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Social Justice and Women's Health: A Canadian Perspective

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Executive Summary

Social justice is based on the idea that all members of society have an equal access to the various features, benefits and opportunities of that society regardless of their position or station in life. Alternatively, a lack of social justice in health can be seen as a risk factor for increased illness, disease (morbidity) and mortality. Creating a health care system that is congruent with the goals of social justice appears to have the potential to contribute to the improvement of women's lives.

This paper examines the extent to which the Canadian health care sector protects and promotes social justice and in particular women's right to health. Gender barriers to physical and mental health are examined. Inequities and injustices that women experience in their interactions with the health care system are revealed. The paper also discusses why gender disparities persist and investigates what areas of the health care system need to be reformed to incorporate social justice into health for women. The author argues that framing women's health in the discourse of human rights is a prerequisite to social justice. However, in themselves, right have no meaning if they are not promoted and protected. Recommendations are suggested for what improvements would be desirable both within the health care system and beyond its confines.

INTRODUCTION

Social justice is based on the idea that *all* members of society have an equal access to the various features, benefits and opportunities of that society regardless of their position or station in life. The importance of social justice in the field of health has been expressed by Canadians.[1] There is an assumption that applying the values and principles of social justice to health leads to more democratic, just communities where people generally enjoy healthier lives. Alternatively, a lack of social justice in health can be seen as a risk factor for increased illness, disease (morbidity) and mortality.

Struggles for social justice are often articulated as struggles for fundamental rights and freedoms. Health is widely recognized as a fundamental right of citizenship. According to the World Health Organization:

> ...the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economics or social condition (WHO 1948).

Moreover, numerous international platforms exist that explicitly focus on *women's* right to health as an integral component of human rights protection and promotion.[2] This was recently reaffirmed at a follow-up session to the Fourth World Conference on Women in Beijing,[3] by the United Nations Commission on the Status of Women in the following:

> The realization by women of their right to the enjoyment of the highest attainable standard of physical and mental health is an integral part of the full realization by them of all human rights, and that the human rights of women and the girl child are an inalienable, integral and indivisible part of universal human rights.[4]

International conventions, documents and platforms obligate the global community – including Canada – to take concrete action to eliminate all forms of discrimination against women.[5] This includes positive steps aimed at respecting, protecting, and fulfilling women's right to health care.[6] Measures to eliminate discrimination against women are considered inappropriate if a health care system lacks services to prevent, detect and treat illnesses specific to women.

Creating a health care system that is congruent with the goals of social justice – in particular framing women's health as a fundamental human right appears to have the potential to contribute to the improvement of women's lives. And yet, despite the fact that women's right to health is recognized, there is a lack of social justice in the Canadian health sector. Numerous barriers exist which prevent women from enjoying the highest attainable standard of physical and mental health. Women continue to experience injustices and inequalities in their health status and in their interactions with the health care system. One can conclude that, "it does not suffice to just have rights. Neither is it enough that these rights be officially recognized. What is necessary is that there be conditions which permit these rights to be exercised."[7] The purpose of this paper is to discuss why gender disparities persist and to reveal what areas of the health care system need to be reformed to incorporate social justice into health for women.

WOMEN'S RELATIONSHIP WITH THE HEALTH CARE SYSTEM

Arguably, one of main reasons that gender disparities remain is that the health care system[8] does not adequately recognize the impact of sex and gender on women's health. Biological factors such as the menstrual cycle, reproductive functions and menopause differentiate

women from men. In addition, gender-based discrimination and inequalities are contributing factors in health disparities between women and men. Women's health status is affected by a host of social, cultural, political, and environmental determinants attributable to gender. These remain largely uninvestigated but impede on women's abilities to acquire the basic resources and necessities for a healthy life. Moreover, sex and gender-based differences lead to distinct needs and interactions vis-à-vis the health care system. For example:

- *Women are the greatest consumers of the health care system*

  In Canada, women have a longer life expectancy than men. However, they also spend a greater proportion of their lives in poorer health and therefore experience distinct life trajectories.[9] Often this is linked with health problems connected with reproduction, violence against women, depression, and effects of aging (WHO 1998).

