based Analysis (GBA) in policy and program development—federal health studies somehow remain gender-blind. *Out of the Shadows* is no

exception. Its inattention to differences in women and men's bodies and social conditions leaves little hope that its proposed solutions will address women's mental health needs.

In a bid to rekindle the discussion, a national ad hoc working group convened by the Canadian Women's Health Network pooled the knowledge of over 25 women's mental health experts from across the country to produce a series of recommendations for improving mental health response and promotion, as well as a set of briefing notes on women's mental health issues ranging from trauma, depression, psychotropic drugs and eating disorders to population-specific issues.

But we need more than another report. The great task of healing our mental health care system must be built around a close examination of gender and diversity. We need a balance of women and men within the Kirby Report's proposed Mental Health Commission, a systematic gender review of mental health, mental illness and substance use in Canada, and greater support for women-centred models of care. We need to address the impacts of poverty and sexual and intimate partner violence on women's mental health, and earmark funds for conditions like depression and trauma-related disorders, which affect women disproportionately.

Twenty years is a long wait, and one we can ill afford to repeat. How much longer will women's needs as patients, providers, paid and unpaid care-givers continue to remain in the shadows? ❧

Laila Malik is a women's rights policy researcher, writer and editor. She was involved in convening the Ad Hoc Working Group on Women, Mental Health, Substance Use and Addictions as acting Director of Communications of the Canadian Women's Health Network.

Harm reduction facility faces renewal challenge

BY MARIE-CLAIRE MACPHEE

FROM THE OUTSIDE, IT APPEARS TO BE A MODEST BUILDING IN VANCOUVER'S DOWNTOWN EASTSIDE. BUT IN THE LAST THREE YEARS, THE CITY HAS BEEN COMPLETELY TRANSFORMED BY INSITE, THE FIRST NORTH AMERICAN GOVERNMENT-SANCTIONED SAFE INJECTION FACILITY FOR PEOPLE WHO USE INTRAVENOUS DRUGS. AS A NEXT STEP, SUPPORTERS WOULD HAVE LIKED TO SEE MORE RESOURCES FUNNELED TOWARD MAKING INSITE'S SERVICES MORE WOMEN-FRIENDLY. NOW, HOWEVER, THE FUTURE OF THE ENTIRE PROJECT MAY BE AT RISK—AND WITH IT, THAT OF ALL THE WOMEN WHO STAND TO BENEFIT FROM SUPERVISED, SAFE INJECTION SUPPORT.

When Insite opened its doors on September 12, 2003, surrounding resident and business communities feared that the facility—which had been approved as a three-year scientific pilot project with an exemption from Federal drug enforcement laws—would bring more drug users and crime to the streets, and would condone and encourage drug use among non-users. However, Insite soon gained not only the support of these communities, but also that of members of Vancouver's RCMP, Police Department, and politicians—including BC's Premier, Gordon Campbell. Though there is room for improvement—particularly in funding more women-friendly services—observers agree that over the last three years Insite has had nothing but a positive impact on local communities, on public health, and most importantly, on the lives of people who inject drugs.

However, to remain open after the expiry of its initial three-year term, Insite required a permit renewal from the new Federal government—some of whose members argued that it's morally wrong to aid illegal drug addiction. Following several months of speculation, in September of 2006, Canadian Health Minister Tony Clement postponed the critical final decision on whether or not Insite would receive another extended exemption from Canada's Controlled Drug and Substances Act until December 31, 2007. During this time, Insite will remain open while the government conducts further studies into how supervised injection sites affect crime, prevention and treatment.¹

This delay has met with mixed reactions from Insite supporters. On the one hand, it is a small victory that will allow Insite to continue saving lives for another 16 months. On the other hand, Clement cited the need for ►

RENEWAL CHALLENGE

more evidence supporting this project as the reason for the delay. However, numerous studies have shown that rather than an increase, there has been a significant decrease in crime rates in the area surrounding Insite. There has also been a major reduction in public injections, and no one has started using drugs at Insite.

Since opening its doors, approximately 6500 individuals have used Insite's facilities and there is an average of 600 injections on site per day. During this time there have been substantial reductions in syringe sharing among primarily high-risk populations, and there has been a notable increase in the number of people enrolling in detox services. The facility works to provide information and education to clients about safe injections and to offer them health care

“In 35 years of research, this is the single most successful project I have ever been involved in.”

~Dr. Julio Montaner, Director of the BC Center of Excellence in HIV/AIDS

services. To date, Insite has managed approximately 500 accidental drug overdoses and has not seen a single death among them.

Speaking at the sixth World AIDS Conference in Toronto last summer Dr. Julio Montaner, Director of the BC Center of Excellence in HIV/AIDS—an organization that has been conducting an arms-length evaluation of Insite—declared, “In 35 years of research, this is the single most successful project I have

ever been involved in.” He added, “It’s unfathomable to me, owing to the body of evidence, why you would not let Insite continue.”

Thomas Kerr, also from the BC Center of Excellence on HIV/AIDS, echoed Montaner’s concerns. He warned that if the government forced Insite to close, there would be significant deterioration of public order, a sharp elevation in HIV prevalence, and many lives would be lost.

VIRTUAL LEARNING COMMUNITY ON WOMEN-CENTRED APPROACHES TO HARM REDUCTION

From March 15 to July 15, 2007, the British Columbia Centre of Excellence for Women’s Health will be sponsoring a virtual learning community on integrating women-centred approaches into harm reduction settings such as needle exchanges, safe injection sites; and into drug policy and harm reduction frameworks for action.

Participants will have access to documents covering current research and practice, and the opportunity to discuss this information in videoconference(s), to contribute to a consensus document, and to plan and deliver a webcast session to share the consensus document with a wide audience.

For more information or to participate please contact: Nancy Poole and Katja Clark c/o kclark2@cw.bc.ca or 604-875-2424 extension 6488.



Coalescing on Women and Substance Use
Linking Research, Practice and Policy

Room for Improvement—Gender Sensitivity, Access, and Drug Policy Issues

Despite all of these groundbreaking results, observers note that Insite, as it exists now, is not nearly as effective as it could be. One major concern is the lack of women using the facility. Also speaking at the World AIDS Conference, Joanne Csete from the HIV/AIDS Legal Network expressed a pressing need for more woman-specific research and services. She noted that women are often “second on the needle”², meaning that they are more likely to share injection equipment, and to seek or require assistance when injecting drugs. This reality means that in many cases, women’s ability to negotiate for clean injection equipment is compromised. Access to clean equipment would not be an issue if women injected at Insite, but the current policy against assisted injections deters many women from visiting.

Csete argued that safe injection site

facilities need to allow for assisted injections, and must do more to attract women who use drugs. Women require specialized support and treatment services at such facilities, including child care and support on a broad range of issues affecting women, such as domestic violence, reproductive health and pregnancy. She further emphasized that it is absolutely imperative that women participate in the design and implementation of these services and programs.


The facility also has a ways to go in terms of wider accessibility. According to Kerr, there are approximately 5000 people who inject drugs in Vancouver, but Insite (at capacity) only serves 500-600 per day. Moreover, Insite is not open 24 hours a day, and during its opening hours there is often a strong police presence outside the facility that frequently leads to police crackdowns on patrons and deters them from regular visits.

Kerr also pointed out broader policy barriers that stand in the way of offering

comprehensive support to people who use drugs. According to Kerr, substance use is a health issue, and must be considered as such, *not* as an enforcement issue. But in Canada, our drug policy is rooted in prohibition and enforcement—the latter of which receives 95% of all ‘drug problem’ funding.

Both Csete and Kerr pointed out that prevalence rates of HIV and Hepatitis C in Canadian prisons are soaring as a result of the hyper-criminalization of drug use and of people who use drugs. They argued that safe injection facilities and further harm reduction practices must be implemented in prisons in order to curb these rates and to help prisoners get off drugs. On a broader scale, Kerr, Csete and other conference activists further demanded that the Government’s war on drugs be replaced with a more progressive policy that prioritizes evidence-based harm reduction practices.

The delayed final decision on Insite’s future has some supporters worried that a

move is underway to undo progressive drug policy reform work, develop a new drug policy that will emphasize programs that reduce drug and alcohol abuse, and stand in the way of harm reduction practices. However, with harm reduction and Insite activists gaining increasing popular momentum as a movement, supporters are likely to put up strong resistance to the retraction of recent advances. 

