

# **Women's Sexual and Reproductive Health in Canada:**

## **A Synthesis of Research by the Centres of Excellence for Women's Health**

### **I. INTRODUCTION**

#### **1.1 Background**

In 1995, Minister of Health, Diane Marleau, launched the Centres of Excellence for Women's Health Program (CEWHP) to improve the health of Canadian women through research that would enhance the health care system's understanding of and responsiveness to women's health issues. Five Centres of Excellence for Women's Health (CEWHs) were selected through a competitive process and founded the following year in Halifax, Montreal, Toronto, Winnipeg, and Vancouver. The Canadian Women's Health Network (CWHN) was established at the same time to provide national coordination of the networking and communications components of the Programme. The CWHN works with the Centres and other interested organizations and individuals at the national, regional, and community level to build links and support the flow of women's health information across all sectors. The Programme is managed by Health Canada's Women's Health Bureau.

Since their inception in 1996, the CEWHs have pursued a broad mandate that includes generating knowledge, providing policy advice, and disseminating information about women's health. Each Centre represents a dynamic partnership of academics, researchers, health care providers and community-based women's and women's health organizations. The Centres do not conduct biomedical or clinical research. Rather, they engage in multi-disciplinary and inter-sectoral work using a determinants of health approach, which recognizes that health is much more than a matter of medical care and that a wide range of social, cultural, political, and economic factors interact to affect people's well-being. It also recognizes that these determinants play out differently in the lives of women and men, girls and boys.

In August 2001, the CEWHP Research Synthesis Group, composed of representatives from each of the five Centres, from CWHN, and from the Women's Health Bureau, identified women's sexual and reproductive health as an important subject for synthesis work. The CEWHs have generated a wealth of research on sexual well-being and reproductive health among Canadian women and girls. It is the purpose of this synthesis paper to elucidate these research findings as well as to identify conceptual or content gaps and make recommendations for future research.

## 1.2 Scope and Structure of the Synthesis

In the fall of 2001, staff at the CEWHs conducted an inventory of research, identifying some 30 documents that deal, directly or indirectly, with the subject of women's sexual and reproductive health. These reports are remarkably diverse in their authorships, in their research questions and methodologies, and in their intended audiences. They range from an eight-page popular booklet that explains the action of estrogen in the body, through scholarly and policy reports dealing with topics such as the ethical dimensions of prenatal and reproductive technologies, to graduate theses that analyse various aspects of women's health care experiences, including access to appropriate health services (See Appendix 1: CEWHs Research). Although these documents constitute a heterogeneous collection, they are linked by a holistic view of women's sexual and reproductive health that both encompasses and transcends definitions traditionally embraced by health professionals, policy-makers, and the public. In the past, women's health was often equated with reproductive health, which, in turn, tended to be reduced to successful conception and childbearing. At the same time, women's sexual health was either absent from medical, social, and policy discussions, or it was treated prescriptively, with doctors, ministers, and politicians dictating the nature of appropriate female sexuality. Since the 1960s and 1970s, however, our conception of sexual and reproductive health has expanded to include the social, economic, political, and cultural realities of people's lives as well as the physical conditions of their bodies. Implicit in this new conception is not only a radically different understanding of women's sexual and reproductive health, but also a recognition that solutions to existing problems and new directions for research and policy are rooted in an inter-sectoral approach.

Because health research, services, policies, and programmes are ultimately shaped by the ways in which we define health, illness, and healing, it is important to understand both the changes and lack of changes in ideas about women's sexual and reproductive health. The synthesis consequently begins with a review of key definitions of women's health – in particular their sexual and reproductive health – that have prevailed during the last century. This section concludes with a close examination of two documents released in 1999 by the Canadian government: *a Report from Consultations on a Framework for Sexual and Reproductive Health* (hereafter referred to as *Framework*) and the *Women's Health Strategy* (hereafter referred to as *Strategy*). These two reports are important for a number of reasons: first, because they capture many public and policy perceptions of women's sexual and reproductive health, and; second, because they help to inform current discussions and debates about the sexual and reproductive health of Canadian women, and set the stage for decisions about future directions in policy, programming, and research. As stated in *Framework*, “the Report presents a starting point for developing the next steps. ... [to] guide collaborative action in determining and addressing the most important and urgent priorities, while ensuring that any actions we take now lay a sound foundation for the future”.