- *Women are overly represented among the poor*

  In Canada, 20% of women live in poverty, and women make up 70% of all people living in poverty.[10] Poverty is one of the strongest indicators of poor health (Cohen 1994, Doyal 1995). And yet, as Susan Sherwin (1996: 198) notes: "the fact that people with low incomes are much less likely than others to have access to adequate nutrition, proper exercise, home and work environments free of toxins, and needed stress management programs surely falls into the category of justice in health care, but it is often overlooked in discussions of this topic."

- *Women are the principal care providers in family and principal managers of family health*

  Women are often the primary caregivers to children, spouses, elderly and disabled relatives. They have the responsibility of recognizing ill health and seeking medical care when a health problem emerges. Recent health reform including deinstitutionalizaton has resulted in greater health care responsibilities for women without support of community services (Anderson and Reimer Kirkham 1998).

- *Women are a majority of health care workers* (i.e., nurses, occupational therapists, physiotherapists, etc.)

  Arguably, creating a health care system that is congruent with the goals of social justice has to recognize the existence and impact of sex and gender differences which have significant implications in the lives of women including their special health care needs. Further, it requires recognition that women, and groups of women, will differ from men and indeed other groups of women in their health and health care needs. Women are not a homogenous group. Any policy or program needs to recognize of how other determinants of health such as class, race, ethnicity, race, ability, sexuality, geography interact with gender. Differences among women, however, do not necessarily entail competing or divisive oppressions. Instead they can be interpreted as intersecting inequalities (Chancer and Buch Baskatte 1997) that the health care system needs to acknowledge.

SOCIAL JUSTICE

A second reason why gender inequities permeate the health care system is linked to the kinds of social justice models which have been applied to measuring the fairness of the system. The concept of social justice can have different

meanings in different contexts. As a political concept, social justice has a long theoretical tradition. Most social justice research deals with state action to distribute resources through its political, health and legal systems. The field has developed most rapidly since the 1940s with four distinct perspectives emerging: relative deprivation,[11] distributive justice,[12] procedural justice,[13] and retributive justice.[14] The most significant advances have been in the area of distributive justice. Distributive justice models are especially significant in the context of health care. Indeed, it is the model most often discussed and debated within the field of health to measure fairness and equality in allocating resources and distributing burdens and benefits of health care. Questions of fair and equal distribution have been clouded by cost containment policies of the 1990s. Financial considerations seem to have trumped considerations of social justice in the health care sector. Increasingly, health care is viewed as an economic commodity rather than a social right of citizenship. Efficiency is relevant to the health care system. However, so are moral values, such as humaneness, generosity and justice (Smurl 1994).

More importantly, while there is a need to consider how health care resources are distributed and what standards are utilized to justify such allocation, arguably distributive justice is inherently limited in its capacity to created the necessary conditions required for true social justice in the health care system. This model is often based on the assumption that all citizens have an equal opportunity to achieve optimum health because all have an equal access to health care (Anderson and Reimer Kirkham 1998). However, as Iris Marion Young points out, justice cannot be reduced to questions of resource distribution because such measurements obscure important consideration about social structures and organization.[15] Various forms of oppression based on gender, race, class which translate into social injustices including exploitation, marginalization, powerlessness and violence both within the health care system but *also outside of its perimeters* are hidden by the equality rhetoric of this paradigm. Simply "equally" distributing health care resources is inadequate without recognizing the wider context in which the health system operates and without recognizing the impact of external social factors influencing health. As Susan Sherwin (1996: 201) correctly notes:

> Many of the continuing health care problems in western societies can be explained by the fact that large segments of the population still suffer from inadequate access to the necessities of life and health: proper nutrition, clean water, adequate housing, prenatal care, safety from physical and [sexual] violence, protection against toxic chemicals in the environment, and a strong sense of self esteem.

