

Canadian Women's  
Health Network



Le Réseau canadien pour  
la santé des femmes

# **Women's Health in Canada: Beijing and Beyond**

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with

The Canadian Women's Health Network

Revised Edition  
September 2005

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Note: This document was prepared as a Health Section for Canada's "NGO" report to the United Nations' Commission on the Status of Women's meeting in March 2005. Although 'health' was not a specific area of discussion at the meeting, a selective commentary on this area, using the *Women's Health Strategy* as an analytic lens, was timely, not only because the *Strategy* has now passed its fifth anniversary but also because health remains a priority at meetings of the Commission on the Status of Women. The document is intended for both a Canadian and international audience.

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The views expressed herein do not necessarily represent the views of Health Canada, Status of Women Canada or the Ontario Women's Health Council.

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# Women's Health in Canada: Beijing and Beyond

by

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Revised Edition, September 2005

## EXECUTIVE SUMMARY

This document was prepared as a Health Section for Canada's "NGO" report to the United Nations' Commission on the Status of Women's meeting in March 2005. It seeks to determine the progress that the Canadian government has made in advancing women's health since Canada adopted in 1995 the United Nations Platform for Action, developed in Beijing at the United Nations World Conference on Women.

Our review in this document focuses on four areas: Gender-based Analysis, Health Services, Prevention Programs, and Research and Evaluation. These reflect the key objectives of the *Women's Health Strategy*, an integrated framework for addressing major women's health issues established with the intent to address the principles of the Beijing Platform.

Even though the review deals with a select number of women's health issues, a number of conclusions can be drawn.

Almost 6 years after the *Women's Health Strategy* was introduced, some progress has been made. On balance, however, it is also clear that much more work needs to be done to realize the federal government's commitments to Beijing and Beijing+5, among other international obligations. In particular, improved accountability mechanisms and program supports are required to ensure that all levels of

government work together and follow through on Canada's stated commitments to women's health and equality.

Current obligations need to be solidified politically and financially. In particular, the *Women's Health Strategy* needs to be renewed and revised so that it can better respond to the myriad of outstanding issues highlighted in this report: the inadequacies of gender-based analysis, health care services, prevention programs, research and evaluation. Accommodating and addressing the complexities of gender and sex differences as well as other intersecting social health determinants is essential for improving the health related quality of care and life for women and for promoting any agenda for gender equality.

### **Recommendations and Suggestions:**

1. Increase accountability mechanisms for the implementation of international agreements across all jurisdictions (i.e. federal, provincial, territorial and municipal levels of government).
2. Enshrine into law a Women's Health Office at the federal level, thereby solidifying the commitment to women's health and health research in Canada.
3. Increase funding for the Bureau of Women's Health and Gender Analysis

and related divisions, branches and offices dealing with women's health and gender analysis.

4. Renew and enhance the capacity of the *Women's Health Strategy*. The process of renewal should build upon regional consultations, including discussions with all relevant key stakeholders. A renewed *Strategy* should include concrete health goals/priorities. An enhanced contributions program which funds research, communication, education, policy advice and outreach activities would be essential – given the complex and distributed mechanisms for health care. This program should also include national, population based and provincial projects. Currently, funding for the *Women's Health Contributions Program*, a key component of the *Strategy*, is approximately \$2.2 million per year compared to, for example, funding for HIV/AIDS which will increase from \$42.2 million (2004) to \$84.4 million annually by 2008-2009.
5. Continue to advance GBA in the health sector, but with a view of how existing approaches and methods of implementation and evaluation can be improved. Add a GBA requirement to the First Ministers' Accord on Health Care Renewal (2003). Establish a FTP committee to provide leadership in the implementation of GBA and models of women centred care. GBA should be an explicit requirement of all federal, provincial and territorial health departments. There must be adequate resources and support for GBA. Capacity building among policy makers needs to be improved. Better coordination between all levels of government and with civil society is also required.

6. Produce annually a report on Women's Health modeled on the one prepared by the Human Resources and Services Administration's Office of Women's Health in the U.S., which collects current and historic data on health challenges facing women, their families and communities and is used as a reference for policy makers at all levels of government.
7. Some specific suggestions for improving the *Women's Health Strategy*:
  - There is no recognition in the existing *Women's Health Strategy* of the global neoliberal context and its potential effects on the implementation of GBA and other women's health objectives. In particular, health care privatization, other reforms (e.g. reduced public participation in health care decisions), and deregulation through free trade agreements are undermining the autonomy and role of countries in determining their health care systems. It is becoming more difficult to sustain existing systems as international pressures to reduce public service spending increases. These changes are having a particular impact on various groups of women as providers and patients and need to be better understood and responded to.
  - While the *Strategy* acknowledges the importance of applying a social determinants approach, more attention needs to be paid to developing a useful inter-sectoral approach that links social, economic and health policies and addresses the determinants of women's lives in their communities. The increasing feminization of poverty and the increasing time stress in the lives of women are results of the failure to take women's needs into account in other policies and programs. More effort is needed to reduce health inequities by addressing factors that

result in inequitable health outcomes (economic, social, political and environmental). This can be accomplished through the establishment of innovative programs that mitigate health inequities by reducing income inequities and social exclusion and by the establishment of Health Impact Assessments as a critical component of governmental decision-making.

- Although the overall *Strategy* promotes gender equality in health, gender-based analysis (GBA) needs to be integrated into all the objectives and commitments made in the *Strategy*. Moreover, the *Strategy* requires all departments within Health Canada to share equally in the implementation of GBA. This responsibility cannot be downloaded solely onto the Bureau of Women's Health and Gender Analysis. Effective monitoring and evaluation should be undertaken on a regular basis. Health inequities can only be remedied if they are recognized. Moreover, GBA efforts at Health Canada need to expand to all other areas of government policy, and policy makers need to recognize the relevance and importance of this perspective for developing effective and efficient policy. GBA is not an end in itself, but rather a tool – one that needs use. Increasing community capacity to monitor GBA initiatives is needed as well.
- A more comprehensive approach that sees health issues in their full social, spiritual and cultural contexts is needed. Such an understanding can only come from speaking to women themselves and finding out what their health care priorities are. As the results from a national consultation held recently concluded, there is “the need for a further and fuller explanation of what many

women in the country consider to be their health priorities, e.g. poverty and equity issues”. Women-centred care models can be helpful in this regard. An excellent example of this, prepared by the Vancouver/ Richmond Health Board, argues that a women-centred care framework should have the following 12 elements: need for respect and safety, the importance of empowering women, involvement and participation of women, collaborative and inclusive work environments, women's patterns or preferences in obtaining health care, women's forms of communication and interaction, the need for information, women's decision-making processes, a gender-inclusive approach to data, gendered research and evaluation, gender sensitive training, and social justice concerns.