For more information about Insite and harm reduction practices, go to:

<http://communityinsite.ca/>
www.vch.ca/sis/
www.aidslaw.ca

Marie-Claire MacPhee is a student and staff member at the Simone de Beauvoir Institute for Women’s Studies at Concordia University in Montréal. She is the programmer and a co-host for CKUT Community Radio’s program Dykes on Mykes and a contributor to www.nomorepotlucks.org. She is also a former intern for the Canadian Women’s Health Network.

¹ Health Canada. News Release: *No new injection sites for addicts until questions answered says Minister Clement*. September 1, 2006. www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2006/2006_85_e.html

² Csete, Joanne. *Second on the Needle: Two-level Strategy for Claiming the Rights of Women who use Drugs*. August 16, 2006. www.aidslaw.ca/publications/publicationsdocEN.php?ref=559

WOMEN INJECTION DRUG USERS AND HIV INFECTION: SOME FACTS

It is estimated that approximately one-quarter to one third of injection drug users (IDUs) in Canada are women. Women are at an increased risk of experiencing physical health complications from IDU. It is a major risk factor for HIV infection in women. The proportion of positive HIV tests attributable to IDU among women 15 and older in Canada has varied between 33% and 48% from 1985 to 2002, with a slight decrease over time. In 2002, 37.2% of all positive HIV tests among women were attributable to IDU use.

From: Girls, Women and Substance Use by Nancy Poole (British Columbia Centre of Excellence for Women’s Health) and Colleen Anne Dell (Canadian Centre on Substance Abuse). To access the full document, visit: www.ccsa.ca/NR/rdonlyres/628CF348-1B92-45D5-A84F-303D1B799C8F/0/ccsa0111422005.pdf



Women and Health Protection wins intervener status in DTCA Charter Challenge

From Women and Health Protection

WOMEN AND HEALTH PROTECTION (WHP), AS PART OF A COALITION OF SEVERAL NATIONAL ORGANIZATIONS, HAS BEEN GRANTED INTERVENER STATUS (PARTY STANDING) IN THE CHARTER CHALLENGE CASE OF CANWEST MEDIAWORKS AGAINST THE FEDERAL GOVERNMENT ON THE ISSUE OF DIRECT-TO-CONSUMER ADVERTISING (DTCA).

In December 2005, CanWest Mediaworks, Canada's largest and most diversified media company, representing over 65 television, radio, newspaper and online brands across Canada filed a lawsuit against the federal government, charging that Canada's prohibition of direct-to-consumer advertising (DTCA) of prescription drugs is an unjustified infringement of the company's freedom of expression, as guaranteed under Section 2(b) of Canada's Charter of Rights. The case is being heard in the Ontario Superior Court, and Health Canada is

responsible for defending the current law against DTCA.


Having intervener status will allow the coalition to share important evidence on at least two critical areas of concern: the impact of DTCA on rising drug costs—and hence the survival of our Medicare system—and its effects on women. As WHP has pointed out, women, and young women in particular, are increasingly the target of pharmaceutical advertising campaigns. However, in many cases there is little or no understanding of the longer term risks of medications that are

increasingly hyped as cure-alls for some of the natural processes of women's bodies. Improper use of drugs is sometimes overtly promoted in advertising messages as well, as was the case with the recent advertising campaign for Xenical, a prescription drug for obesity which last year was marketed widely to Canadian women suggesting use for mild (cosmetic) weight loss.

With a range of side-effects including increased, oily or fatty bowel movements, urgent need and/or inability to control bowel movement, gas with discharge, stomach pain and irregular menstrual periods, Xenical is certainly not appropriate for wide use amongst healthy women who wish to lose a few pounds—which is precisely what the Xenical ads suggest. The illegal advertisements appeared in many of Canada's national and regional newspapers, including the *Globe and Mail*, the *Toronto Star*, the *Winnipeg Free Press*, and in Canadian magazines, such as *Reader's Digest*, *Chatelaine*, *Maclean's*, on television, including CBC TV, and in French and English on billboards in bus shelters, buses, subway cars and stations across Canada.

With women the frequent targets of prescription drug advertising campaigns, fear mongering is another common tactic employed to promote worry and doubt in viewers' minds. A recent campaign promoting the use of anti-cholesterol drugs (statins), using a bull poised to charge at a red sheet being hung by a woman alone in her back yard, manages to "crystalize images of assault, vulnerability, and violence", notes York University professor Harriet Rosenberg, currently working on a discussion paper on women and statins for WHP.

Intervener Status: Long Term Potential

CanWest Mediaworks' Charter challenge will be heard some time in 2007. In the bigger picture, however, the Coalition's achievement holds even greater potential in that it could set a precedent in how and to whom intervener status is awarded in future cases. 

WHP is a coalition of community groups, researchers, journalists and activists concerned about the safety of pharmaceutical drugs. The group keeps a close watch over ongoing changes in the federal health protection legislation and examines the impact of those changes on women's health. Their documents make clear recommendations to the government for Canadian legislation that truly provides "health protection".

Other Coalition members in the CanWest Charter Challenge case are: the Canadian Federation of Nurses Unions, Canadian Union of Public Employees, the Canadian Health Coalition, the Communications, Energy and Paperworkers Union of Canada, the Society for Diabetic Rights, the Medical Reform Group and Terence Young.

Why prohibit direct-to-consumer advertising of prescription drugs?

- Prescription drugs are not like other consumer goods. Even when used properly, they can cause serious harmful effects, sometimes even death.
- Advertising does not provide the impartial, objective information consumers need to make informed health choices. Its main goal is to increase product sales.
- A sick person is not like someone shopping for a new perfume or car. People are vulnerable when they are ill and often have to make difficult treatment choices.
- Companies almost always advertise their newest products to gain market share and recoup development costs. Many new drugs are no safer or more effective than older drugs, but are costlier. Often little is known about rare or long-term risks.
- Advertising of medicines promotes unnecessary medicalisation of normal life. Drug treatment for baldness, restless legs, shyness, toenail fungus, pre-menstrual syndrome, or occasional sexual problems may do more harm than good.
- Studies show that the doctors who rely more on information from drug promotion prescribe less appropriately. Similarly, promotion aimed at the public is likely to lead towards less appropriate medicine use.
- Prescription drug advertising drives up health care costs.

From the Women and Health Protection (WHP) Citizen's Guide to CanWest's Charter Challenge on prescription drug advertising. The Citizen's Guide can be found on the WHP website at: www.whp-apsf.ca/pdfcharter_challenge_en.pdf

NEWCOMERS IN HEALTH CARE LIMBO – QUEBEC GROUPS PROTEST

Community groups protest as Quebec joins Ontario, New Brunswick and British Columbia in forcing new immigrants to spend three months in limbo before health care coverage kicks in.

Women are especially vulnerable to the delay.

BY JILL HANLEY

with Project Genesis

MMARIELLE¹ CAME TO WORK AS A NANNY IN CANADA ON A TEMPORARY WORK PERMIT UNDER THE LIVE-IN CAREGIVER IMMIGRATION PROGRAM. SIX WEEKS INTO HER NEW JOB, MARIELLE BECAME VERY ILL. SOON AFTERWARDS, SHE WAS DIAGNOSED WITH CANCER AND WAS NO LONGER ABLE TO WORK. ALTHOUGH SHE HAD BEEN TOLD THAT SHE WOULD BE COVERED BY PROVINCIAL HEALTH INSURANCE, SHE DISCOVERED THAT THERE WAS A 3-MONTH WAITING PERIOD BEFORE SHE WOULD BECOME FULLY INSURED. UNFORTUNATELY, SHE HAD BECOME ILL BEFORE THE THREE MONTHS WERE UP AND WAS FACING HOSPITAL BILLS IN THE TENS OF THOUSANDS OF DOLLARS. ALTHOUGH SHE RECOVERED FROM HER CANCER, THE DEBT MARIELLE ACCUMULATED HAS BECOME A SIGNIFICANT BARRIER TO HER DREAM OF SPONSORING HER FAMILY TO JOIN HER HERE IN CANADA.

Research has documented the many barriers to health faced by immigrant women: poor work conditions, high stress, cultural clashes with health service providers, gender and ethnic stereotypes at work in the health system, language barriers, and the list goes on. These forms of discrimination come together, for example, among immigrant women who, unable to find jobs in their fields of training, end up doing factory work: a supposedly docile workforce. After long years of repetitive work in unhealthy conditions, Quebec community groups have had many reports of older immigrant women being pushed out of their jobs. Rendered ill by the work, they are no longer considered good workers by their employers and are harassed to the point of quitting. However, several provinces around the country – most recently Quebec – have found a way to add one more barrier to the list. As of 2001, all permanent residents and temporary workers arriving in Quebec have had to wait three months from their declared arrival before being covered by public health insurance (referred to as the *Délai de carence*).