Women's health is therefore clearly affected by more than just the internal operations of the health care system. Health reform is therefore inherently limited in its ability to bring about social justice without a commitment to changing social conditions which constrain health and create vulnerability for women to carry the heavier burden of illness and poor health. At the same time, however, the health care system itself needs to examined and evaluated for its adherence to social justice and in particular, promoting women's positive right to health. And at a minimum, the gender neutral goal of equality which appears to currently underpin the Canadian health care system should be replaced with a substantive objective of equity.

EQUITY

Misunderstandings of the meaning of equity often occur because it is a term frequently used interchangeably with equality. Equality is a concept that is based on individual merit and

market justice. Equity refers to conditions largely out of an individual's control that create unjust differentials in health status (Whitehead 1991).

Equity and inequality are clearly defined by Draper (1989) in the following:

> If you live longer than I do or if you suffer from less sickness and disability, our health status is unequal. There is inequality between us, but no necessarily inequity. The difference may not result from our living conditions that may be essentially the same, but from accidents, genetics or lifestyle choices.
>
> If however, the differences in our health status result from different living conditions, mine being less satisfactory than yours, a question of inequity arises. I may have less access to nutritious foods, difficulty in finding decent housing or high-quality health care sensitive to my particular needs. My income may be lower, and my work stressful and demoralizing, punctuated by frequent periods of prolonged unemployment. In this case, inequalities in health status are the result of inequities in life.

Equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that none should be disadvantaged from achieving this potential, if it can be avoided (WHO 1998: 26). Conversely, inequality is caused by differences which are *avoidable* and *unnecessary* and moreover are considered *unfair* and *unjust* (Whitehead 1992). Based on this approach, the goal or objective is not the elimination of **all** health differences but elimination or reduction of those factors that cause avoidable health differentials. Thus equity in health is concerned with creating the opportunities for attaining full health potential and reducing health differentials "down to the lowest possible level".[16]

GENDER EQUITY

Perhaps one of the most clear articulations of what gender equity in health entails is detailed in the Pan American and World Health Organization's Subcommittee on Women, Health and Development's 1998 report *Toward Gender Equity in Health Sector Reform Policies.* It reads as follows:

1. With regard to the state of health: the elimination of unnecessary, unjust, and avoidable differences between men and women and their potential for enjoying good health and in their likelihood of becoming ill, disabled, or dying from preventable causes.
2. In the access to and the utilization of health services: that men and women receive care in accordance with their needs
3. In the financing of care: that both women and men contribute in accordance with their economic capacities and that women are not obliged to contribute more than men by reason of the biology of reproduction and their greater longevity.
4. In participation in the development of health: the health care activities, whether remunerated or free, be recognized, facilitated, and appropriately valued, that women and men share in decision-making on an equal footing in the micro and macro spheres of the health care system.

THE CANADIAN HEALTH CARE SYSTEM AND GENDER EQUITY

Canada is credited as having one of the best health care services in the world (Anderson and Reimer Kirkham 1998). The *Canadian Health Act* sets out principles that constitute

the framework of the Canadian health care system. According to the Act:

> The primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.

The Canada Health Act is based on the principles of accessibility, universality, comprehensiveness, portability, and public administration. It is important to note that equity does not form an explicit part of the statement of objectives of the *Canada Health Act.* However, because of its universal health care system, Canada is considered to be an equitable system because services at the point of delivery are free. Moreover, there now exist numerous documents that broadly support equity or where equity is emphasized as an essential component of the value system which underpins Canadian health policies and strategies. These include the *Canadian Charter of Rights and Freedoms*,[17] *Ottawa Charter for Health Promotion*,[18] *Setting the Stage for the Next Century: The Federal Plan for Gender Equality,*[19] and more recently, *The Women's Health Strategy* in which Health Canada identifies women's health as a priority and has developed a strategy to begin responding to women's health concerns. The Strategy states that when interpreting and enforcing the Canadian Health Act, the government will consider the particular needs of women by ensuring that gender impacts of policy interpretations or changes are fully assessed (p. 21). The Women's Health Strategy has four objectives:

1. To ensure that Health Canada policies and programs are responsive to sex and gender differences and to women's health needs.
2. To increase knowledge and understanding of women's health and women's health needs.
3. Support the provision of effective health services to women.
4. Promote good health though preventative measures and the reduction of risk factors that more imperil the health of women.