- Despite stating that it will be sensitive to issues of diversity, the current *Women's Health Strategy* does not adequately take into account the diversity and health inequities among women: women who are poor, women with disabilities – both mental and physical, Aboriginal women, older and elderly women, and immigrant, refugee and other racialized women. In general, more attention is needed on the relationship of not only sex and gender but also other intersecting forms of discrimination and oppression. And, when arguments are made about the significance of gender, these must transcend the essentialization associated with biomedical explanations, which downplay diversity among women and fall in the trap of treating all women as equivalent.
- Communication among researchers in all distinct areas of health research inquiry needs to be improved to promote: inter and trans-disciplinary investigations;

mixed methods approaches; participation of NGOs, women's organizations, and women consumers in setting research priorities; and in the end, facilitate a comprehensive understanding of women's health and establish a valuable approach to measuring, monitoring and, ultimately, improving all Canadian women's health. More recognition needs to be given to the role of non-Western scientific traditions and knowledge as well as traditional and indigenous health approaches, techniques and beliefs (i.e. complementary medicine).

- We need to ensure that any strategy for women's health is a living, flexible framework, one that is able to identify, clarify, accommodate and prioritize new and emerging issues. It must be properly resourced to span departments within Health Canada and all departments of the federal, provincial and territorial governments. Effective and meaningful mechanisms for monitoring and evaluation must be put into place.

# Women's Health in Canada: Beijing and Beyond

## Overview

The 4<sup>th</sup> World Conference on Women in **Beijing** (1995) marked an important watershed in international efforts to further gender equality. The conference had four objectives:

- Review and appraise the advancement of women since 1985;
- Mobilize women and men at both the policy-making and grassroots levels;
- Adopt a “**Platform for Action**” (PFA); and
- Determine the priorities to be followed in 1996-2001 for implementation of the Strategies within the United Nations system (UN, 1996).

The PFA was “inspired by Article 2 of the **Convention on the Elimination of All forms of Discrimination Against Women (CEDAW)** which obligates States parties to repeal or abolish all existing laws, regulations, penal provisions, customs and practices that are discriminatory against women” (Hannan, 2004). Both CEDAW and the PFA contain specific sections on women's health that mutually reinforce the link between women's health and human rights, since CEDAW is a human rights treaty with the force of international law and the PFA is a policy commitment of the highest order, confirmed by the UN General Assembly in 1995 and again in 2000. Article 12 of CEDAW imposes on states parties (Canada acceded to CEDAW in 1981) to “take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health

care services, including those related to family planning.” The PFA has a section that prioritizes the right to the enjoyment of the highest attainable standard of physical and mental health for women. Significantly, it emphasizes a social determinants approach to understanding women's health by stating that:

“Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Women's health involves their emotional, social and physical well-being and is determined by the social, political and economic context of their lives, as well as by biology. ...

The prevalence among women of poverty and economic dependence, their experience of violence, negative attitudes towards women and girls, racial and other forms of discrimination, the limited power many women have over their reproductive and sexual lives, and lack of influence in decision-making are social realities which have an adverse impact on their health.”

The PFA also includes five strategic objectives for women's health including:

- improving access throughout the life cycle to appropriate affordable and quality health care information and related services;
- strengthening preventive programmes;
- undertaking gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS, and sexual and reproductive health issues;
- promoting research and disseminating information; and
- increasing resources and monitoring.

In June 2000, the General Assembly met in special session (**Beijing +5**) to review and assess the implementation of the PFA and to consider the types of actions and initiatives required for overcoming obstacles to its effective implementation. The outcome document of the special session included a resolution to further deal with areas of concern set out in the PFA, including women and health.

It was noted that progress in member countries “has been constrained by the absence of a holistic approach to health and health care for women and girls based on women's right to the enjoyment of the highest attainable standard of physical and mental health throughout the life cycle; ...the unequal power relationships between women and men and a lack of communication and understanding between men and women on women's health needs; and the lack of information on availability and access to, *inter alia*, appropriate, affordable, primary health-care services of high quality, including sexual and reproductive health care” (UN, 2000a).

Also in 2000, the United Nations adopted the Millennium Declaration, which set out the following eight **Millennium**

**Development Goals (MDGs):**

Goal 1: Eradicate extreme poverty and hunger

Goal 2: Achieve universal primary education

Goal 3: Promote gender equality and empower women

Goal 4: Reduce child mortality

Goal 5: Improve maternal health

Goal 6: Combat HIV/AIDS, malaria and other diseases

Goal 7: Ensure environmental sustainability

Goal 8: Develop a global partnership for development (UN 2000b).

While all the goals are relevant for women's health, Goal 3 in particular is thought to build upon the work of women's advocates at various UN conferences, in particular the 4th World Conference on Women, and the five-year review of the Conference's Platform for Action.

### ***The Canadian Response***

In 1995, Canada adopted<sup>1</sup> the United Nations Platform for Action, developed in Beijing at the United Nations World Conference on Women. That same year, the government of Canada introduced a national policy to advance women's equality. ***The Federal Plan for Gender Equality (1995-2000)*** stated that all subsequent federal legislation and policies were to include, where appropriate, an analysis of the potential for differential impacts on men and women (Status of Women Canada, 1995:17). While the plan was intended to cover all areas of policy, specific attention to women's health was made in Chapter 3 – “Improving the Health and Well-being of Women.” In this chapter, the government committed itself to a women's health strategy<sup>2</sup>, which was

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<sup>1</sup> The term ‘adopted’ refers to agreements the government of Canada has made in an international forum. These agreements reflect Canada's values and approach to an area of concern internationally. In Canada, they do not have the force of law but rather can provide guidance at high federal levels. However, there are no direct accountability mechanisms between these international statements and federal, provincial or municipal policies, budgets or actions. Furthermore, given the roles and responsibilities of different levels of government in the provision of health and other related services, the monitoring and evaluation of progress in the implementation of the Beijing Platform for Action is even more challenging.

<sup>2</sup> Under Objective 3, number 160: “The federal government is committed, therefore, to developing a comprehensive and integrated women's health strategy to guide work on women's health, to identify priorities and criteria for periodically assessing and resetting priorities and to ensure that gender-impact analysis is

introduced four years later in 1999 by Health Canada. Ironically, the federal government budget that followed the Beijing Conference also brought some of the broadest and far-reaching set of social service and program cuts Canada has ever seen (Yalnizyan et al., 2004), negatively affecting all areas of women's health.

The **Women's Health Strategy (1999)** is an integrated framework for addressing major women's health issues and was intended to address the principles of the Beijing Platform. The overarching goal of the *Strategy* is to improve the health of women in Canada by making the health system more responsive to women and women's health through the realization of the four following objectives:

1. Ensure that Health Canada policies and programs are responsive to sex and gender differences and to women's health needs;
2. Increase knowledge and understanding of women's health and women's health needs;
3. Support the provision of effective health services to women; and
4. Promote good health through preventive measures and the reduction of risk factors that most imperil the health of women (Health Canada 1999a).

The *Strategy* has seven main features: it is balanced, respectful of diversity, egalitarian, evidence-based, coherent, multi-sectoral and incremental. The departmental lead for the *Strategy* is the Bureau of Women's Health and Gender Analysis.<sup>3</sup>

In 2000, the federal government re-affirmed

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an integral part of health programs, policies and regulatory activities.”