For Canadians migrating from other provinces to Quebec, this waiting period is bothersome but rarely dramatic; these people remain insured by their previous province of residence. The big change is in terms of health insurance for international migrants, people arriving in Quebec as permanent residents or temporary workers. In most cases, this means that unless they purchase expensive and/or limited private health insurance, newly arrived immigrants are unprotected from debt should they fall ill during their first three months. However, newly arrived immigrants generally do not have the means to purchase private services. For the more than 130,000 women migrants landing in Canada as immigrants per year (CIC, Facts & Figures 2005), three quarters of them dependent on a third party for their status, the likelihood of having the means to pay for private health care is even less.

Fear of “Health Tourism”

According to the current government, the introduction of this delay was meant to harmonize Quebec laws on this matter with those of its neighbouring provinces (Ontario and New Brunswick have a similar three-month waiting period, as does British Columbia), thereby avoiding abuse of the healthcare system by people who come to Quebec temporarily in order to benefit from free healthcare. However, the government has never offered any statistics or research to justify its fear of “health tourism”. They have only provided a rough estimate of \$2 million lost to “abuse” of the healthcare system (from a

Health Care budget of many billions) without any mention of what role, if any, migrants play in this supposed abuse.

The decision is also unconvincing given the “healthy immigrant effect”, which indicates that new immigrants make much less use of healthcare services than Canadian-born individuals. Not only are immigrants screened for good health before being allowed into Canada, but many also avoid using public services for minor health problems out of the fear of being considered a burden on Canadian society. There is a worry that being documented as having ill health will hurt their eventual efforts to become Canadian citizens.

Community Response

Not surprisingly, this rollback of immigrant rights brought on a strong response from the community organisations whose members began reporting stories similar to Marielle’s. The arguments against the health insurance delay were quick to arise. Quebec-wide coalitions, such as the “Alliance des Communautés Culturelles pour l’Égalité dans la Santé et les Services Sociaux” (ACCESSS) and the “Table de Concertation des Organismes au Service des Personnes Réfugiées et Immigrantes” (TCRI), opposed the new policy for its impacts on permanent residents, supported by community-based organisations such as Project Genesis and the Immigrant Workers’ Centre. Unwilling to accept this troubling restriction of human rights, we at Project Genesis, in coalition with many other community organisations, have demanded the abolition of the *Délai de carence* and access to public health care for all.

On a basic level of principles, Quebec’s *Délai de carence* contravenes the right to physical and mental health guaranteed in provincial, federal, and international human rights charters. In fact, in 1998, the Canadian Council for Refugees, the Canadian Council for Churches and the Inter-Church Committee for Refugees presented a brief to the UN arguing that Canada’s patchwork eligibility for health care coverage, which imposes lengthy waiting periods and disqualifies applicants on the basis of their status, or the status of their parents, violates Article 12(1)(d) of the International Covenant on Economic, Social and Cultural Rights by failing to “assure to all medical service and medical attention in the event of sickness” as well as Article 2(2) – that those rights be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.³

In light of such UN provisions, and given the high cost of private insurance, the *Délai* denies recent migrants their right ►

HEALTH CARE LIMBO

to health care. The *délai* also works contrary to the government's stated ideals of integration by sending migrants the message that they are "second-class citizens", a sense already documented to be widely present among women under sponsorship as wives or mothers.² And although they are technically legal, such *délais* also go against the spirit of universality and accessibility enshrined in the Canada Health Act.

On a technocratic level, community groups have also pointed out the irrationality of the policy. The government says the *Délai* "saves" \$2 million, a mere 0.01% of the provinces \$2 billion healthcare budget. Considering that 40,000 immigrants are affected by this rule per year, they represent only 6/10 of one percent of the population! So, even if they made an 'average' use of the healthcare system (which they don't, given the previously mentioned "healthy immigrant effect"), covering new immigrants under the public health insurance would only cost \$1 million – at most. Even more importantly, we have to remember that immigrants are not visitors here. They are integrating into Quebec and Canadian society and contribute through their labour and taxes from the moment of their landing and are therefore entitled to the same coverage as anyone else.

On a human level, community groups have seen many cases of families avoiding seeking health services because of prohibitive costs and being thrown into crisis when saddled with massive healthcare debt. We, at Project Genesis, have come across many cases where problems arose for hospitals and patients in terms of debt and debt col-

lection, and consequent harassment, especially in a context where hospitals have been chronically under-funded.

It is important to note that, for recent immigrants, massive debt has more serious repercussions than the usual fear of having your assets seized. For many newcomers to Quebec, sending remittances to their families was a major motivation

Immigrants are not visitors here. They are integrating into Quebec and Canadian society and contribute through their labour and taxes from the moment of their landing and are therefore entitled to the same coverage as anyone else.

for leaving their homes; losing the possibility of doing this is disastrous for them. Having to pay off healthcare debt can also delay the possibility of sponsoring other family members, thereby prolonging the heartbreaking family separation faced by so many migrants. For the more than 3,000 Live-In Caregivers arriving each year, such as Marielle, these considerations shape their decisions about accessing health care.

Research has shown that increased complexity in qualifications for public

health insurance coverage increases bureaucratic confusion in health care establishments, brings intolerance toward those not holding medicare cards, and increases cases of refusal to treat. And, although community groups have convinced the government to allow certain exceptions to the *Délai* (notably in women's prenatal care, infectious diseases and children's vaccination), health care practitioners and health insurance bureaucrats are not always adequately informed of exceptions and of the details of the law, causing even more difficult situations for all those involved.

The *Délai de carence* differs from some of the other ways the government has introduced privatization into health care. This is the first time, for example, that an entire category of people – newly arrived immigrants and workers – have been excluded from public insurance.

In fact, the *Délai* is part of a larger trend toward the privatization of Quebec and Canada's health care systems. The costs of this policy are being borne by new immigrants, to the profit of private insurance companies. And the costs to Canadian society of having a whole category of people who may not access healthcare when they need it have yet to be fully understood or calculated. ❧

Jill Hanley, PhD, is Assistant Professor at the McGill School of Social Work and has been an active member of Project Genesis for more than 10 years.

If you would like to get involved or want more information, please contact Rachel at the Health Action Committee of Project Genesis: (514) 738-2036 or rachel@genese.qc.ca

¹ Not her real name.

² Côté A, Kérisit M, Côté M: Sponsorship... for Better or Worse: The Impact of Sponsorship on the Equality Rights of Immigrant Women. Ottawa: Status of Women Canada; 2001

³ The full brief, "A Draft Statement to the UN Committee on Economic, Social and Cultural Rights," can be viewed at www.equalityrights.org/ngoun98/interchurch.htm.



THINKING ABOUT GENDER AND WAIT TIMES

BETH JACKSON, ANN PEDERSON AND MADELINE BOSCOE

Women and Health Care Reform

THIS SUMMER SAW THE RELEASE OF THE *Final Report of the Federal Advisor on Wait Times*, THE FIRST MAJOR DOCUMENT INVESTIGATING AN ISSUE THAT HAS GENERATED INCREASING ANXIETY IN CANADA OVER RECENT YEARS. ALTHOUGH GENDER-BASED ANALYSIS (GBA) DID NOT FALL WITHIN FEDERAL ADVISOR DR. BRIAN POSTL'S MANDATE, THE REPORT ACKNOWLEDGES THE PRESSING NEED TO APPLY GBA IN HEALTH CARE REFORM RESEARCH TO ENSURE THAT APPROPRIATE HIGH QUALITY CARE IS AVAILABLE TO ALL MEN AND WOMEN, BOYS AND GIRLS. THE REPORT SUPPORTS THIS CALL WITH A RECOMMENDATION THAT ONGOING WAIT TIMES RESEARCH ADOPT A BROAD APPROACH TO GBA.

By way of beginning this process, a partnership was struck between Women and Health Care Reform (WHCR) and Dr. Postl, as a result of which WHCR authored a paper exploring how gender analysis can contribute to the discussion of wait time management. This paper is included in the appendix of the Final Report.