The Women's Health Strategy can been seen as the culmination of the efforts of the women's health movement in Canada[20] and the growing government recognition of women's health care needs that began after the 1985 United Nations Conference on Women in Nairobi where strategies for improving women's health globally were outlined.[21]

EVALUATING CURRENT SITUATION

In the Canadian health care system, social justice should be measured as: 1) the "right *to* health care" and 2) the "right *in* health care". The former refers to issues of access. Measuring whether a health care system is consistent with the goals of a social justice perspective, however, requires taking into account more than the issue of access. Gender equity in health should be understood as more than just the absence of discrimination on the basis of a person's sex in opportunities and the allocation of resources, benefits, or in access to services.[22] It is equally important to consider women's right *in* health care which deals with issues of quality of care once one enters into the system. Measuring the actual outcomes of policies, programmes and services within the health care system is essential for assessing the extent to which gender disparities are reduced and women are being positively impacted.

Despite the mechanisms that are in place to realize gender equity in health and other sectors of women's lives which may impact on

health status, social justice for women in the health care system is far from being realized. In order to describe a certain situation as inequitable the cause has to be examined and judged to be unfair in the context of what is going on in the rest of society. Certainly not all gender inequities in health can be solved exclusively within the health sector and social justice efforts may often need to extend beyond the realm of the health care system. And yet, there are many limitations to the health care system itself. The following areas need further attention, research, evaluation if Canada is to be successful in realizing health as fundamental right of citizenship for women.

Gender Differences in Access to Health Care

Universal access to comprehensive health care and health services is one of the most important components of equity in the health care system. Historically, Canada has been praised for providing a system which is free of user fees for all of its citizens. This leads to the assumption that in Canada everyone has equal access to quality health care. However, there are many obstacles to access including:

- De-funding and under-funding of women-centered and controlled health facilities (NAC 1998) raises barriers to equitable access to services which women need.
- Access to basic reproductive health services such as abortion and midwifery are uneven across the country. In the case of the former, the ongoing threat of criminalization presents a continuing threat to access.
- Ease of access to health care services is disparate in urban vs. rural communities.
- Health care costs extend beyond doctors' and hospital fees. Many Canadian women do not have coverage of other important health needs including dental care, eye care, prescription drugs, home care (ie.for the disabled and elderly), and special diets. There is also some signs of extra-billing for basic services. One province is charging $5 fees to cover disposable supplies and instrument sterilization for Pap smear testing.[23]
- Health care services are designed for middle-class Canadians who are fluent in English and who have Euro-Canadian backgrounds. For women who are members of different groups, the health care system is not necessarily culturally responsive or *accessible* to them (Anderson and Reimer Kirkham 1998).
- Accessibility is also a class issue. Hours of operation for many health services conflict with regular work hours. There are segments of Canadian women who are unable to miss work, cannot afford lost wages or cannot absorb transportation costs associated with seeking health care. Similarly, women with childcare responsibilities cannot always pay for child care while attending to their health care needs.
- Privatization is being seriously contemplated and some provinces are considering the implementation of the 2-tiered health care system based on the ability to pay (CCPA, Choices 1998).
- Numerous socio-economic policy developments are threatening access to health care that have unique repercussions for women. The implementation of the Canada Health and Social Transfer is influencing how much the federal government can influence provincial spending and set national standards in the area of social policy. When one considers the significant cuts to all systems which affect or have the potential to affect

women's health it is clear as Armstrong argues that Canada is "moving away from an equity agenda" (Armstrong 1996: 145).