In elaborating a framework for programme and policy development, these reports also provide a valuable blueprint for reflecting upon the work of the CEWHs. The remainder of the synthesis analyses selected CEWHs reports and publications as they relate to each of the seven strategic directions

outlined in *Framework*: i) personal choices; ii) societal values; iii) access to services; iv) physical environment; v) families and communities; vi) social and economic conditions; vii) research, evaluation, and information. In this way, we can hope to appreciate new knowledge in the field of women's sexual and reproductive health produced by the CEWHs, and to identify persistent gaps in Canadian research, policy, and programming.

## **2. THEORIZING WOMEN'S SEXUAL AND REPRODUCTIVE HEALTH**

### **2.1 The Traditional View**

Historically, women's sexual behaviours and reproductive roles have been studied, feared, debated, and policed. Western societies, whether denouncing female sexuality as immoral or celebrating motherhood, have seldom regarded women's sexual and reproductive capacities with indifference. Indeed, ideas about women's bodies were and still are woven into the fabric of civil society, from the institutions and rules of governance through cultural rites and symbols to the research questions posed by doctors and scientists (Duden, 1991; Ehrenreich & English, 1974; Fausto-Sterling, 1992; Laqueur, 1990; Jordanova, 1989; Ladd-Taylor & Umansky, 1998; Laqueur, 1990; Lupton, 1994; Mitchinson, 1991; Scott & Morgan, 1993; Suleiman, 1986; van den Wijngaard, 1997).

Female sexual and reproductive health have long been defined narrowly, in terms of the ability to conceive and bear a number of healthy children (Arnup, Levesque, & Pierson, 1990; Gallagher & Laqueur, 1987; Leavitt, 1986; Mitchinson, 2002; Moscucci, 1990). In fact, theologians and scientists of the 19<sup>th</sup> century believed that women themselves could be reduced to their reproductive function. As one physician remarked in 1895, "Will we never make our skirted publishers and sociologists in dresses understand that a woman is neither equal nor inferior nor superior to a man, that she is a being apart, another thing, endowed with other functions by nature than the man with whom she has no business competing in public life? A woman exists only through her ovaries"(Laqueur, 1990:149). Such ideas had predictable consequences for the care of women. Every illness, every behavioural anomaly was explained by reference to malfunctioning or malformed reproductive organs, and therapies of all kinds targeted the uterus and ovaries (Lorber, 1997; Mitchinson, 1991).

Although Western society has changed a great deal during the 20th century, ideas about women's sexual and reproductive health have not always kept pace. Research on the female hormonal cycle in the 1930s, for example, served to entrench biological determinism as an explanation for health and illness in females (Chrisler & Levy, 1990). Women might be able to vote, but they were still ruled by their bodies. This is not to suggest that women did not benefit in any way from developments and discoveries related to sexual and reproductive health. Antibiotics saved thousands from the depredations of sexually transmitted infections (STIs), including dementia, infertility, and death, while new forms of contraception, particularly the birth control pill, allowed women to explore their sexuality and sexual health independent from their reproductive capacity. Nonetheless, many of these technical innovations have been based on traditional views of women's bodies and pose serious threats to

women's physical, mental, and social well-being. As Lupton notes, "The freedom from worry about contraception provided by the pill and the associated potential for sexual enjoyment comes at the cost of long-time medicalization and potential health-threatening side-effects (Lupton, 1994: 140. See also Faulkner & Arnold, 1975; Marks, 2001; Meyer 1997; Wajcman, 1991; Walsh, 1980; Watkins, 1998). At the same time, women's health continues to be equated, consciously or unconsciously, with reproductive issues while women themselves are still sometimes reduced to their reproductive biology. Critiques of biomedical research in the United States, for example, reveal that female subjects are often omitted or excluded from clinical investigations on cardiovascular diseases because their hormonal cycles are deemed to be complicating variables (Cotton, 1990; Dresser, 1992; Rosser, 1991).