In *Gender-based Analysis and Wait Times: New Questions, New Knowledge*, WHCR authors Jackson et al point out that women and men have different experiences of health, illness

and treatment, have different health care needs, access health care differently and may experience different outcomes from programs and services. An examination of the available literature on wait times for hip and knee replacements (total joint arthroplasty or TJA), for example, suggests that there are gender differences in the need for this surgery as well as in who is more likely to be on the waiting lists for it. More specifically, available evidence indicates that women have twice the rate of osteoarthritis as men, fewer resources to deal with the impact ►

GENDER AND WAIT TIMES

of the disease than women living with other chronic conditions, and more arthritis pain than men. Women are also more likely than men to be disabled as a result of arthritis, and are more likely than men to require personal assistance with daily activities—but less likely to report unpaid help (in part because elderly women are more likely to live alone). Present definitions of wait times and the constitution of wait lists for TJA obscure these and other differences in men's and women's 'patient journeys'

through the health care system.

The case study of hip and knee replacements demonstrates that GBA is better science—it produces more valid and reliable evidence about wait times—and the evidence produced by GBA can lead to better recommendations, better strategic interventions, and better outcomes for individuals, households, communities and economies.

WHCR continues to apply GBA to the issue of wait times and timely access to health care. In January 2007 WHCR

will present the findings and recommendations from *New Questions, New Knowledge* at a Health Canada policy forum in Ottawa, to demonstrate for policy makers the application of GBA to wait times. Early in 2007 WHCR will release *Women and Wait Times*, a plain language guide that explains how wait times are a women's issue, and what the issues are for women. [↗](#)

Women and Health Care Reform [formerly known as the National Coordinating Group on Health Care Reform and Women] is a collaborative group made up of the Centres of Excellence for Women's Health (CEWH) and the Canadian Women's Health Network. Our mandate is to coordinate research on health care reform and to translate this research into policies and practices. Women and Health Care Reform receives support from the Women's Health Contribution Program, Health Canada. The views herein do not necessarily represent the views of Health Canada.

Gender-based Analysis and Wait Times: New Questions, New Knowledge (2006) by Beth Jackson, Ann Pederson and Madeline Boscoe can be found online at the WHCR website: www.cewh-cesf.ca/PDF/health_reform/genderWaitTimes.pdf. and at www.cewh-cesf.ca/healthreform/publications/summary/gbaWaitTimes.html, where other examples of the work of the group can be found.

The full *Final Report of the Federal Advisor on Wait Times* can be found on the Health Canada website, at: http://hc-sc.gc.ca/hcs-sss/pubs/care-soins/2006-wait-attente/index_e.html

WHCR Recommendations on equitable wait times research and policy

- Gender and diversity analysis should guide wait time management strategies and associated research, policies, programs and services.
- The definition of 'wait time' should be sensitive to women's and men's different 'patient journeys' through the health care system—specifically, the definition should be sensitive to the mechanisms that create delay at every point in the journey, including gender disparities in referral patterns for procedures.
- Data in wait time reports should be sex disaggregated, as well as disaggregated by other important markers of social location (e.g. race/ethnicity, age, socioeconomic status or income, disability, geographic location).
- "Historical utilization patterns" should NOT be used to estimate current need for TJA, as they underestimate women's need for the surgery. Historical utilization patterns should be used with caution to estimate need in other clinical areas.
- Clinicians and wait list coordinators should receive training in gender analysis. Gender-sensitive diagnostic and referral tools should be developed and implemented to more equitably assess men's and women's symptoms and needs (both pre- and post-intervention).
- Equitable construction and management of wait lists must take into account the supports that men and women require post-intervention, as a lack of support may affect both patients' and clinicians' willingness to consider treatment.



LOW INCOME WOMEN SPEAK OUT THROUGH "PHOTOVOICE" PROJECTS IN WINNIPEG AND SASKATOON

By Nadia, a Saskatoon Photovoice participant

From the Prairie Women's Health Centre of Excellence

PUBLIC POLICIES HAVE A SIGNIFICANT EFFECT ON THE LIVES AND HEALTH OF WOMEN LIVING IN POVERTY. LOW-INCOME WOMEN ARE OFTEN SUBJECT TO CAREFUL SCRUTINY AND SURVEILLANCE BY OTHERS. YET THEY ARE RARELY GIVEN A VOICE IN SHAPING THESE POLICIES. IN THE FALL OF 2005, PRAIRIE WOMEN'S HEALTH CENTRE OF EXCELLENCE (PWHCE) BEGAN WORKING ON TWO PROJECTS TO ADDRESS THIS SITUATION IN PARTNERSHIP WITH TWO COMMUNITY-BASED ORGANIZATIONS, THE WINNIPEG NORTH END WOMEN'S CENTRE AND THE SASKATOON ANTI-POVERTY COALITION. TOGETHER WE INITIATED PHOTOVOICE PROJECTS WITH SMALL GROUPS OF LOW-INCOME WOMEN IN WINNIPEG AND SASKATOON. ►

LOW INCOME WOMEN SPEAK OUT

Rather than putting them *under* the lens, the photovoice projects put women *behind* the lens, allowing others to see the world through their eyes. In each project, women received training from a professional photographer and discussed the ethics of taking pictures of other people. Then each woman was given a disposable camera and encouraged to take photographs that would represent her experiences of living in poverty, the barriers and the supports found in her community, and the policies and programs she would like to change or keep.

After taking their photographs, the women met several times to share their pictures with each other and to talk about what the photos meant to them.

“How much does it cost as a society to deal with crime, illness on the end of people not having enough money?” asked one participant from Winnipeg’s North End. “Why can’t we make some proactive decisions, and start putting it into preventative health care, preventative crime prevention? As opposed to waiting until we are sick, and scared and alone.”

With their permission, we tape recorded these discussions, and used them as the basis for creating captions for each photograph. Each woman selected which of her photographs and words she wanted to include in a public display. The photographs were then enlarged and mounted on plaques.

Private showings were held in each city for the photographers, their fami-



“You cannot understand how I feel by studying books, by taking courses. You can only understand how I feel by crawling into my skin and living my life.”

lies and close friends. These events were followed by public showings of the women’s work. In Winnipeg, the photovoice exhibit, entitled *Poverty: Our Voices, Our Views*, was on display at the University of Winnipeg during the MayWorks events on May 1, 2006. Since then the Winnipeg project has been shown at Warehouse Artworks in October 2006 and the Label Gallery in December 2006. In Saskatoon, the photovoice exhibit, entitled *Looking Out/Looking In: Women, Poverty and Public Policy*, was launched at the SCYAP Gallery on May 9, 2006 and remained on display until May 31.

“The reality is—I am disabled,” wrote Nadia, another participant, under her photograph of a wheelchair in a kitchen. “I am a woman. I live in poverty, my voice is not heard. The truth is—my spirit

has risen above this. There are times, though, when people or situations come along to remind me of what I am and try to put me back in my place. You cannot understand how I feel by studying books, by taking courses. You can only understand how I feel by crawling into my skin and living my life.”

The photovoice exhibits are available for display to raise public awareness of the realities of living in poverty and to stimulate action for just social and economic policies to improve the conditions of women’s lives. They can be viewed online at: www.pwhce.ca/program_poverty_photovoice.htm

ABORIGINAL WOMEN RESPOND TO MOUNTING AIDS CRISIS

*Winnipeg
organization
launches project
in response to
growing threat
of HIV infection*



THE RAPIDLY RISING RATE OF NEW HIV INFECTIONS AMONG ABORIGINAL WOMEN IN CANADA HAS GENERATED INCREASING ALARM OVER THE PAST TWO DECADES. ACCORDING TO THE CANADIAN ABORIGINAL AIDS NETWORK (CAAN), ABORIGINAL WOMEN ACCOUNTED FOR APPROXIMATELY 50% OF ALL HIV-POSITIVE TEST REPORTS AMONG ABORIGINAL PEOPLE IN 2003, COMPARED WITH ONLY 16% OF THEIR NON-ABORIGINAL COUNTERPARTS. ABORIGINAL COMMUNITY MEMBERS HAVE LONG LAMENTED THE ABSENCE OF RESOURCES FOR ABORIGINAL, WOMEN-SPECIFIC RESEARCH, PROGRAMS, SERVICES AND SUPPORTS TO ADDRESS THE GROWING CRISIS. NOW, ONE COMMUNITY ORGANIZATION HAS STEPPED IN TO HELP FILL THE GAP IN MANITOBA. ►

ABORIGINAL WOMEN RESPOND TO AIDS CRISIS

Aboriginal Women Responding to the AIDS Crisis (AWRAC) is an 18 month project aimed at empowering women to take the lead in determining the growing impact of HIV/AIDS, Hepatitis C and Sexually Transmitted Infections (STIs) on the Aboriginal community and respond to it swiftly. Spearheaded by *Ka Ni Kanichihk* Inc, a Manitoba-based community organization, the project will educate Aboriginal women about HIV/AIDS, HCV and STIs, function as a link between AIDS service organizations and Aboriginal programs, and increase capacity to provide sexual health and injection drug use harm reduction initiatives amongst Aboriginal service providers.