<sup>3</sup> The Bureau of Women's Health and Gender Analysis became the new name for the Women's Health Bureau in January 2005.

its commitment to gender equality by approving the **Agenda for Gender Equality (AGE)**, a five-year government-wide strategy. Its objectives include accelerating the implementation of GBA, including civil society in the policy process so that women's experiences and perspectives can inform issues on the policy agenda and to meet Canada's commitments to international treaties and related obligations such as the Beijing PFA and Beijing+5 Political Declaration and the Outcome Document.

Despite these responses and some progress made in Canada in the area of women's health, significant challenges remain. As the United Nations has noted, “new approaches are needed to address the opportunities and challenges within the Platform's vision of gender equality” (UN, 2001). Within the Canadian context, this includes critically analyzing the effectiveness of existing strategies and concomitant tools for monitoring and evaluation. Because the *Women's Health Strategy* is considered to be the key response to the health objectives of Beijing's PFA, it is the primary document through which Canada's response to improving the health status of women can be assessed.

When the *Strategy* was first introduced, it was thought to have significant potential for making change. First, it explicitly laid out the government's commitment to improved health through action on the social determinants of health. The framework provided a clear rationale for why a specific women's health strategy in Canada was needed. It stated that Health Canada would work with “other departments to promote a holistic, multi-sectoral approach to health and social policy development.” And finally, it emphasized that gender would be integrated into all policies and programs. The vision was both progressive and congruent with

international objectives and priorities in the area of women's health. However, from the onset there was at least one major shortcoming. There were no mechanisms put in place for operationalizing the *Strategy* or the commitment to GBA within the provinces and territories. The *Women's Health Strategy* is now more than 5 years old. Typically, any federal government strategy that has been in place for such a period of time is reviewed and/or renewed. Should the *Strategy* undergo such a review, it is essential that the process is public and moreover, that it is informed by as much information as possible regarding its overall efficacy.

### ***This Review***

Our review in this document focuses on four areas: Gender-based Analysis, Health Services, Prevention Programs, and Research and Evaluation, which reflect the key objectives of the *Women's Health Strategy*, to determine the progress that the Canadian government has made in advancing women's health. Even though the review deals with a select number of women's health issues, a number of conclusions can be drawn. Almost 6 years after the *Women's Health Strategy* was introduced, some progress has been made. On balance, however, it is also clear that much more work needs to be done to realize the federal government's commitments to Beijing and Beijing+5, among other international obligations. In particular, improved accountability mechanisms and program supports are required to ensure that all levels of government work together and follow through on Canada's stated commitments to women's health and equality. We end with a number of observations that are intended to inform the federal, provincial and territorial levels of government, as they consider future directions and government strategies for effectively responding to the diversity of women's health

and health care needs in Canada.

### **I. Gender-based Analysis**

The first objective of the *Women's Health Strategy* is to ensure that Health Canada's policies and programs are responsive to sex and gender differences and to women's health needs: "In keeping with the commitment in the *Federal Plan for Gender Equality*, Health Canada will, as a matter of standard practice, apply gender-based analysis (GBA) to programs and policies in the areas of health system modernization, population health, risk management, direct services and research" (Health Canada, 1999a:21). Health Canada defines Gender-based Analysis as: "...an analytical tool applied to research, policies, program design, and evaluations to ensure that appropriate questions about both men and women yield sensitive and accurate analyses and programs" (Health Canada, 2002a:22). Not only is GBA a response to the UN Platform for Action, it is also consistent with the *Convention on the Elimination of All Forms of Discrimination Against Women*, and the recognition of health as a human right for women.

In 2000, Health Canada developed a **Gender-based Analysis Policy**. The policy confirms the department's commitment to the implementation of a gender-based analysis and outlines ways in which it is being integrated into the policies, programs of Health Canada. The Bureau of Women's Health and Gender Analysis is central to this initiative. The Bureau coordinates the implementation and evaluation of GBA, and ensures that women's health concerns are integrated and responded to appropriately by Health Canada. In 2003, Health Canada released *Exploring Concepts of Gender and Health*. Its authors write that the guide "advances Health Canada's commitment to fully implement GBA throughout the

department. One of several capacity-building tools developed by Health Canada's Women's Health Bureau, it suggests ways for researchers, policy analysts, program managers and decision makers to integrate GBA into their day-to-day work."

According to Joseph Caron, author of the 2003 Report on Governmental Health Research Policies Promoting Gender or Sex Differences Sensitivity, "GBA implementation is ongoing, and development of GBA training modules has generated particular tools for gender-sensitive research and evaluation" (2003:54). Currently, a GBA training program for Health Canada staff is underway. Training manuals are continually being revised to be more responsive to specific policy needs of those who work across a diversity of branches and areas within Health Canada.

As well, the Women's Health Contribution Program, an approximately two million dollar per year initiative, funds four Centres of Excellence for Women's Health, research networks focusing on Health Protection, Health Reform, Aboriginal Women's Health, and the Canadian Women's Health Network. This in turn supports GBA by producing and disseminating new and better knowledge of women's health (see [www.centres.ca](http://www.centres.ca)).

Recently, in Health Canada's Report on Plans and Priorities produced for the 2003-4 Estimates, the department stated:

"The fundamental planning considerations for the Department that are specific to health are complemented by the integration of ongoing government-wide priorities that have implications for the health of Canadians. For example, sustainable development perspectives and gender-based

analysis are integrated into planning for the development, implementation and review of policies, programs and operations" (Health Canada, 2003b).

In reality, however, GBA has not been consistently incorporated into policy development, implementation or evaluation.

One stark example of a failure to implement GBA into health planning and reform is evidenced in the **Royal Commission on the Future of Health Care (Romanow Commission)**, which published its report in November 2002. While praised for its recommendation to re-enforce and expand Medicare, it was criticized for failing to incorporate a gender lens in its analysis and proposals. As noted by the National Coordinating Group on Health Care Reform and Women (NCGHCRW) in its *Reading Romanow: The Implications of the Final Report of the Commission on the Future of Health Care for Women*, "...the Report is fundamentally flawed. By not offering a gendered analysis, it fails to consider women's places in the health care system and the consequences of health care reforms for women in different locations throughout the system" (2003:7).

Moreover, the **First Ministers' Health Accord on Health Care Renewal** that was derived from the Romanow Report and signed by the provinces and federal government in February 2003 was also void of any kind of gender analysis. This can be partly explained by the fact that although "almost all health care is provided by women and women are most of those who receive care, women are a minority of those making policy decisions about health care. They have few means of influencing how major policy decisions are made, even though their daily practices bring so many of them into direct contact with the

health care system” (NCGHCRW, 2003:5). A similar lack is also apparent in the recent report of the Health Council of Canada, *The Health of Canadians* (2004). While highlighting the importance of health disparities, the potential role of GBA in furthering the understanding of such disparities is not recognized. The absence of gender from these initiatives is an example of the isolated nature of women’s health policy and gender analysis within the machinery of government.