## **2.2 A Determinants of Health Approach**

In 1974, Canadian Minister of Health Marc Lalonde released a report, entitled *A new perspective on the health of Canadians*, that heralded a fundamental shift in our understanding of the meaning of health, the causes of illness, and the nature of our response to disease. He argued that health is not only a product of human physiology, but also of the social and physical environments in which we live, work, and play. "It is evident now," he wrote, "that further improvements in the environment, reductions in self-imposed risks, and a greater knowledge of human biology are necessary if more Canadians are to live a full, happy, long and illness-free life." (Lalonde, 1981: 6) Much of the earliest work in this area examined the relationship between poverty and health (Antonovsky, Zola & Kosa, 1969; Davis, 1978; Ewig & Krasner, 1989) While the effects of poverty on health continues to absorb the attention of researchers, the variable has become more nuanced, including both the social and economic impact of income on health status and access to health care. (Backlund, Sorlie, & Johnson, 1996; Hay, 1994; Lynch, 1996; Raphael, 2001; Townson, 1999) At the same time, Lalonde's original "health field concept" – known now as the determinants of health – has been elaborated in a variety of ways: to make explicit reference to additional determinants of health, such as gender, sexual orientation, and ability; to reflect the complex interplay among determinants of health, particularly for those experiencing intersecting inequities, and; to acknowledge both collective and individual responsibility for health and care (Anderson, 1998; Bloom, 2001; Cattell, 2001; Doyal, 1995; Foster, 1995; Goldman & Hatch, 2000; Graham, et al, 2001; Kishnuk, 2001; Marmor, Barer, & Evans, 1994; Marmot & Wilkinson, 1999; Mustard, 1991; Raphael, 2002).

It has also opened an avenue for researchers to move beyond biological determinism in discussing the health of women and girls, including their sexual and reproductive health. Twenty-five years after the Lalonde report appeared, Health Canada released two documents with implications for our understanding of and response to the sexual and reproductive health needs of Canadian women and girls: *Report from Consultations on a Framework for Sexual and Reproductive Health* and the *Women's health strategy*. Both reports are rooted in a determinants of health approach and, together, they exemplify evolving perceptions of women, women's health, and women's sexual and reproductive health. *Strategy* discusses the health status and health needs of women and girls without privileging reproduction or biology while *Framework* examines the sexual and reproductive needs of Canadians without focussing on women and girls. The two reports are complementary in other ways as well.

*Strategy* is a policy document that builds on Canada's commitment to gender equality, in support of the Platform for Action affirmed at the Fourth United Nations World Conference on Women, held in Beijing in 1995. It recognizes systemic gender biases and outlines Health Canada's plans for reforming health research and health care "to make [them] more responsive to women and women's health".

*Framework*, in contrast, is not a policy document, though it arose in part from the recommendations of the 1993 Royal Commission on New Reproductive Technologies. It is the product of consultations with representatives from provincial, territorial, and federal governments as well as from national non-governmental organizations, and it aims to foster a "coherent, coordinated approach for promoting sexual and reproductive health" structured around specific priorities, guiding principles, and strategic directions.

Neither of these documents is perfect (Planned Parenthood & Pro-Choice Action Network, 2001). *Framework* ostensibly addresses both the sexual and reproductive health of Canadians, but it concentrates on reproductive issues, such as low birth weight, teenage pregnancy, infertility and sexually transmitted infections (STIs), rather than on healthy sexuality. *Strategy* points out that "certain groups of women are doubly disadvantaged because of their ethnicity or their sexual orientation or because they have a disability," but it focusses on marginalized women, rather than on the systemic discrimination that is often responsible for poor health and inappropriate care. Both documents bring constitutional issues to the fore as well: they represent federal initiative in an area of responsibility and action that is legally reserved for the provinces and territories. Competition and tension between levels of government may consequently curtail the impact of these analyses of women's health and the sexual and reproductive of Canadians.