Since its inception in August 2006, AWRAC has established an Advisory Council and held a press conference to launch the project. It is currently in the process of conducting focus groups with project partners on the development of a capacity building training model. The training concept and framework will then be presented and reviewed with stakeholders at a one-day forum and field tested in early 2007 with organizations that provide services to Aboriginal women. Once revised and finalized, the training program tools and resources will be shared with other community groups in Manitoba and across Canada.

In a 2004 national survey conducted among Canadian Aboriginal persons living with HIV/AIDS by CAAN, women participants requested services aimed specifically at women living with HIV/AIDS, and emphasized the need for services that provide trustworthy, private and/or anonymous counseling. Women also

reported more problems than men with travel and transportation, either to visit distant home communities or to get to medical appointments and treatment or support services in their local area.

Ka Ni Kanichihk—“those who lead” in the Ininew (Cree) language—provides a range of culturally based Aboriginal led programs and services that are rooted in the restoration and reclamation of cultures.

“The very real threat of HIV and AIDS to our communities commands our full and immediate attention,” says Astrid MacNeill, Coordinator for the White Wolf Speaking Program of the Sexuality Education Resource Centre (SERC) and a member of the project’s advisory council.

“We are asking the Aboriginal community to look at this crisis and the sacred responsibility given to us within the natural law of our ancestors. This great law holds us accountable to ensure survival for succeeding generations so that they may have *“wholeness of life”*. We invite the community to work together to prevent the further spread of the virus, in ways that are congruent with the world views of Aboriginal people. We ask you to consider our kinship with those already living with AIDS, and the care and support they and their families require. The leadership for addressing the HIV/AIDS crisis must come from our communities, with the full support of the federal, provincial and territorial governments.” ❧

For more information on AWRAC, contact:

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In a 2004 national survey conducted among Canadian Aboriginal persons living with HIV/AIDS by CAAN, women participants requested services aimed specifically at women living with HIV/AIDS, and emphasized the need for services that provide trustworthy, private and/or anonymous counseling.

MOVING WOMEN'S HEALTH KNOWLEDGE FORWARD:

CIHR Introduces New Policy on Gender and Sex-Based Analysis

THE CANADIAN INSTITUTES OF HEALTH RESEARCH (CIHR) HAS MADE AN IMPORTANT NEW ADDITION TO ITS GENERAL GRANTS AND CONTRIBUTIONS POLICY. AS OF JUNE 2006, CIHR FUNDING APPLICANTS HAVE BEEN ASKED TO DEMONSTRATE THE USE OF GENDER AND SEX-BASED ANALYSIS (GSBA) IN THEIR RESEARCH PROPOSALS. THIS IS GOOD NEWS FOR WOMEN AS IT INCREASES THE LIKELIHOOD THAT NEW RESEARCH WILL FACTOR IN WOMEN'S AND MEN'S BIOLOGICAL AND SOCIAL DIFFERENCES OR SIMILARITIES.

To facilitate this process, the CIHR has also released a *Guide to Gender and Sex-Based Analysis in Health Research*. It provides a clear explanation of GSBA and includes a general checklist of guiding questions for research applicants as well as a range of instructive examples. The Guide is designed to help both CIHR peer reviewers and applicants consider when and how sex and gender are implicated in proposed research projects, and is part of a larger initiative to advance GSBA throughout the CIHR, thereby embedding it in the culture of health research in Canada. Other goals of this initiative

include the incorporation of a reference to GSBA in the *CIHR Peer Review Process – Policies and Responsibilities of Grants Committee Members*, and the inclusion of criteria for GSBA in the program description for clinical trials peer reviews.

Gender and sex-based analysis takes genetic, physiological, social and cultural diversity into account in the production of new knowledge across the gamut of health research. It ensures a more relevant and accurate evidence base on which to develop practice, programs, policies and further research. This new knowledge produces more gender-sensitive ►

GENDER AND SEX-BASED ANALYSIS

information that can enhance the health of all. By encouraging the use of this analytical framework, the CIHR can contribute to knowledge about the ways in which sex and gender—and the interactions between them—influence the health of men and women.

These initiatives are intended to initiate a conversation between CIHR, peer reviewers, and health researchers on the development of guidelines for the application of GSBA in health research. CIHR welcomes feedback to ensure that the resource guide evolves in ways that

will meet the needs of as wide an audience as possible. [↗](#)

To access the *Guide to Gender and Sex-Based Analysis in Health Research* and provide feedback, visit: www.cihr-irsc.gc.ca/e/32019.html#toc5

GUIDING QUESTIONS

The following questions are provided as a general checklist for CIHR applicants and reviewers. Applicants are asked to give careful consideration as to how their research addresses these queries and should, where applicable, provide detailed response to these questions in their proposals.

APPLYING GENDER- AND SEX-BASED ANALYSIS

Research Question

- Are sex and/or gender identified and defined? Are the definitions supported by recent academic literature?
- Does the proposal demonstrate awareness of what is known about sex, gender and diversity (ethnicity, socioeconomic status, sexual orientation, migration status, etc.) in this area of research?
- Are the concepts of sex, gender and diversity taken into account in the development of the research question(s)?
- Are the concepts of sex, gender and diversity applied clearly and appropriately?
- If used in the study, does the researcher identify and justify the choice of the sex of cells, cell lines, and/or animals?
- If the applicant asserts that sex and/or gender and diversity are not relevant to the proposed research, what evidence is presented?
- Does the research question reflect the diversity in and among females and males?

Data Collection

- Does the sex/gender/diversity composition of the sample reflect the research question?
- Does the sample match the researchers' plans for generalizing from the data?

- Have research instruments (i.e., surveys, measurements) been validated to reflect gender/sex and diversity?
- If sex is used as a proxy for weight, height and body fat/ muscle ratios, is there an explicit explanation and analytical strategy provided for employing this approach?
- In the case of clinical trials: Does the sample reflect the distribution of the condition in the general population? For proposed clinical trials, are sufficient numbers of women and men included in the sample to enable safety as well as efficacy analysis? Where appropriate, how will the clinical trial track and account for female menstrual cycles? Does the applicant plan to analyze results in the context of known sex-specific adverse effects, height-weight-sex relationships, and interactions with commonly used drugs?

Data Analysis and Interpretation

- Will the researchers disaggregate and analyze data by sex/gender?
- Does the use of gender as a variable mask or intersect with other potential explanatory factors such as socioeconomic status, physical attributes and/or ethnicity?
- What assumptions are being made about gender and/or sex—especially as they intersect with other diversity indicators such as ethnicity, sexual orientation, socioeconomic class, etc.—while formulating the research problem, sampling, data collection, analysis and interpretation?

STATUS OF WOMEN CANADA CUTS A LOSS FOR HEALTHY DEMOCRACY

Grassroots organizations play an instrumental role in government accountability and contribute to healthy public policies

BY KATHLEEN O'GRADY

dECEMBER 2006 WAS WITNESS TO TWO IMPORTANT MOMENTS IN THE HISTORY OF WOMEN'S RIGHTS IN CANADA THAT ARE CLEARLY AT ODDS.

December 10 was the 25th anniversary of Canada's ratification of the UN Convention on the Elimination of all Forms of Discrimination against Women—something to celebrate. But the same week also marked a series of hearings on the Hill conducted by the House of Commons Standing Committee on the Status of Women tasked with assessing the response to recent budget cuts and reforms by the ruling Conservative government to Status of Women Canada (SWC). And what was the response? Well, let's just say that women's groups across the country are not

ready to make nice.

In November 2006, Status of Women Minister Bev Oda announced sweeping reforms to SWC in the name of 'streamlining' and 'efficiency.' The changes include substantial cuts to the SWC operating budget (a loss of 40%) and the subsequent closure of regional SWC offices (from 16 down to 4).

These significant economic reductions to an already miniscule SWC budget, during a booming time in the Canadian economy, and while the government is reporting ►

GRASSROOTS

a (continued) budget surplus, have summoned up appropriate boos and cries of shame by opposition parties hurled at the ruling Conservative party. Media pundits also rightly question why the Conservative government would seek shallow savings from organizations—grassroots women’s groups across the country—that can afford it the least, literally ripping the shirts off their backs.

But what was often hidden in the general outcry and coverage of the SWC cuts was a fundamental change to the SWC mandate that was about a lot more than just money, and which should make all those interested in a healthy democracy sit up and take notice.