As the government of Canada itself acknowledges, “we still face challenges to mainstream and institutionalize the application of gender equality objectives, analyses and processes in the work of governments” (Canada’s Response to UN, June 2004:4).

*First*, the integration of GBA is often hindered by a lack of political will and adequate government financing and support. There is little coordination between levels of government and the general public has not been educated around GBA.

*Second*, even when GBA is integrated into some areas of policy, it is rarely applied in a systematic fashion to all policy areas including for instance, economic and technology policies that effect health (Rankin and Vickers, 2004). Indeed, the current neo-liberal policy context, characterized by privatization and deregulation, is consistently at odds with gender equality (Teghtsoonian, 2000).

*Third*, women’s organizations and women who are both providers and users of the health care system are rarely consulted (Hankivsky, 2005c). As well, the infrastructure for women and equity seeking groups has been reduced significantly, thereby decreasing the likelihood of the ongoing monitoring required

to support change.

*Fourth*, the distinctions between sex and gender, as well as the relationship between the two concepts, are not well understood (Hankivsky, 2005b). Finally, attention to diversity and difference within GBA requires a better understanding of how gender interfaces with other variables such as ethnicity, class, age, sexuality, and so on (Hankivsky, 2005a).

It is clear that a commitment to GBA within the federal health sector is not, by itself, a guarantee of meaningful change. Most importantly, although the Bureau of Women’s Health and Gender Analysis does provide progress reports on the process and implementation of GBA across Health Canada, the *Women’s Health Strategy* and the *Gender-based Analysis Policy* have not undergone any formal evaluation.<sup>4</sup> It is also worth noting that the activities at the provincial and territorial levels in relation to GBA have been uneven. Some provinces or regions have undertaken actions on their own such as setting up Offices of Women’s Health (many of which have now closed), establishing women’s health as a priority area, adopting “Models of Women Centred Care” as policy statements to guide service provision and development, or providing GBA training to staff. Few provinces have the necessary resources, training capacities or accountability mechanisms in place to effectively implement and evaluate GBA. However, there are no mechanisms for national reporting or coordination. And, most community-based women’s and health groups remain unaware of GBA.

Thus, it is not possible to determine with any

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<sup>4</sup> Personal correspondence, Bureau of Women’s Health and Gender Analysis, Health Canada, November 10, 2004.

certainty whether GBA has been effective at the level of health policy, programs and services, or indeed across other policy sectors that directly affect health. Not surprisingly, activists and other health care professionals remain unsure as to whether or not GBA has had any impact on the women's health community or for women's health in Canada.

## II. Health Services

Access to and improvement of a range of health services is prioritized in Objective 3 of the *Women's Health Strategy*. Certainly, the recommendation by the Royal Commission on the Future of Health Canada to re-enforce and expand Medicare was welcome news for women (NCGHCRW, 2003:1). The Commission concluded that because Canadians are committed to the core values of Medicare – equity, fairness and solidarity, health care services should continue to be provided on the basis of need, as a right of citizenship, rather than be contingent on wealth or status (Romanow, 2002). Medicare is especially important for women, as they are the majority of both recipients of health care and paid and unpaid health providers, and are more likely to be without extended health insurance or poor. The Commission also concluded that “the evidence has not been forthcoming” (Romanow, 2002:xx) that privatization would improve the system.

The finding that a publicly insured and managed system was more cost effective and provided higher quality care is important not only for Canadians, but internationally for those countries which are being increasingly pressured to allow for-profit services to manage their health care.

There have also been a number of improvements in some areas for both the users of the system and unpaid care providers, the majority of whom are women. For

instance, in the *Health Care Accord* of 2003, the federal government introduced a basket of services for short-term acute home care, including acute community mental health, and end of life care. In 1998, the caregiver tax credit for individuals that reside with and provide care to low-income parent, grandparent or an infirm, dependant relative was established. In 2004, Employment Insurance Compassionate Care benefits were introduced, allowing some workers temporary absence from work to provide care to a closer family member with a serious medical condition with significant risk of death within six months. Such benefits, however, only benefit a small portion of the population, and exclude the great number of female caregivers who are underemployed or unemployed.

Significant shortcomings continue to exist in the areas of primary care, home care, and pharmacare because of an absence of GBA. For example, comprehensive, innovative and effective primary health care services for women, such as women-centred health centres that provide effective gender-specific interventions and preventions, comprehensive reproductive health services, and midwifery programs, are lacking (Donner and Pederson, 2004). There is no national home care program that attends to long-term care, chronic care or care for people with disabilities. This has clear gender implications. Women constitute 80% of those who provide unpaid personal care in the home as well as the majority of those who require care in their home (NCGHCRW, 2003). Not surprisingly, caregiving primarily affects the health of women rather than men and in particular immigrant, refugee and visible minority women (Morris 2001a). In terms of pharmacare, women continue to be over-prescribed a variety of drugs that they often cannot afford or whose intended and unintended health effects are not fully known.

Access to abortion services varies widely across Canada – from province to province and region to region. For example, Newfoundland, Ontario, British Columbia, Alberta and Manitoba are the only provinces to fully cover the cost of abortions performed in community-based clinics. Since 1983, there have been no abortion facilities in Prince Edward Island (CARAL, 2003). In addition, women living in rural and remote regions have to travel long distances to access care. Furthermore, insufficient attention is paid to women’s health across the lifespan in the development and design of health services even though it is essential for understanding and attending to health care needs of all age groups, especially older women who are prone to a range of chronic health illnesses (Health Canada, 2003c) and who often lack the financial means and other supports to adequately deal with their health status.

The needs of other vulnerable groups of women are especially not reflected in the majority of existing services. For example, the ability of all women, and in particular Aboriginal women living in rural, remote, northern communities, to obtain essential health services in a timely fashion, closer to home continues to be undermined (Ministerial Advisory Council on Rural Health, 2002; Sutherns et al., 2004). Aboriginal women consistently experience a lack of appropriate services, such as reproductive and anti-violence services (Bent, 2004). Immigrant and refugee women, a group that is more likely to report poorer health than Canadian-born women, have access to a paucity of services that respond to their unique health care needs (Vissandjée et al., 2004). Many shelters and drop-in centres across the country are not accessible to immigrants and refugees because of linguistic barriers and lack of culture-appropriate services (SCPI 2003). There is a pressing need for health care services that are “culturally appropriate, anti-

racist, and inclusive of all members of Canadian society regardless of race, gender, socio-economic situation, immigration status or other suppressions” (WHIWH, 2001). Women with disabilities are also not well understood within the health care system, have few opportunities to engage in preventive healthcare activities, do not have adequate access to primary healthcare (appropriate screening for breast and cervical cancer, supports for making appropriate reproductive health choices), hospital care and long-term care services (Morris, 2001b; Wendell, 2001; Gill, 1997).

Further, there is a lack of consumer and women’s NGO participation and control in service development and delivery, and little attention paid to incorporating the perspectives and needs of health care workers.