Gender Biases in Medical Research Informing Health Care Services and Treatment

Power differences permeate research priorities, treatment modes, and the production of medical knowledge (Lorber 1997). Because research carriers both benefits and burdens, equity requires that no one group receive disproportionate benefits or bear disproportionate burdens of research (Institute of Medicine 1994). To exclude women or to have them underrepresented in clinical trials[24] or other important areas of health research is inequitable and places women at an unfair disadvantage. Similarly, to focus narrowly research on stereotypical women's health issues carries enormous social and economic costs.[25]

And yet, a growing body of literature has emerged documenting the gender bias in health research which includes a bias not only in the selection of research topics but also in the design of such studies (WHO 1998). It is now generally recognized that medical research has been and continues to be gender-biased. The topics chosen, the methods used and the subsequent data analysis all reflect a male perspective in a number of important ways (Rosser 1994).

There is a range of illnesses and chronic disease that have not been adequately researched for women and specifically for different groups of women.[26] The need continues to increase knowledge of the causes of diseases and treatment options unique to women (i.e., ovarian, cervical and breast cancers), of those more common in women (e.g., multiple sclerosis, lupus, osteoporosis, rheumatoid arthritis), and of those less well understood in reference to women (e.g., cardiovascular disease, HIV/AIDS, pharmaceutical drugs treatments, naturopathic and other treatments).

Research in health must also seek to understand the influence of, for example, poverty, social and economic exclusion, working conditions, multiple roles, caregiving, and violence on women's health. Canadian research on the social determinants of women's health is in its early stages and much more needs to be directed to questions of the effects of social and cultural contexts of women's lives on health and illness.

Certainly there are groups nationally conducting research in a broad range of women's health issues.[27] The emergence of the Canadian Women's Health Network and five national Centres of Excellence for Women's Health whose focus is on collaborative, participatory research of the social determinants of women's health are also considered important developments for linking individuals and groups concerned with women's health and for producing policy-relevant research.[28] Currently, tranformations to health research are being proposed by the establishment of the Canadian Institutes of Health Research. The highly political struggles over what type of Institutes should be established may pose an increased threat to the future of women's health research in Canada.

Gender Inequalities in Quality of Care

Canadian women have questioned some of the fundamental approaches to how health care services are delivered and have interrogated accepted assumptions of "quality of care". Appropriate care can be defined as "the right service, at the right time, delivered by the right person in the right place". There are, however, considerable obstacles to appropriate, quality of care for women. Firstly, women are underrepresented in all positions of power

within the system. Senior positions such as physicians, administrators or policy-makers are male-dominated. For example, women represent approximately 24% of all Canadian physicians and less than 7% of the Canadian Medical Association positions are held by women (Birenbaum 1995). This has an impact on how seriously gender is taken into account within the system.

Moreover, health care institutions and their practices remain Eurocentric and classist (Anderson and Reimer Kirkham 1998). Consequently, there is a lack of cultural competency and sensitivity to understanding women from diverse social and cultural communities. Women from these communities are increasingly revealing the barriers having their health care needs met (Tudiver and Hall 1996). Among those women who report experiencing profound marginalization are: lesbians, women with disabilities, aboriginal women,[29] immigrant and refugee women, rural and farm women.