Nonetheless, *Strategy* and *Framework* have the potential to affect women's sexual and reproductive health in unprecedented ways. In adopting a determinants of health framework, the reports underscore the need for a more holistic view of health and a more comprehensive approach to reforming health care, including changes in both attitudes and practices. As the authors of *Strategy* note: "Only recently have health policy makers and health service providers acknowledged in a tangible way the extent to which social, economic, and cultural factors influence health. Similarly our health system has been slow to recognize that sex and gender are ... significant determinants of health". At the same time, these two documents outline principles for maintaining, protecting, and promoting health as well as strategic directions for collaborative research, policy, and programming initiatives that are relevant for understanding and improving the sexual and reproductive health of women and girls in Canada. *Strategy* and *Framework* consequently provide a useful structure for a substantive evaluation of research produced by the five CEWHs.

### **III. AN ANALYSIS of WOMEN’S SEXUAL AND REPRODUCTIVE HEALTH in CENTRES OF EXCELLENCE FOR WOMEN’S HEALTH RESEARCH**

#### **3.1 Framing the Analysis**

To a considerable degree, the choice of a structure for assessing the work of the CEWHs is arbitrary. We could easily choose to examine these reports and publications in chronological order, by institution of origin, by intended audience, by methodology, or according to specific aspects of the content. After consulting with staff at the CEWHs, we have elected to utilize the strategic directions outlined in *Framework* because they create an analytical structure that consistently shifts the emphasis from physiology to a consideration of other social, economic, political, and cultural influences on health. At the same time, this approach allows for a genuine synthesis of research because the analysis focusses on cross-cutting themes rather than subject areas. And because “the strategies are quite general, providing a comprehensive yet flexible foundation for development of more specific actions by various partners,” they encourage a constructive analysis of gaps in the research as well as practical recommendations for further work. Finally, this approach sets the stage for evaluating the usefulness and comprehensiveness of Health Canada’s strategic directions for developing a policy framework for the sexual and reproductive health of Canadians.

#### **3.2 Strategic Directions**

The following excerpt from *Framework* serves to elaborate on the meaning of the seven strategic directions around which this analysis is organized.

- a) *Personal choices*. Increase opportunities for all individuals to develop and sustain the knowledge, attitudes, capacities, skills and behaviours needed to make healthy choices about sexuality and reproduction.
- b) *Societal values*. Promote societal values and attitudes about sexuality and reproduction that enable and support healthy personal choices throughout life.
- c) *Access to services*. Facilitate equitable access to effective health services that prevent problems and promote, protect and restore sexual and reproductive health.
- d) *Physical environment*. Reduce risks and conditions in the physical environment that are harmful to sexual and reproductive health.
- e) *Families and communities*. Strengthen the capacity of families and communities to maintain and improve the sexual and reproductive health of their members.
- f) *Social and economic conditions*. Reduce social and economic risk conditions, particularly poverty and discrimination, which limit opportunities to achieve sexual and reproductive health.

- g) *Research, evaluation and information.* Stimulate and support research and evaluation on factors and interventions that enhance sexual and reproductive health throughout life, and ensure availability of information to assist with planning and implementation of effective policies and programmes.

The distinctions between these strategic directions are sometimes quite blurry. Poor social and economic conditions, for example, not only increase risk of illness, but also impinge on access to appropriate care. Similarly, family and community capacity to maintain and improve the sexual and reproductive health of members is delimited by efforts to reduce risks in our physical environment and to alter harmful societal values. Not surprisingly, every report or publication under review here pertains to more than one strategic theme. For the sake of clarity and to avoid unnecessary repetition, we have clustered the reports under their primary theme and have referred to them under secondary or tertiary themes only when it serves to illuminate the analysis.