Despite increasing evidence demonstrating the affects of poverty and social exclusion on the health of individuals and populations, insufficient attention is paid to social, political, and economic factors and related policies, services, and programs that affect women’s health and health care needs. These include for example, food and economic security, shelter and housing, social services and assistance, education, the environment, and continuing gender discrimination that horizontally cuts through all social structures and institutions of society.

Calls for action to protecting Canadian social programs, new or existing, go unheeded. National child care, pharmacare, and homecare programs will need protection if they are to become not for profit and publicly managed – an essential component for managing quality and cost effectiveness. The effects of globalization and trade agreements and how they relate to all aspects of the Canadian health care system also remain largely unexamined by government decision-

makers.

Finally, no effective gender-based analysis of what is currently being delivered, and no long term planning among the federal, provincial and territorial governments that prioritizes the diversity of women's unique health service needs have been put into place.

### **III. Preventative programs that promote women's health**

According to Objective 4 of the *Strategy*, Health Canada has a responsibility to reach individuals before they adopt health-threatening lifestyles and to assist them in avoiding high-risk situations, behaviours and products that lead to negative health conditions or disease. A number of health issues highlighted under this objective and consistent with Beijing's Platform For Action are: violence against women,<sup>5</sup> tobacco, mental health, HIV/AIDS, and sexual and reproductive health issues. These represent only a snapshot of issues, disease, and experiences relating to women's health that require further attention and sustained policy responses. Prevention initiatives also need to recognize the interconnections and common denominators created by social determinants in all women's health issues and concerns. To illustrate: over-medicalization, over-prescription of drugs, marketing of unsafe medical devices and unnecessary surgery continue without a

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<sup>5</sup> CEDAW is an important human rights tool in combating violence against women because it now defines such violence as a form of gender-based discrimination. In 1992, the international experts on the Committee on the Elimination of Discrimination Against Women, usually known as the CEDAW Committee, which monitors implementation of CEDAW by states parties, affirmed that both public and private forms of violence ("all forms of discrimination") against women are human rights violations in the CEDAW Committee's Recommendation 19, which confirmed the links between violence and discrimination.

clear understanding of how they undermine rather than protect and promote women's health (Batt, 2002).

The increasing focus on "pills for prevention" is a trend that is particularly troubling for those advocating healthier and safer prevention options. Examples include hormone "replacement" therapy for osteoporosis, certain hormonal drugs (e.g. Tamoxifen) to prevent breast cancer in healthy women and statins to prevent cardiovascular disease. These trends are being heavily influenced and nourished by direct-to-consumer advertising of prescription drugs, despite the fact that this practice is illegal in Canada. A heavy focus on drugs for prevention is not only more costly to the health care system, it carries risks (as do all prescription drugs) – some of them still to be determined – and takes the focus away from healthier all-around primary prevention measures such as exercise, stress reduction, poverty reduction, food security and smoking cessation. As with a growing reliance on drugs to 'cure' anxiety, shyness and depression, this focus shifts priorities away from healthier options that consider the full range of responses to social determinants on our health.

### Violence against Women

The partial estimated costs of violence against women are over \$4.2 billion annually (Greaves, Hankivsky & Kingston-Riechers, 1995). The effects of these experiences are manifest in higher costs for the health care and social services systems (Yodanis, Godenzi, & Stanko, 2000). The physical and mental health implications of violence include: acute physical injuries, unwanted pregnancies and miscarriages, STDs including HIV/AIDS (Gielen et al., 2000; Martin et al. 1999; Zierler, 1997) and psychological trauma and poorer mental health (Cascardi,

O'Leary, & Schlee, 1999; Herman, 1992; Mouton, Rovi, Furniss & Lasser, 1999). Over their lives, abuse survivors experience more surgical interventions, physician and pharmacy visits, hospital stays, and mental health consultations than other women, even when controlling for other factors affecting health care utilization (Heise & Ellsberg, 1999).

On behalf of the federal government and 12 partner departments, Health Canada coordinates the Family Violence Initiative (FVI). The goal of the FVI is to reduce the occurrence of family violence in Canada. Funding for the program is \$7 million annually. Health Canada also manages the National Clearinghouse on Family Violence (NCFV). The Clearinghouse provides information on all forms of violence, prevention and intervention initiatives, referrals and treatment programs. An Alliance of Violence Research Centres undertakes important policy-based research and recently, the federal government dedicated specific monies to fund initiatives led by Aboriginal women's groups on issues of violence against women. Research and policy efforts nationally are also extending to issues of trafficking in women and children (e.g. establishment of the Interdepartmental Working Group on Trafficking in Persons).

Despite the FVI and related initiatives, over the last decade significant cuts have been made to abused women's community services and supports in many Canadian provinces (Morrow, Hankivsky & Varcoe, 2004). These have put all women at increased risk for abuse and sexual assault, poverty and homelessness, made it more difficult for women to leave abusive relationships, and led to decreased access to justice for women who experience abuse. The changes have affected all women, but especially those most vulnerable, such as Aboriginal women, women of colour,

immigrant women, poor and low-income women, women with disabilities and lesbian, bi-sexual and transgendered women. Specifically, racialized and gender-based violence against Aboriginal women continues to go largely unchecked. The stress and emotional burden placed on women who are not able to leave an abusive relationship often manifest themselves in an increase of physical/mental illness and disease (Campbell et al., 1997; Campbell & Soeken, 1999; Day, 1995; Gerlock, 1999).

### Tobacco Prevention

According to a recent survey, overall, 26% of women in Canada smoke. The percentage of women aged 15 to 19 who smoke is 31% compared to 27% for men the same age. A breakdown of women smokers (1998) indicates that women in lower income groups are more likely to smoke (Health Canada, 1999c). Smoking causes many health problems, more so for women than men (Morris, 2001b). For example, women face particular health risks from smoking: cervical cancer, osteoporosis, early menopause, increased risk of heart attacks and stroke, more difficulty getting pregnant, complications in pregnancy, and low birth-weight babies, who often experience health problems of their own (Health Canada, as cited in Morris, 2001b: 5). The Heart and Stroke Foundation has reported that 60 per cent of Aboriginal women aged 15 or older are regular smokers. In the Northwest Territories, up to 80 per cent of Inuit women are smokers, compared to fewer than 40 per cent of non-Inuit women (McCulla, 2002).

The Canadian government maintains that the issue of women and tobacco is integral to a wide range of health promotion and disease prevention programs. The Tobacco Control Initiative (TCI) has four important components: legislation and regulations, enforcement, research and public education.

Current strategies focused on cessation, reduction of tobacco use and protection of non-smokers pay very little attention to gender differences or the full socioeconomic context of women's lives. There are key factors, such as child care responsibilities, time stress, income adequacy, body image and the nature of women's work that cause women to experience the effects of broad tobacco policies differently. For Aboriginal women in particular, cultural issues, socioeconomic disadvantages and discrimination issues need to be explicitly considered (with their direct input) in the process of developing community-based approaches to prevention and cessation (ANAC, 1999). Without consistent gender analysis of tobacco policies and women-centred policy (Greaves & Barr, 2000), smoking related disease will continue to be the number one killer of Canadian women, and little progress will be made in terms of understanding the unique effects of tobacco on women's health.