According to Tudiver and Hall (1996), women have identified the following as affecting their quality of care:

- differentials of power and authority between the roles of doctor and patient, feeling intimidated to question professional expertise or refuse treatment
- sexist and paternalistic attitudes and behaviours that may influence the interactions between male doctors and female patients and may affect treatments, as in unnecessary hysterectomies, or result in abuse, i.e., 43% of Canadian women have changed doctors because they were dissatisfied with the way they were being treated (Four of the six most frequent reasons were related to the "doctor's attitude" – Women's College Hospital Health Survey, March 1995.)
- severe time constraints on most medical encounters which limit communication between patient and caregiver
- lack of sufficient information and access to resources to make informed decisions about proposed treatments
- fragmented care, so that a patient requiring coordinated care feels she is no more than the sum of her body parts
- inappropriate use of technologies, drugs, and devices

CONCLUSION

Lingering inequities certainly call into question the efficacy of using a human rights framework for the promotion and protection of women's health. Framing women's health in the discourse of rights, however, is a prerequisite to social justice. At the same time, rights have no meaning unless they are promoted and protected. For women's health this requires concrete changes to improve women's lives both outside the perimeters of the health care system but also, within the system itself. Social justice therefore is a threat to the status quo. However, this should not deter the work required to end gender discrimination and to secure better lives for women. The changes in health care should reflect consideration of equity which extend beyond the confines of distributive justice. To this end, policy decision-makers, advocates, women's health professions, researchers, and community organizations may want to consider the following in their work towards incorporating social justice in women's health:

- the establishment of a women's health equity act
- the development of a women's health model which incorporates biomedical and social determinants perspective

- analyzing the relationship between gender mainstreaming and women-focused holistic care, research and policy
- involving women consumers in the design, implementation and evaluation of all health policies and programmes
- estimating the significant costs of social injustice in responding to women's health
- disaggregating all health data by sex, age, and socio-economic status
- identifying innovative quantitative and qualitative methods to document gender inequalities in the health care system and other sectors impacting on women's health
- gender-sensitivity[30] and gender-awareness[31] training for all policy analysts
- evaluation of all relevant health policies and research
- investigation of multi-sectoral responses to women's health as more efficient, effective approach than relying solely on the health care system as the policy area responsible for people's health and well-being

References

1. See National Forum of Health *Maintaining A National Health System: A Question of Principle(s) - and Money* Ottawa: Health Canada, 1996.
2. United Nations Charter 1945, United Nations Universal Declaration of Human Rights, International Covenants on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights, 1966.
3. See United Nations, Platform for Action in *Report of the Fourth World Conference on Women, Beijing,* September 4-15, 1996.
4. Revised draft agreed conclusions on women and health submitted by the Chairperson of the Commission, United Nations Economic and Social Council, Commission on the Status of Women, 43rd Session, March 1-12, 1999.
5. This task is largely the responsibility of Status of Women Canada.
6. Paragraph 12 1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care.
7. T. Douglas addressing the Canadian Labour Congress, Edmonton, 1970.
8. I refer to the "system" as a wide-spectrum of public arrangements and institutions for health care including hospitals, health clinics, community centres, health insurance and other relevant social services. It also includes all the actors which shape and influence the system including policy makers, health care providers.
9. Tudiver and Hall, 1996.
10. Joan Grant Cummings, M. Ann Phillips, NAC Health Committee, 1998.
11. This research is concerned with the satisfaction and dissatisfaction that people experience in the distribution of goods and services. It is closely linked to comparisons between what people have and alternatively, feel that they deserve (Tylor 1997).
12. This stream is concerned with the fairness of outcome distributions of goods and services, pay and promotion.
13. Procedural justice deals involves that examination of the fairness of different ways of resolving conflicts or making allocations.
14. This field of justice research is focused on the breaking of social rules and the implications of this kind of behaviour.
15. See *Justice and the Politics of Difference* (Princeton: Princeton University Press, 1991).
16. Whitehead, 434.
17. Section 15 (1) states:

    Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age, or mental or physical disability. Moreover, Section 28 states that: Notwithstanding anything in this Charter, the rights and freedoms referred to in it are guaranteed equally to male and female persons.
18. The Ottawa Charter states that: "The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. Improvement

in health requires a secure foundation in these basic prerequisites." It identifies a general strategy consisting of three interlocking components: (1) intersectoral action to achieve healthy public policy as well as public healthy policy, (2) affirmation of the active role of the public in using health knowledge to make choices conducive to heath and to increase control over their own health and over their environments, and (3) community action by people at the local level. Strengthening public participation and public direction of health matters is at the heart of the health promotion strategy.