While most coverage and concern was focused on the SWC regional office closures, the words “equality,” “advocacy,” and “action” were quietly removed

If Shell or Microsoft or Bell want to start a trainee program for women, they may get taxpayer money to do so, but your regional, provincial/territorial or national women’s organization that deals daily with Canadian women and families on issues of violence or health or poverty can no longer get government funding from SWC.

from the Terms and Conditions of the SWC mandate, and from various SWC documents, such as their website (a chilling process of erasure that attempts to change history—borrowed directly from the Bush administration’s ‘handling’ of women’s organizations in the US).

Oda also eliminated virtually all funding for research on women and women’s issues and made it impossible for women’s organizations involved in advocating or lobbying governments to be eligible for SWC money. At the same time, Oda made for-profit organizations eligible for SWC funding.

What does this mean? It means that if Shell or Microsoft or Bell want to start a trainee program for women, they may get taxpayer money to do so, but your regional, provincial/territorial or national women’s organization that deals daily with Canadian women and families on issues of violence or health or poverty can no longer get government funding from SWC to undertake research, nor can they educate government officials or government policy makers on their knowledge and experience.

Some critics have declared the SWC cuts ideological and, thus, from a right-wing government, not too surprising. With these new strictures for SWC firmly in place, the Conservative government has clearly attempted to muzzle women’s voices across the country.

But this is ironic, and contradictory, given that this government was voted in on—and continues to preach—a platform of accountability, democracy and evidence-based policy making. Grassroots women’s organizations across the country, many of which received their funding from SWC, fulfill an essential democratic process and function as an accountability mechanism to government, to make sure that policy is based first in evidence (research) and experience (on the front lines), and on the actual needs of Canadian women and their families.

Important advocacy work undertaken by women’s organizations, far from partisan, is an instrumental means to continue to educate and engage our elected officials on what is going on regionally in this vast country. It is a critical avenue of public discourse that only makes government policies stronger, more informed, and more complete.

Disagreement and debate from women's organizations with government officials or departments is not something that should be feared and quashed by the Conservative government, or by any government, but the sign of a healthy and vigorous democracy.

A government that can listen to the voices of those who work on the front lines and make a difference is an accountable government. A government that engages with the organizations that meet the direct needs of individual Canadians is one that is flexible and resilient enough to govern for all Canadians.

The Harper government has made a serious miscalculation if it believes that Canadians consider equality—women's or anyone's—and advocating for equality issues, a partisan or an ideological issue. Grassroots women's organizations in our country employ a host of women and men with various political leanings, and work on behalf of communities that vote for all political parties.

Equality is a Canadian value, not an ideological option. Advocating for equality in order to improve public programs and policy is also not partisan, but simply good public policy. And funding organizations (a pittance) to educate our elected officials on what they know—through both research and experience—can only benefit all Canadians, and ensure the most efficient delivery of services to all pockets of our regions.

The Harper government has also seriously miscalculated if it believes that women's equality has been fully achieved or has somehow been (effortlessly) won and is now over. Sadly, this is not the case. One in nine Canadian women live in poverty, according to Statistic Canada (2006); women still earn only 70.5% of what men earn for full-time work (Statistics Canada, 2006); and the bulk of unpaid caregiving—for children, seniors and the disabled—continues to be done by women. Too many women also continue to be on the receiving end of violence in the home. The list could go on; there is clearly much work that needs to be done.

Of course there are many different ways to tackle the problems of inequity in our country—and the means and methods can become a partisan or ideological discussion. But to silence the voices of those who work directly with the communities that most need our attention is helpful to no one. And it certainly does not make the needs of these communities go away.

The Harper government has seriously miscalculated if it believes that women's equality has been fully achieved or has somehow been (effortlessly) won and is now over. One in nine Canadian women live in poverty; women still earn only 70.5% of what men earn for full-time work; and the bulk of unpaid caregiving continues to be done by women.

Grassroots organizations have valuable knowledge and experience that should be an essential part of the discourse that informs decision-making. Sustaining organizations that carry out the equality-seeking work embedded in our Charter, and which work toward the equality values that all Canadians can be proud of, can only make Canada a better place. ❧

Kathleen O'Grady is a Research Associate at the Simone de Beauvoir Institute, Concordia University and the Director of Communications for the Canadian Women's Health Network.

A version of this article first appeared in the Montreal Gazette, December 20, 2006.

THE CUTEST BABIES MONEY CAN BUY

BY ABBY LIPPMAN

TITLE: *The Baby Business: How money, science, and politics drive the commerce of conception*

AUTHOR: Debora L. Spar

PUBLISHER: Harvard Business School Press, 2006

299 pages (including endnotes, acknowledgments and index)

US \$26.95

IT'S PROBABLY A TOSS UP WHETHER MORE MONEY IS SPENT in the USA on preventing pregnancy or on creating children. Exactly how and where this \$3 billion (US) changes hands annually in the production of what Deborah Spar calls "a good that is inherently good...children for people who want them" is detailed in her book, "The Baby Business."

Unlike others who have examined reproductive technologies (e.g., donor insemination, in vitro fertilization [IVF], surrogacy, egg "donation,") on ethical, social, or health grounds, Spar uses a different lens. Claiming to set aside the intractable moral issues inherent in all these practices, as well as in adoption, Spar explores their use and marketing as evidence of why the US government needs to play a "more active role in regulating the baby business."

As might be expected from a professor of business administration at Harvard, Spar's "The Baby Business" is primarily a small-l liberal call for some order in this market where babies, and the cells from which they arise, are increasingly commodified and commercialized. Spar builds a case for some regulation not so much to protect directly the health and well-being of the women and children who are the stock-in-trade for this market, but to ensure it functions most efficiently to "manufacture embryos that turn into babies" accessible to all who want them.

Spar documents in detail the current commercial, market-driven, unregulated baby business as it exists in the USA and the ripples it creates elsewhere. She underlines how the option(s) chosen for its regulation will vary according to whether it is pregnancies, children, or something else that is to be distributed fairly through this marketplace. And she lays out different ways of viewing this business, grounding these approaches in her claim that this commerce, whose end product is "a child to raise," is unlike all others.

One major difference is the potentially endless demand (for eggs, embryos and "surrogate" mothers, etc.), a demand constrained primarily in the US by prices that limit availability to this "material" to only to the wealthiest who alone can pay out-of-pocket for these "luxury" purchases not covered by insurers, public or private. Noting that science puts some limits on the "supply side," Spar reminds us that these are nevertheless quite elastic: each approach to meeting some specific demand in turn creates yet another new market.

For example, an experimental procedure, egg-freezing, first offered prior to cancer chemotherapy for selected women who might want to bear children later in their lives, almost overnight became an entrepreneurial opportunity. Egg banks now post internet ads promoting their storage facilities to young women who don't want to interrupt their careers for childbearing until their 40s or 50s.

Besides its unusual supply/demand relationships, other special features of the baby business also lead Spar to argue for government intervention. "Normal" market mechanisms don't apply when, in selling their assisted reproductive services, failure is, paradoxically, more lucrative than "success": repeated attempts at IVF when no baby is born are more profitable for clinicians than is creating a pregnancy on the first go. Relevant, too, is the global nature of the commerce: those who can't get women's eggs where they live can locate a "donor" on the internet. If surrogacy is against the law in one country, it can be arranged "offshore"—with the contracting couple coming home from a holiday holding a newly born infant in their arms.

But, rather than propose any one (or more) policy/regulatory model specifically to address all this, Spar calls for "an intense political debate" from which she envisions consensus

regulations emerging—and offers some principles with which to guide this debate.

It's hard to carp at Spar's quite Canadian ("let's have a public discussion") solution to these vexed problems. After all, from 1989-1993, Canadians went through a multi-million dollar Royal Commission on new reproductive technologies, with this followed by several long difficult years of talk and consultation as Parliament debated multiple draft bills until finally passing, in March 2004, the Assisted Human Reproduction Act. Politicians and citizens here mostly accepted several of Spar's guiding principles for regulation (i.e., assured access to information about the risks, benefits, and costs of the various interventions; some enforceable set of laws; possible limits on individual choice), but two years later, we have yet to see regulations or the Agency to refine and enforce them in action. Given the advanced state of the baby business in the US, to say nothing of irreconcilable differences about the "status of the embryo" or of the absence of publicly-funded health insurance, it's not easy to see any public discussion there arriving at consensus on policy proposals, their urgency notwithstanding.