### Mental Health

Evidence shows that certain health complaints are diagnosed more frequently as mental illnesses in women, that women utilize the mental health care system more frequently than men, and that women require a wider range of treatment options than are currently available (Rhodes et al., 2002; F/P/T Advisory Committee on Population Health, 1996). Links between social conditions and women's mental health have also been well documented. For example, after the onset of puberty, a woman's risk of developing depression increases to twice that of men (CMHA, 2003). Mood disorders and anxiety disorders are more common for women (Statistics Canada, 2003). Eating disorders affect girls and women more than boys and men (Health Canada 2002b). Poverty, which disproportionately affects women and

specifically women with disabilities, Aboriginal women, and single mothers, is linked to poorer mental health (Wiebe & Keirstead, 2004).

However, this evidence has not been translated into policy and practice in the mental health system (Morrow, 2003). Few services are able to respond to important issues that influence mental health such as violence, addictions, or effects of child sexual abuse (Morrow, 1999). According to the *Canadian Community Health Survey*, over 22% women reported they needed help for their emotions, mental health, or use of alcohol or drugs but did not receive it (Statistics Canada, 2003). Services that are available tend to over-medicalize women while not providing them with appropriate counselling to meet their specific needs. Moreover, women consumers experience mental health care services and access to them differently. There is a current lack of racially, culturally and linguistically appropriate mental health care to serve the needs of different ethno-cultural communities. In a recent study, Canadian mental health providers were consistently unable to diagnose Post Traumatic Stress Disorder (PTSD) in immigrant and refugee women who had experienced war, rape, torture, persecution, natural disasters and other traumas, and it was also found that very few programs existed to help the children of these women, many of whom also suffer from PTSD (IRVMWS, 2001).

Critical position papers, educational material on mental illness and descriptions of 'best practices,' in mental health still typically fail to discuss gender in relation to other social determinants of mental health. The most recent example of this is the Standing Senate Committee on Social Affairs, Science and Technology three-volume report on Mental Health, Mental Illness and Addictions

released in November, 2004, where gender is mentioned only briefly in relation to suicide and women are not included as one of the priority populations identified. There is no evidence in this report of any gender-based strategy, one that is attentive to the range of social inequities that affect women's mental health. Such omissions point to the critical importance of developing a national women's mental health strategy, utilizing and expanding the evidence base on women's mental health and applying a gender-based analysis to policy and program development (Morrow, 2003).

### HIV/AIDS

According to Health Canada (2004), women represent an increasing proportion of reported HIV cases in Canada, accounting for 25.1% of positive HIV test reports in 2002. The proportion varies considerably by age and is highest among young women (15-29 years old). Aboriginal and Black women have also been identified as vulnerable populations. For instance, Black women make up to 23% of the AIDS related deaths in some regions of Canada (WHIWH, 2001). Lately, the Pauktuutit Inuit Women's Association has received funding to further HIV education, prevention, care, treatment and support of Inuit Women. In January 2005, a new Federal Initiative to Address HIV/AIDS and an Action Plan were announced. The Department of Foreign Affairs and International Trade has introduced a strategy on HIV/AIDS and the Canadian International Development Agency is developing a framework for HIV/AIDS. These documents are uneven in their attention to gender and systematic incorporation of GBA.

For the most part, HIV/AIDS is still not considered to be a women's health issue and few programs and initiatives have specifically targeted women, especially vulnerable groups

of women. Many women simply do not receive the diagnostic and treatment services that could benefit them in the early stages of their infection. Social and community supports are rarely available to women who are HIV positive because they have not been developed with their specific needs in mind. Not surprisingly, girls and women are often less educated than men about HIV/AIDS and do not have the support structures they require. Disease manifestations attributable to HIV/AIDS are also often different in women, which has also led to delays in diagnosis and appropriate treatment (Canadian HIV/AIDS Legal Network, 2004). The challenge of engaging civil society organizations in setting policy priorities, translating policies into effective practice, ensuring policies address gender and intersecting determinants, and establishing the evidence base for gender sensitive policies and practice remains. In sum, there is a pressing and urgent need to develop a clear vision for a women and HIV/AIDS strategy.

### Reproductive Health

Beyond HIV/AIDS, other sexual and reproductive health issues still require much more government attention and leadership. Despite the recommendations of a Royal Commission that explored issues of reproductive technologies, infertility and reproductive health, there is no coherent action plan in place. In 1999, Health Canada released its *Report from Consultations on a Framework for Sexual and Reproductive Health*. No steps were taken to develop more specific and concrete initiatives to build upon the principles and strategic directions contained in the Report. The *Canadian Guidelines for Sexual Health Education* acknowledges the need for awareness around 'gender-related issues' and that 'access and content' should not discriminate against individuals on the basis of gender, but there is

no explicit GBA in its guiding principles. A national strategy, which uses a GBA framework for addressing sexual and reproductive health in both education and prevention initiatives, is long overdue. A gender lens reveals the extent to which many girls and women hold less power in heterosexual sexual relationships, which affects their ability to delay sexual activity and to insist on protection during sexual contact (Kinnon, 1994). According to one study, one-third of Aboriginal women indicated they were afraid of being abused if they refused to have sex with a partner (ANAC, 1996).

These power imbalances are compounded by the continuing paucity of effective and appropriate information regarding birth control, STIs, pregnancy, fertility, reproduction and childbirth. Despite the positive experience in other countries, emergency contraception pills (ECP) are only available by prescription. A federal consultation to make ECP non-prescription has been going on for over two years.<sup>6</sup> To increase access, several provinces have delegated prescription authority to a pharmacist, but in many cases this change has meant increased costs for women.

Media literacy training for adolescent sexuality education programs is underdeveloped and not attentive to the specific needs of girls. STIs remain high among young women. Reported rates of chlamydia in girls between 15 and 19 years of age are nine times the national rate (Health Canada 1999d). Pregnant teens, especially Aboriginal teens, are also at greater risk of health problems, including, for example, anemia, hypertension, renal disease, eclampsia and depressive disorders as well as increased poverty (Bent, 2004; Combes-

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<sup>6</sup> Editor's note: ECP was made non-prescription in April 2005.

Orme, 1993; Turner et al., 1990). And while Canada's Prenatal Nutrition Program (CPNP) has been established, more emphasis on maternal health care, including midwifery, is required. The fact that women are more and more frequently required to travel long distances to give birth needs to be addressed. Increasingly, women are postponing motherhood. Postponing motherhood increases risks of infertility and the likelihood of the uses of assisted reproductive technologies. At the same time, women between the ages of 18 and 24 who give birth are more likely to be poor.

More than 10 years after the Royal Commission on Reproductive Technologies, the *Assisted Human Reproduction Act* was finally passed in 2004, albeit with many delays. The regulation, licensing and monitoring regimes are as yet years away as services, mostly provided in the for-profit sector, continue. Far more attention is also needed in the management of reproductive technologies.