19. In this document, the federal government states its commitment "to ensuring that all future legislation and policies, include, where appropriate, an analysis of the potential for different impacts on women and men" (p. 17).

20. Beginning in the 1960s women began voicing concerns over rights to reproductive freedom (Cornice 1990), overmedicalization of women, pregnancy and childbirth (Armstrong 1993; Pierson 1993). Eventually, these issues developed into a wider concerns about health care practices and services for women. The Vancouver Women's Health Collective (Kleiber and Light 1978), *Health Sharing* magazine and in 1982 Canadian Women's Health Network are all examples of responses to critiques of the health care system and need to raise awareness and actively participate in facilitating changes to meet women's health care needs. It was also the women's health movement that pioneered community-based approaches to women's health care and pressed for the recognition that social determinants such as poverty, unemployment and violence affect women's health (Cook and Michensios 1996).

21. 1986 Department of Health and Welfare conducts survey on women' s health issues

    1988 National Symposium: Changing Patterns of Health and Disease in Canadian Women

    Establishment of a Federal/Provincial/Territorial Working Group on women's health issues

    1990 Publication of *Working Together for Women's Health: A Framework for the Development of Policies and Programs*

    1992 Publication of *Breast Cancer: Unanswered Questions, Report of the Standing Committee on Health and Welfare, Social Affairs, Seniors and the Status of Women*

    SSHRC and Health Canada establish funding for five Research Centers in Family Violence and Violence Against Women and six Centres for Health Promotion of Women's Health

    1993 National Forum on Breast Cancer Research and initiation of The Canadian Breast Cancer Research Initiative

    Establishment of Women's Health Bureau

    1994 Canadian Advisory Council on the Status of Women holds a national symposium entitled "Working in Partnership: Working Towards Inclusive, Gender-Sensitive Health Policies"

    1995 Health Canada announces the establishment of five Centres of Excellence for Women's Health and a Women's Health Network

    1996 Canada/US Forum on Women's Health

22. WHO Gender and Health Technical Paper (1998).

23. Robert Chisholm, NDP Health Critic, October 28, 1997.

24. See M. Eichler et al. (1992), "Gender Bias in Medical Research", *Women and Therapy* 12, 61-72 and V. Merton (1994), "Review Essay: Women and Health Research", *Journal of Law, Medicine and Ethics* 22, 272-279.

25. Over 70% of research funding in 1994 and 1995 at SSHRC, MRC and NHRDP was alloted to issues of reproduction.
26. For example, Aboriginal women contract cervical cancer at much greater rates than the rest of the female population.
27. These include among others: the Toronto Hospital Women's Health Program, Women's College Hospital Centre for Research in Women's Health, York University Centre for Health Studies, Women's Health Academic Program Council, University of Ottawa, McMaster University, Women's Health Bureau, Winnipeg Women's Health Clinic and BC Women's Hospital and Health Centre, Centre d'études des interrelations biologuiques entre la santé et l'environment, Université du Québec à Montreal.
28. These centres are being criticized for not meeting the needs of women who have been traditionally marginalized and for not being in primary control of grassroots women's organizations or having mechanisms in place to ensure the participation of grassroots women from diverse communities (NAC 1998).
29. The Aboriginal Program of the Canadian Public Health Association (CPHA) is being carried out in partnership with national Aboriginal organizations, professional associations of Aboriginal public health workers, and Human Resources Canada. Included in the partnership is the Native Women's Association of Canada and Aboriginal Nurses Association of Canada.
30. Ability to perceive existing gender differences, issues and inequalities and incorporate these into strategies and actions (WHO 1998).
31. Understanding that there are socially determined differences between women and men based on learned behaviour, which affect their ability to access and control resources.

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