Thus, while "The Baby Business" is an eye-opener about the nasty undersides of the "commerce of conception," Spar doesn't get down to details about what to do. Further, by not assessing the pros and cons of what other countries (Canada, the UK, even China) have done to impose some control on the (in) fertility industry, she offers no insights into what the US could do differently (better?) in face of a continually growing, cross-border trade. And even if she had, the question remains: will it really matter? Without considering how to manage the "reproductive tourism" developing as differences in regulatory regimes between countries lead individuals to go elsewhere to purchase what is forbidden or unavailable at home, it is hard to estimate the impact of national legislation in any one jurisdiction. To avoid the worst hazards accruing to the most vulnerable and the most marginalized women, those who will provide, or help produce, the "raw materials" of the "goods" sought—happy, healthy children" for others—some international, or at least supranational, control is essential.

Spar gives readers a more realistic picture of assisted reproduction than is provided by newspaper photos of some very

pregnant 63 year old woman or of rosy-cheeked infant triplets. And learning the details of how postmenopausal pregnancies and multiple births are made—and bought—should begin to rally support for getting this industry under some control. But for control to be truly respectful of women, and women's lives, we need also to understand the causes of infertility (why is there such an increasing demand for outside assistance in making babies in the first place?) and not only the profits made by circumventing it. Good policy development must also deal with the current disjunction between the excessive societal attention to and investment in reproductive technologies and the meager and decreasing efforts to improve the social and economic conditions that will let women have—or keep—the children they want when they want them.

As a society, we tend to become galvanized when the "fix" is technological, yet too willingly turn away, and cut services, when the intervention addresses root causes. Moreover, we seem to care very much about how children are created, but much less so about creating the conditions to allow children to thrive. Spar seems to consider these "moral," not "business" matters, and omits them from her analysis. We don't have this luxury. Fashioning regulatory policies that will control the market without controlling or coercing women,

requires expanding Spar's vivid picture of a (sometimes quite ugly) profit-driven world of sellers, buyers, and brokers of eggs, sperm, embryos, bodies, and babies. It means acknowledging the inherent social, ethical, political, and cultural issues that make this boundary field between medicine and industry so troubling to everyone. Most importantly, it means we must start investing in the well-being of women and children, not their acquisition. ❧

Abby Lippman has been observing—and criticizing—developments in reprobogenetics for over 25 years as an academic (McGill University) and women's health activist (currently chair of the Canadian Women's Health Network). She was a member of the federal Advisory Committee on New Reproductive Technologies.

A version of this article first appeared in the Globe and Mail, May 27, 2006.

As a society, we tend to become galvanized when the "fix" is technological, yet too willingly turn away, and cut services, when the intervention addresses root causes.

By Barbara Bourrier-LaCroix, Information Centre Coordinator, with Kim Parry, Mona Dupré-Ollinik

Making Lesbians Visible in the Substance Use Field

**Edited by Elizabeth Ettorre
(Harrington Park Press, 2005)**

Lesbians and bisexual women are more likely than heterosexual women to report alcohol and substance abuse, yet existing alcohol and drug services are inadequate to meet the needs of this community. Substance use for these women is often enmeshed in issues relating to sexual orientation, gender identity, and/or making connections with queer people and communities. Lesbian substance users aren't able to bring forward the whole of their experiences when they are in environments that are non-supportive and where they experience homophobia. They become invisible. This book is a step in helping to create environments in which the hurt of invisibility can begin to be healed. The various papers captured here

Criminalizing Women: Gender and (In)Justice in Neo-Liberal Times **Edited by Gillian Balfour and Elizabeth Comack (Fernwood Publishing, 2006)**

This recently released edited collection is an exploration of the issues feminist thought brings to the field of criminology. Women and women's relationships to the criminal justice system are often overlooked within the context of the criminology canon. This book demonstrates the broad range of work in this area being done by feminists that considers the conditions of women's lives and analysis of systemic oppression. *Criminalizing Women* is a book that both provides space for criminalized women's narratives and, with a section on making change, it looks to the future with a toolbox full of feminist strategies to be used to address the issues revealed by these narratives.

highlight how a lesbian sensitive perspective on lesbian health and substance use can shed new light on this neglected research area, as well as illuminate important areas of concern for treaters and researchers alike.

Relative Stranger: A Life After Death

**By Mary Loudon
(Doubleday Canada, 2006)**

Mary Loudon's book is a remembrance of her sister Catherine's life. It is also the documenting of the author's journey to uncover and tell that story. Catherine lived with schizophrenia; an illness that had profound effects on the way she lived her life and on her family. Loudon's memories of growing up with her sister and of trying to maintain a relationship (mostly in vain) are explored after Catherine's death from cancer. She effectively weaves in stories and memories with useful information about what it means to live with schizophrenia. I found this book worked to undo some of the rigid definitions of mental illness and normality and created a story that we could all learn from.

"Our lives are predicated upon basic cultural certainties. Among

The Birth House

**Ami McKay
(Knopf Canada, 2006)**

And now for something completely different... our first fiction review!

Set in Scots Bay, Nova Scotia, *The Birth House* tells the story of a midwife, Dora Rare around the First World War. However, change is in the air as a doctor sets up his practice in the area. He promises painless childbirth by using the newest technologies and scientific knowledge. The conflict between traditional knowledge of the midwife and the new and modern medical knowledge weaves it way throughout the whole story.

This is a celebration of women's ways of knowing and an examination of the role that midwives played in communities at that time. Through Dora, McKay tells us not only the extraordinary life of one woman; she also captures a moment of our social history. Reminding us that the personal is definitely political.

the most critical of these certainties is that life should be lived within particular parameters and that human beings possess, if you like, a default setting of normality from which any significant deviation may be regarded as a cause for concern or worse. That our ideas of normal behaviour are so firmly established allows many people genuinely to wonder what a life is for if it is lived on the border of sanity. It allows them to uphold the belief that life is only worth living or, more serious still, that you are only worth your life as long as you are reasonably happy, well and rational" (Loudon, 2006, p. 334).

Gestational Diabetes: What to Expect: Your Guide to a Healthy Pregnancy and a Happy, Healthy Baby (Fifth Edition)

(American Diabetes Association, 2005)

Gestational diabetes is not something you want to hear about when you're pregnant. It can leave you feeling quite anxious and overwhelmed. You have plans for your pregnancy and your new baby, and

Family and Friends' Guide to Domestic Violence: How to Listen, Talk and Take Action When Someone You Care About is Being Abused

Elaine Weiss
(Volcano Press, 2003)

It's hard to know what to do when a friend or family member is in an abusive relationship—sometimes we feel angry, and oftentimes, we feel pretty powerless to help. But family and friends can make an enormous difference to someone who is trapped in the web of violence. Our involvement may be as simple as a well-thought-out sentence spoken at just the right time, or it may be a longer-term commitment. This book explains the many ways you can help someone you care about, by first teaching about intimate partner violence, so that we can truly understand the complexities of the victim's life. It then takes time to teach us words and actions that can make a difference as she works to break free. Finally, the author shows us how we can remain involved by providing ongoing support to someone who has escaped from an abuser, either recently or long ago.

learning you have diabetes may cause you to worry about your baby's health. Luckily, this book, written in clear, plain language, offers all the information you need to help you understand what you need to do to stay healthy and have

a healthy baby. The book covers many topics, including: learning about what you need to do to stay well, information on insulin therapy, exercise and pregnancy, nutrition, how to monitor gestational diabetes, and sample meal plans.

Staying Alive: Critical Perspectives on Health, Illness, and Health Care

Edited by Dennis Raphael, Toba Bryan and Marcia Rioux

(Canadian Scholars' Press Inc., 2006)

The meaning of health can no longer be defined as simply "the absence of disease," given what we know about the complexity of social relations and the human being. Health studies must now look at the experience and understanding of illness and disability; differential access to both health and health care; the political, economic, and social forces that shape health and health care; and the intersection of social class, gender, and race with all of these issues. Despite these issues, most of the research and professional health care preoccupations remain narrow, focused on the biology of disease, individual risk factors, and identifying and evaluating the efficacy of medical interventions. The contributors of this book address these narrow preoccupations by providing articles that look at the latest conceptual developments and empirical findings concerning the status of health, illness, and health care in Canada.

The Adventures of Carrie Giver: The Cost of Caring

(TR Rose Associates Inc., 2006)

Theresa Funicello, Diane Pagen, Eduardo Savid, Winona Nelson, Rob Hawkins

Just for the record, I am a big comic book geek. I'll never turn down the chance to review a new comic series, particularly if it stars a super-heroine (preferably in costume). So imagine my delight when I came across this new title, which aims to highlight the costs and burdens of unpaid caregiving on women! Our super heroine, Carrie Giver, and her alter ego, Carrie Miller, battle everyday prejudices and save people from life-altering hazards of chance or circumstance (as well as the occasional boogeyman). This is a very American story, but can still be entertaining, not to mention informative, to Canadian audiences. Using comics as a way to talk about the value of caregiving, to both children and older people, is new, and hopefully, Carrie Giver's adventures will continue.