### **3.2.1 Personal Choices**

Personal choices, such as eating habits and levels of exercise, have frequently been blamed for illness, even when the link between lifestyle and disease is hazy at best (Nelkin & Gilman, 1988; Sontag, 1977; Sontag 1989; Lupton, 1993). Women, in particular, have borne the brunt of blame for a myriad of “problems” associated with sexuality and reproduction; from the inability to conceive and raise healthy children to the spread of STIs (Ladd-Taylor & Umansky, 1998; Spongberg, 1997; Marsh & Ronner, 1996; May 1995; Arnup, 1994; Mitchinson, 1991). Although *Framework* would have benefitted from a stronger statement about the perils of focussing on lifestyle rather than environment as the cause of illnesses, it does shift the emphasis from individual responsibility for “poor” choices to collective responsibility for improving the ability of individuals to make healthy choices. *Strategy* is rooted more firmly in a determinants of health approach, with the result that it explicitly addresses the interplay of personal, social, and economic factors in women’s health, including their sexual and reproductive health.

The work undertaken or supported by the CEWHs, like much feminist health research, advances this strategic direction by seeking to empower women through the provision of knowledge and encouragement to develop new skills. *Women’s Self Care* (2000), a book developed by the Women’s Health Network of Newfoundland and Labrador and produced by the National Network on Environment and Women’s Health, is an excellent example. Its purpose is to increase women’s awareness of their own health needs in order for them to make informed choices for healthier lives, and to help them find effective ways to navigate the health care system to meet their needs. As a result, the book not only details salient health issues and conditions, but also outlines medical procedures and possible ways of coping with stress or distress. With respect to sexual and reproductive health, for example, the book underscores the importance of Pap tests in the prevention and management of cervical cancer, describing both the procedure and the meaning of test results. This section also includes suggestions for dealing with nervousness, such as letting the doctor know that you are uneasy.

*Women's Self Care*, unlike some self-help health guides for women, pays some attention to sexuality, sexual choices, and sexual relationships, exploring issues such as safety in relationships and sexual orientation. Some readers might feel the "advice" is patronizing, as when they are told that whether to have sex "is a big decision that should be thought about carefully. It is a good idea to talk about our decisions with friends (people we trust) and our potential partner"(p.85). Nonetheless, the book reinforces the point that healthy sexuality is a positive and life affirming component of human experience. It also outlines some of the necessary conditions for healthy sexuality, including: self knowledge; opportunities for healthy sexual development and positive sexual experience, and; the capacity for different kinds of emotional and physical intimacy.

*Getting Through Medical Examinations: A Resource for Women Survivors of Abuse and Their Health Care Providers* (2002), produced by the Prairie Women's Health Centre of Excellence, similarly seeks to empower women through the provision of advice for managing medical examinations. Here again, the emphasis is on the ways in which social and economic conditions dictate personal choices. Written in an accessible and popular style, the brochure points out that sexual abuse has potentially devastating effects on women's sexual and reproductive health. It may cause physical as well as emotional damage that has serious consequences for women later in life. Having positive sexual relations, for example, becomes difficult when early sexual experiences are non-consensual and/or exploitive. Physical examinations also become frightening when they incite traumatic recollections of sexual abuse or replicate conditions of powerlessness. The brochure seeks to improve a woman's sexual and reproductive health by outlining practical ways to make medical examinations less distressing for victims of abuse, including: consulting a health care provider she trusts; knowing and exercising her rights; bringing music or a comfort object, such as a favourite sweater, to the appointment; learning coping techniques, such as deep breathing exercises. In this way, the document serves as a resource for women to take control of their health and health care.