Specific needs of women with disabilities and lesbians continue to be marginalized in all areas of sexual and reproductive health: Women with disabilities are often assumed to be asexual and therefore are not asked questions about reproductive health or fertility (Morris, 2001b). Lesbians receive fewer regular pap smears to test for cervical cancer because doctors regularly assume that they are not at risk for sexually transmitted diseases (Health Canada, 2000, as cited in Morris, 2001b:1).

#### **IV. Research and Evaluation**

Objective 2 of the Strategy focuses on increasing knowledge of women's health. Clearly there have been attempts at a number of important initiatives in this regard. In 1996-1997, Health Canada announced its

### **Inclusion of Women in Clinical Trials**

policy. Its goals are to guarantee the inclusion of women at the earliest stages of drug development (this includes the specific targeting of women of child bearing age), to ensure identification of potential sex-related differences, and to make certain that these are taken into account when planning Phase III pivotal trials. The policy is also aimed at generating data to better inform physicians and other key stakeholders of any sex-related characteristics of new drugs. At present, “no systematic mechanism for monitoring the policy has as yet been put into place at the present time, although such implementation is possible in the future” (Caron, 2003:53).

Further, the federal government seems hesitant to act in areas where it does have authority—direct to consumer advertising for drugs is proliferating—a direct contravention of existing regulations. Calls for an improved transparent drug approval system with improved citizen engagement in drug reviews, five-year temporary licenses for new drugs, registries for products such breast implants and Depo-Provera, mandatory adverse event reporting and post marketing surveillance have been ignored.

In 2000, the federal government, as part of new program of funding for health research in Canada, established the **Institute of Gender and Health** (IGH) within the Canadian Institutes for Health Research (CIHR) – despite a strong push from the women’s community for a Women’s Health Institute (Greaves, Hankivsky et al., 1999). The mandate of the IGH is “to support research to address how sex (biological factors) and gender (socio-cultural experiences) interact with other factors that influence health and create conditions and problems that are unique, more prevalent, more serious or different with respect to risk factors or effective interventions for women and girls,

men and boys.”

From 2003 to 2004, for example, IGH provided funding for over 50 grants and awards, covering the four CIHR pillars of biomedical, clinical, health services, and population health, across five research priorities: access and equity for vulnerable populations, promoting health in the context of chronic conditions, gender and health across the lifespan, promoting positive health behaviours, and gender and the environment.

The IGH also has provided leadership in advancing the careers of women scientists. The IGH, however, has a small budget used for strategic projects in comparison to the general operating grants. A gender and health peer review committee has been put in place. However, there is no legislative direction to undertake GBA within the CIHR, as there is in the USA, or a policy framework within the CIHR itself to require a gender approach to research.

Launched in 2002, Health Canada's **Women's Health Indicators Project** is a research initiative led by the Bureau of Women's Health and Gender Analysis to develop, validate and evaluate a core set of indicators that takes gender and diversity into account. The aim is to improve the ways in which women's health is measured and to more accurately monitor changes in women's health status/outcomes. During the first stage of the project, an excellent overview was prepared and gaps in women’s health data and indicators were identified (Colman, 2003) and research is now underway to develop and validate health indicators. How this work has or will interface with other federal, national or regional work is unclear.

**The Women’s Health Surveillance Report: A Multidimensional Look at the Health of Canadian Women (2003)**, funded jointly by

the Canadian Institute for Health Information (CIHI) and Health Canada, reported on gaps in women's health surveillance and recommendations were made for developing a system in which a broad range of data is used to "support the development of gender-sensitive monitoring systems, policies and programmes aimed at improving women's health across Canada" (Caron, 2003:55). This report highlighted the health inequities between women and men and among women, the burden women carry in chronic disease, and the increasing feminization of poverty especially for sole support mothers and unattached older women. How this groundbreaking report (Health Canada, 2003b), available only on-line and receiving limited exposure, and the results from the indicators projects will be used remains unclear.

Further, the Women's Health Contribution Program, an approximately two million dollar per year initiative, funds four Centres of Excellence for Women's Health and research networks focusing on health protection, health care reform, and Aboriginal women's health, as well as the Canadian Women's Health Network. This unique program provides an infrastructure for innovative projects that address community needs and provide critical responses to policy initiatives. The program was renewed recently – until March 2008.

The **Tri-Council policy on ethical conduct**, developed by the former MRC, NSERC and SSHRC, includes two important sections for women's health research. In the Introduction to Section 5, justice and the fair distribution of benefits and burdens are emphasized and Section 5B – Research Involving Women, 3.2 of the policy states "Women shall not automatically be excluded from research solely on the basis of sex or reproductive capacity." No evaluations, formal or informal, have been made of this policy

(Caron, 2003). And finally, the Policy Research Fund of **Status of Women Canada**, which supports independent policy research on gender equality issues, has also been instrumental in funding research that furthers the understanding of linkages between health and other determinants of women's health.

On balance, the strides made in the area of women's health research over the last five years have been substantial. However, many challenges remain.

*First*, as the importance of evidence-based research increases, for numerous reasons, women's needs continue to be marginalized.

*Second*, there is no formal mechanism requiring GBA in health research.

*Third*, there is an under-representation of women in science and health careers.

*Fourth*, current health indicators are narrowly conceptualized and inadequate because they "do not reflect women's specific health concerns (outside of reproductive health), nor their central place in the health care system as both recipients and providers of care" (NCGHCRW, 2003).

Moreover, as Colman (2003) correctly notes, indicators need to go "beyond a mere listing of male-female differences in health determinants, health status and health determination. Rather, understanding must be grounded in analysis of gender roles, socio-cultural context, power and economic relationships, structural and systemic biases, and diversity (including the particular circumstances of Aboriginal, immigrant, visible minority and disabled women)" (xiv). For example, the need to expand indicators of this is supported by lack of responsiveness to the increase in feminization of poverty, especially for sole support mothers and

unattached older women.

The lack of equitable income supports and safe housing has significant associations with health status and yet there are no public health initiatives to address these problems. With the exception of the province of Quebec, which recently passed Bill 112 – which commits the government to reducing poverty and income inequalities, no levers have been put in place to reduce income and health inequities in a systematic way. And, although the concept of ‘Health Impact Assessments’ of policy and programs has been discussed, no jurisdiction has put these into place.

*Fifth*, researchers continue to research in their disciplinary homes, with little meaningful communication across perspectives taking place. The ongoing discriminatory effects of research agendas (e.g. biological essentialism and gender blindness) persist. And most importantly, those with the direct experience – NGOs, women activists, and women themselves – continue to be largely excluded from influencing the research agenda, participating in developing research plans and priorities, and shaping tools for monitoring and evaluation. Indeed, funding for voluntary sector groups and organizations has been decreasingly steadily, despite the Voluntary Sector Initiative (VSI), which was intended to increase the capacity of this sector and engage it more actively in health decision-making.