Breastfeeding and Human Lactation (Third Edition)

Jan Riordan

(Jones and Bartlett Publishers, 2004)

This revised and updated textbook, already considered one of the best reference tools for health workers on breastfeeding, brings together the latest clinical techniques and research findings that direct evidence-based clinical practice. It provides quite extensive coverage of breastfeeding basics: what to do, when to do it, and how to properly assist the lactating mother. The book looks at and addresses the many concerns new moms have during the postpartum period following her and baby's return home. Of special note, the authors also address the special needs of preterm babies and their mothers. A CD-ROM containing digital photos (depicting situations related to breastfeeding) is also included.

Turning Heads: Portraits of Grace, Inspiration, and Possibilities

Jackson Hunsicker

(Press On Regardless, 2006)

When my best friend Deanna's cancer came back, she wanted to refuse treatment. "I can't go back to being a bald freak again, Barb," was what she said to me over the phone. I understood her fears. I remembered the stares we used to get when out and about in malls and restaurants. I witnessed it again when a member of the CWHN family underwent chemotherapy. The looks of pity, or worse, fear. For Deanna, it was a constant reminder that she was sick, that her time here on earth was very limited. As the editor of this work says, "In a perfect world, we shouldn't feel ashamed of the way we look while fighting cancer; we shouldn't want to hide... How we currently perceive the disease, how we shrink away from it, requires an attitude adjustment—for the patient, for the people who love that patient, and for the rest of us." By collecting these photographs of women of all ages and walks of life who have lost their hair to cancer treatment, she's on her way to changing how we look at cancer.

The Handbook of Lesbian, Gay, Bisexual, and Transgender Public Health: A Practitioner's Guide to Service

Edited by Michael D. Shankle

(Harrington Park Press, 2005)

Lesbians, and bisexual and transgendered women often face many barriers that prevent them from gaining access to adequate healthcare services, including homophobia, heterosexism, healthcare professionals who are not trained in the healthcare needs of these populations, and dis/mis information about the health problems and concerns of these women. These barriers can result in poor health. In order to address these barriers, this publication collects various research lesbian, gay, bisexual, and transgender research findings in one volume. Readers are given access to practical theories and solutions for overcoming the problems and disparities experienced by this community.

Want to Know More About Midwives?

(Atlantic Centre of Excellence for Women's Health, 2006)

One of the priority areas of work for the Atlantic Centre of Excellence for Women's Health is focused on sexual and reproductive health, in particular on improving maternity and newborn care services for women. The ACEWH believes that an integral part of improving these services is for women to have access to publicly-funded services of midwives. To this end, they have produced this booklet for the general public that describes what a midwife is, what they do, and why midwifery is important. The booklet also look at midwives as primary health care providers, examines their scope of practice, as well as the contribution midwifery has made to primary health care renewal.

Nursing Against the Odds: How Health Care Cost Cutting, Media Stereotypes, and Medical Hubris Undermine Nurses and Patient Care
Suzanne Gordon

(Cornell University Press, 2005)

Nurses give direct, hands-on care and their primary mission is the care of the sick, aging, infirm, vulnerable, and dying patient. Having witnessed two dear friends battle different illnesses in hospital, I've observed the conditions that affect these nurses who provide (excellent) direct care. Cost-cutting measures in health care have hit nurses hard. When hospitals look at operating dollars, the large proportion devoted to nursing services always stands out. These services are often cut when nurse leaders cannot produce evidence that

Gender-based Analysis and Wait Times: New Questions, New Knowledge

Beth E. Jackson, Ann Pederson, and Madeline Boscoe
Women and Health Care Reform (WHCR) , 2006

Waiting for health care services has been and continues to be a major issue for Canadians. A gender-based analysis of wait times is important because women and men have different experiences of health, illness and treatment, have different health care needs, access health care differently and may experience different outcomes from programs and services. In this paper, the authors demonstrate a gender-based analysis of wait times with respect to hip and knee replacements and recommend that this model be applied to research and policy development in other clinical areas and to the examination of wait times in general.

Also available online at:

www.cewh-cesf.ca/PDF/health_reform/genderWaitTimesEN.pdf

defends their nursing resource needs. The author addresses this issue and studies the impact of cost cutting on the delivery of nursing care and the nurses who provide it. She digs even further into the nursing profession and looks at the relationship between nurses and doctors, and how nursing is portrayed in the media, which have significant consequences for the ability to retain and recruit nurses.

Turning a New Leaf: Women, Tobacco, and the Future

Edited by Lorraine Greaves, Natasha Jategaonkar, and Sara Sanchez
(BC Centre of Excellence for Women's Health and International Network of Women Against Tobacco, 2006)

Currently, 1.1 billion people worldwide are smokers, and this number is expected to increase to 1.6 billion by 2025. Although overall rates of smoking are declining in some coun-

tries (including Canada), they are increasing in many developing nations, particularly among women. By 2020, 20 percent of the world's women will be smokers. Given these escalating rates of cigarette smoking among women, women's susceptibility to related diseases, and the lack of knowledge about the effects of tobacco policies on girls' and women's lives, it is clear that the world is on the verge of an international epidemic of female morbidity and mortality arising from women's use of tobacco. This report provides a much-needed picture of women's tobacco use in different social contexts, identifies the health effects of tobacco, and describes women's role in tobacco production and marketing. It also provides direction on assessing and addressing the gendered issues of tobacco control in policy, programming, and research in order to reduce the devastating effects of tobacco on women.

about us:

Canadian Women's
Health Network



Le Réseau canadien pour
la santé des femmes

CANADIAN WOMEN'S HEALTH NETWORK

INFORMATION • COMMUNICATION • ACTION

The CWHN was created in 1993 as a voluntary national organization to improve the health and lives of girls and women in Canada and the world by collecting, producing, distributing and sharing knowledge, ideas, education, information, resources, strategies and inspirations.

We are a far-reaching web of researchers and activists, mothers, daughters, caregivers, and family members, people working in community clinics and on hospital floors, at the university, in provincial and federal health ministries, and in women's organizations, all dedicated to bettering women's health and equality.

We are guided by a woman-centred vision of health and wellness and believe that in order to improve the health status of women we must address social and economic conditions such as education, housing, environment and gender which all impact on health.

We recognize and respect the diverse needs and realities of women's lives, and take an active stance to prevent discrimination based on gender, race, religion, sexual orientation, age, ability, language and geographic region.

CANADIAN WOMEN'S HEALTH NETWORK PROGRAMS:

www.cwhn.ca

Our website is one of Canada's top bilingual sites for women's health information with almost one million hits per month. It is updated regularly to give you easy access to valuable information and resources on women's health, including breaking news, feature articles, an on-line database and links to other useful sites.

Publications:

Network Magazine

Our bilingual magazine is the Canadian front-runner for the latest on health issues that affect women, as well as topical debates, national and international health news and reliable resources. Available in print and electronic formats.

Brigit's Notes

Our free monthly bilingual e-mail bulletin keeps you up-to-date on hot issues related to women's health.

Women's Health Information Centre:

Our comprehensive and always-expanding bilingual collection of women's health publications and resources from across Canada and the world is catalogued on our website. This gives you—free of charge—access to some 10,000 documents, reviews, projects and organizations covering a wide range of information on women's health and women's lives. Aiding searches in the database is CWHN's unique bilingual and Canadian women's health thesaurus. A list of over 4000 key words and terms allows quick and easy access to topics related to women's health. We also answer requests to help find health infor-

mation through our national toll-free numbers (including TTY) or our website.

E-mail Discussion List:

CDN-WOMEN is a moderated discussion list that joins together and strengthens links among organizations, individuals and groups across Canada involved in women's health.

Community Outreach and Networking:

Our network is a trusted source of women's health information for individuals, organizations, the media, policy makers and key health planning groups across Canada.

We participate in regional and national conferences, consultations, events and workshops and distribute credible women's health information materials. We also help people come together for action on women's health by supporting and building networks, coalitions and joint projects.

Media Relations:

Our comprehensive bilingual communications, media and public relations program has resulted in the CWHN being an important choice for journalists seeking information on women's health issues in Canada.

THIS IS YOUR NETWORK – JOIN US!

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