Another report supported by the National Network on Environments and Women's Health, entitled *Does Gender Count: Differences in English Canadian Beliefs, Attitudes and Behaviours Towards Breast Cancer and Infertility* (1999), demonstrates salient differences in women's and men's understanding of the causes of breast cancer and infertility. Perceptions of infertility, specifically, are relevant to this discussion because they have the potential to influence personal decisions as well as policy decisions about the provision of services. For example, this study found that women are significantly more likely than men to identify themselves as infertile even though men are commonly infertile. Similarly, women in this study were 6 times more likely than men to be told by their doctors that they are infertile or would have trouble conceiving. Gender bias and sexism, which cast reproduction as a 'woman's issue', are pervasive in our society and in the health care system, and they are undoubtedly responsible for the exclusive focus on manipulation of female reproductive physiology as a solution to infertility. Interestingly, the authors also found that a diagnosis of infertility or knowing someone who has had difficulty conceiving or bearing children tended to alter beliefs about causes as well as treatment preferences. For example, those with more knowledge about or experience with



infertility were typically more interested in alternative and low-tech, non-invasive therapies. This finding challenges the conclusions of the 1993 Royal Commission on New Reproductive Technologies as well as the concerns of many policy makers. *Framework*, for example, presents the costs of in vitro fertilization as a problem for Canadians, without appreciating the full range of personal and social reasons women resort to a painful, expensive, and uncertain medical procedure. The study demonstrates that education on the subject of infertility would not only help women to make more informed choices about their sexual and reproductive health, but would also help to dispel many myths about infertility that currently distort experience, research, policy, and programming.

### **3.2.2 Societal Values**

One of the most important lessons learned from the determinants of health model is that societal values contribute to the onset and exacerbation of illness. Negative perceptions of unwed mothers, for example, have traditionally disadvantaged women and their children (Clow, in press; Ladd Taylor and Umansky, 1998; Soario, 1967; Young 1954). Mental illnesses and disabilities, real or imagined, have likewise resulted in social exclusion of both women and men (Gilman, 1988; Hubert, 2000; Sayce;1999; Thomson, 1997; Wahl, 1999). Among the societal values that impinge on health are those that pertain to ethnicity, language, religion, etc., because they can negatively affect access to services. We will discuss these issues later in the synthesis under the headings of social and economic conditions, and access to services. In this section, however, we want to focus on popular and medical perceptions of human sexuality and reproduction, and their implications for women's health.

The burgeoning field of cultural studies of the body has helped to explicate the many ways in which the human body – particularly the female body – is stylized, disciplined, and commodified in western societies. Sexualized female bodies are regularly invoked by manufacturers eager to sell everything from cars and cigarettes to vacations and medications. Hairstyles, cosmetics, clothing, dieting, exercise, and surgery have become the modern rituals associated with attaining, enhancing, and preserving this ideal (Lupton, 1994; Fausto-Sterling, 2000). But neither the physical ideal itself nor the means necessary to achieve it are healthy for women. Anorexia and bulimia develop more often and at an earlier age as woman and girls strive for thin bodies while cosmetic surgery, such as breast augmentation, has created serious health conditions for many (Stewart, 1998; Stinson, 2001; Brumberg, 2000; Gilman, 1999; Health Canada, 1999b). Moreover, those who do not, cannot, or will not conform to the physical ideal are often at a social disadvantage, as is the case for women who have undergone mastectomy (Gilman, 2000).

Social and medical interpretations of reproductive functions may also create obstacles to timely and appropriate care for women. For instance, the introduction of the vaginal speculum in the mid-19<sup>th</sup> century caused considerable controversy because it allegedly threatened womanly virtues by inciting sexual passions and stripping unmarried women of their virginity (Lupton, 1994). As one writer for the British *Lancet* concluded in 1850, “the female who has been subjected to such treatment is not the

same person in delicacy and purity as she was before”(quoted in Moscucci, 1990: 115). Unfortunately, sexism is not just history. As late as the 1990s, gynecological texts popular in British medical schools still took a dim view of complaints about menstrual pain, dismissing it as a product of sexual frustration, exaggeration, or unhealthy lifestyle (Laws, 1990).

Because *Strategy* explicitly aims “to focus beyond maternity” in its consideration of women’s health – an approach we heartily applaud – it pays limited attention to the impact of societal attitudes regarding sexuality and reproduction. *Framework*, in contrast, recognizes the need to “promote societal values and attitudes about sexuality and reproduction” that will foster healthy choices, but it does not refer to specific attitudes that need changing nor does it define more salubrious values. While we clearly need more research on factors influencing women’s health we must not abandon our efforts to understand the ways in which attitudes to and assumptions about sexuality and reproduction contribute to poor health and poor care for women and girls in Canada. Many reports produced by the CEWHs touch upon this subject, but we will focus on the experiences of two groups of women, lesbians and teenagers, to deepen our appreciation of the relationship between societal values and sexual and reproductive health.