### **Recommendations and Suggestions:**

1. Increase accountability mechanisms for the implementation of international agreements across all jurisdictions (i.e. federal, provincial, territorial and municipal levels of government).
2. Enshrine into law a Women’s Health

Office at the federal level,<sup>7</sup> thereby solidifying the commitment to women’s health and health research in Canada.

3. Increase funding for the Bureau of Women’s Health and Gender Analysis and related divisions, branches and offices dealing with women’s health and gender analysis.
4. Renew and enhance the capacity of the *Women’s Health Strategy*. The process of renewal should build upon regional consultations, including discussions with all relevant key stakeholders. A renewed *Strategy* should include concrete health goals/priorities. An enhanced contributions program which funds research, communication, education, policy advice and outreach activities would be essential – given the complex and distributed mechanisms for health care. This program should also include national, population based and provincial projects. Currently, funding for the *Women’s Health Contributions Program*, a key component of the *Strategy*, is approximately \$2.2 million per year compared to, for example, funding for HIV/AIDS which will increase from \$42.2 million (2004) to \$84.4 annually by 2008-2009.
5. Continue to advance GBA in the health sector, but with a view of how existing approaches and methods of

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<sup>7</sup> In the United State for example, a bill entitled: “Women’s Health Office Act” has been introduced and if passed into law would provide permanent authorization and appropriate levels of funding for offices and positions of women’s health in five federal agencies: the Department of Health and Human Services (HHS); the Centers for Disease Control and Prevention (CDC); the Agency for Healthcare Research and Quality (AHRQ); the Health Resources and Services Administration (HRSA); and the Food and Drug Administration (FDA).

implementation and evaluation can be improved. Add a GBA requirement to the First Ministers' Accord on Health Care Renewal (2003). Establish a FTP committee to provide leadership in the implementation of GBA and models of women centred care. GBA should be an explicit requirement of all federal, provincial and territorial health departments. There must be adequate resources and support for GBA. Capacity building among policy makers needs to be improved. Better coordination between all levels of government and with civil society is also required.

6. Produce annually a report on Women's Health modeled on the one prepared by the Human Resources and Services Administration's Office of Women's Health in the U.S., which collects current and historic data on health challenges facing women, their families and communities and is used as a reference for policy makers at all levels of government.
7. Some specific suggestions for improving the *Women's Health Strategy*:
  - There is no recognition in the existing *Women's Health Strategy* of the **global neoliberal context** and its potential effects on the implementation of GBA and other women's health objectives. In particular, health care privatization, other reforms (e.g. reduced public participation in health care decisions), and deregulation through free trade agreements are undermining the autonomy and role of countries in determining their health care systems. It is becoming more difficult to sustain existing systems as international pressures to reduce public service spending increases. These changes are having a particular impact on various groups of women as providers and

patients and need to be better understood and responded to.

- While the *Strategy* acknowledges the importance of applying a **social determinants approach**, more attention needs to be paid to developing a useful inter-sectoral approach that links social, economic and health policies and addresses the determinants of women's lives in their communities. The increasing feminization of poverty and the increasing time stress in the lives of women are results of the failure to take women's needs into account in other policies and programs. More effort is needed to reduce health inequities by addressing factors that result in inequitable health outcomes (economic, social, political and environmental) (Labonte, 1997). This can be accomplished through the establishment of innovative programs that mitigate health inequities by reducing income inequities and social exclusion and by the establishment of Health Impact Assessments as a critical component of governmental decision-making.
- Although the overall *Strategy* promotes gender equality in health, **gender-based analysis (GBA)** needs to be integrated into all the objectives and commitments made in the *Strategy*. Moreover, the *Strategy* requires all departments within Health Canada to share equally in the implementation of GBA. This responsibility cannot be downloaded solely onto the Bureau of Women's Health and Gender Analysis. Effective monitoring and evaluation should be undertaken on a regular basis. Health inequities can only be remedied if they are recognized. Moreover, GBA efforts at Health Canada need to expand to all other areas of government policy, and policy makers need to recognize the relevance

and importance of this perspective for developing effective and efficient policy. GBA is not an end in itself, but rather a tool – one that needs use. Increasing community capacity to monitor GBA initiatives is needed as well.

- A more comprehensive approach that sees health issues in their full social, spiritual and cultural contexts is needed. Such an understanding can only come from speaking to women themselves and finding out what their health care priorities are. As the results from a national consultation held recently concluded, there is “the need for a further and fuller explanation of what many women in the country consider to be their health priorities, e.g. poverty and equity issues” (RIWC, 2005). **Women-centred care** models can be helpful in this regard. An excellent example of this, prepared by the Vancouver/Richmond Health Board (2000), argues that a women-centred care framework should have the following 12 elements: need for respect and safety, the importance of empowering women, involvement and participation of women, collaborative and inclusive work environments, women’s patterns or preferences in obtaining health care, women’s forms of communication and interaction, the need for information, women’s decision-making processes, a gender-inclusive approach to data, gendered research and evaluation, gender sensitive training, and social justice concerns.
- Despite stating that it will be sensitive to issues of **diversity**, the current *Women’s Health Strategy* does not adequately take into account the diversity and health inequities among women: women who are poor, women with disabilities – both mental and physical, Aboriginal women,

older and elderly women, and immigrant, refugee and other racialized women. In general, more attention is needed on the relationship of not only sex and gender but also other intersecting forms of discrimination and oppression. And, when arguments are made about the significance of gender, these must transcend the essentialization associated with biomedical explanations, which downplay diversity among women and fall in the trap of treating all women as equivalent (Weisman, 1997).

- Communication among researchers in all distinct areas of health research inquiry needs to be improved to promote: inter and trans-disciplinary investigations; mixed methods approaches; participation of NGOs, women’s organizations, and women consumers in setting research priorities; and in the end, facilitate a comprehensive understanding of women’s health and establish a valuable approach to measuring, monitoring and, ultimately, improving all Canadian women’s health. More recognition needs to be given to the role of non-Western scientific traditions and knowledge as well as traditional and indigenous health approaches, techniques and beliefs (i.e. complementary medicine).
- We need to ensure that any strategy for women’s health is a living, flexible framework, one that is able to identify, clarify, accommodate and prioritize new and emerging issues. It must be properly resourced to span departments within Health Canada and all departments of the federal, provincial and territorial governments. Effective and meaningful mechanisms for monitoring and evaluation must be put into place.

Clearly, as Canada assesses its success in

responding to its international commitments, and in particular the Beijing Platform for Action and the Outcome Document of the Twenty-Third Special Session on the General Assembly (UN, 2000a), an ideal opportunity exists to consider Canada's track record in the area of women's health. While some improvements have been made, current obligations need to be solidified politically and financially. In particular, the *Women's Health Strategy* needs to be

renewed and revised so that it can better respond to the myriad of outstanding issues highlighted in this report: the inadequacies of gender-based analysis, health care services, prevention programs, research and evaluation. Accommodating and addressing the complexities of gender and sex differences as well as other intersecting social health determinants is essential for improving the health related quality of care and life for women and for promoting any agenda for gender equality.

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