Two studies supported by the Atlantic Centre of Excellence for Women’s Health capture the attitudes and experiences of adolescents and expose serious barriers to sexual and reproductive health among teenagers in Nova Scotia. For example, *So Many Bricks in the Wall: Developing Understanding from Young Women’s Experiences with Sexual Health Services and Education in Amherst, Nova Scotia* (1999) reveals that sexual coercion is not uncommon among young women in Nova Scotia, many of whom may be in relationships with older men. Overt and subtle pressure from male partners may extend to decisions about contraception, which can lead to unwanted pregnancies. Young men also contend with pressures to have multiple sexual partners in order to “prove” their masculinity, and these kinds of social expectations can contribute to the spread of STIs. At the same time, community values may create additional barriers to adolescent sexual and reproductive health. Teenagers who live in highly religious or conservative communities, where pre-marital sexual activity is frowned upon, may find it harder to acquire contraceptives. Adolescents living in small communities are also reluctant to purchase condoms at the local pharmacy because they are sure to be noticed by people they – or their parents – know. Birth control pills offer more privacy, but they do not protect sexually active teenagers from disease.

Together with *So Many Bricks in the Wall*, another report *Adolescent Sexual Health Services and Education: Options for Nova Scotia* (2000), demonstrates the limitations of existing educational strategies. Teenagers complained that sexual health education programmes offered through the schools were neither challenging nor helpful. Adolescent females recommended that teachers should create an environment in which it would be possible to explore feelings and develop ways to manage different sexual situations. Teenagers also noted that while teachers were prepared to discuss pregnancy and STIs, they devoted little or no attention to healthy sexuality: “So they would talk about ... like how to use birth control and a condom. They never talked about sex itself and when people start ... the consequences ... they just kind of skipped right over it ... like they were almost too scared to talk to us

about it” (Langille, Graham, & Marshall, 1999: 11). While some instructors might simply be uncomfortable talking about feelings associated with sexual activity, they may also be bowing to pressure from parents or school boards whose values do not allow them to support public education on this subject.

These reports are valuable for the light they shed on the relationship between societal values and the sexual and reproductive health of adolescents; they also serve as a reminder that researchers and their results do not exist outside of cultural frameworks. In his review of adolescent sexual health services, Langille remarks on the financial costs of teenage pregnancy, including perinatal care, abortion services, and social supports. He also notes that in 1993 alone, 2,700 teenaged mothers in Nova Scotia received social assistance. In this way, Langille echoes the views set forth in the *Women’s Health Strategy*, which depict teenaged pregnancy as a social and economic problem. While we would not want to down play the serious consequences of pregnancy for teenagers, it is worth remembering that adolescent motherhood is accepted, even celebrated, in many other countries and cultures (Geronimus, 1992).

In addition to providing one of the first explorations of lesbian health in Canada, *Out in the Cold: The Context of Lesbian Health in Northern British Columbia* expands our understanding of the relationship between societal values and the sexual and reproductive health of women. Heterosexism and homophobia are common in our society as well as in our health care system. Some health care providers consequently have little appreciation of or sympathy with the barriers facing Canadians who are not heterosexual. From a series of interviews and focus groups conducted with 40 women living in northern BC, this study concludes that lesbians generally have to choose between passing themselves off as heterosexual or coming out to health care providers. Either approach has risks. On the one hand, misdiagnosis or improper care may occur when health care providers are unaware of salient aspects of their patients’ lives, including their sexual lives. Lesbians typically have low rates of STIs, for example, but the factors that place them at risk are different than those for heterosexual women. On the other hand, disclosure of sexual orientation can lead to hostility and/or inappropriate treatment. Ignorance or lack of familiarity with lesbian sexuality might lead some doctors to misinform clients about safe sex practices. As the *Women’s Health Strategy* points out, when health care providers assume that all women are heterosexual, it “increases the discomfort level of lesbians and can result in an avoidance of the system or treatment oversights.”

While the document does not focus on the reproductive health of lesbians – a lamentable omission given the “lesbian baby boom” in some parts of Canada – it does point out that lesbians who are not mothers are disenfranchised and disadvantaged by the systemic preoccupation with female reproductive issues (Shroff, 1999). Moreover, the authors point out that there is a dearth of epidemiological research on lesbian health and wellness that is linked to societal values and institutionalized attitudes.

Clearly, these reports could be discussed in relation to other themes: *Out in the Cold* describes conditions of discrimination relevant to social and economic conditions; *So Many Bricks in the Wall*

addresses risks in the social environment; and *Adolescent Sexual Health Services* has implications for family and community capacity building. But these documents also advance our appreciation of the complex relationship between the values and attitudes that prevail in our society and the ability of women and girls to make informed and healthy choices about sexuality and reproduction. As *Framework* concludes, supportive social environments are essential to enable and sustain healthy choices about sexuality and reproduction.

### **3.2.3 Access to Services**

During the 1990s, federal, provincial, and territorial governments embraced various strategies in an effort to reign in escalating health care expenditures: services were cut or “out-sourced”; health care facilities across the country were closed, “downsized”, or amalgamated; and responsibility for care and the costs of care were increasingly shifted from governments to communities and individuals (Armstrong, 2002). Privatization became the mantra of many health care reformers. While this approach to reform was adopted in the name of efficiency as well as cost containment and recovery, it seriously threatened access to services, particularly for women who are the majority of those giving and receiving care.

Availability of services has an obvious impact on access, but many other elements combine to determine whether or not women in Canada get the care they need. Geography, for instance, may limit access for those living in rural, remote, or northern communities where care providers and care facilities may be scarce or non-existent. Poverty likewise impedes access to care: the costs of transportation, food and accommodation, childcare, etc., may make it impossible for the poor to consult a health care provider while the costs of drugs, medical supplies, and nursing home care are beyond the reach of many Canadians. Language, gender, and cultural differences also result in systemic barriers that compromise timely and equitable access to effective and appropriate health services.

Issues of access affect every dimension of women’s health, including their sexual and reproductive health. Invasive cervical cancer, for example, is commonly found among women who have never had a Pap test or who have not been screened on a regular basis: Aboriginal women and impoverished women are over-represented in these groups (Colman, 2000). Similarly, women of European descent appear to be at higher risk of breast cancer than are women of African descent, yet Black women are more likely than White women to die of the disease (Miller, et al., 1996; Strategy, 1999). Although lack of knowledge about screening programmes may be partly responsible for the plight of these women, it is also likely that many simply did not have ready access to mammograms, regular Pap tests, or treatments with the potential to save their lives. This is clearly the case for women who live in rural or remote areas. Two CEWHs reports, *A Rural Women’s Health Program: The Experience of the South Westman RHA*, supported by the Prairie Women’s Health Centre of Excellence, and *PEI Well Women’s Clinics: A Case Study of Gender Specific Clinics to Increasing Screening Rates*, supported by the Atlantic Centre of Excellence for Women’s Health, contribute to a considerable body of literature that documents the impact of geographic isolation on access to health care services. Both

studies conclude that there are still many women at “high risk” for certain conditions, such as cervical cancer, who are beyond the reach of mainstream institutions. Services, concluded one author, need to “go where the people are”(Vardy Dell & Gorfy-Dyke, 2001). Moreover, decentralization of health care in the 1990s has not worked well for women living in rural and remote communities, as evidenced by a study supported by the National Network on Environments in Women’s Health, entitled *Moving in the Right Direction? Regionalizing Maternity Care Services in British Columbia, Canada* (2000). The authors of this report found that non-urban women had little choice in maternity care service providers, limited access to maternity care services in general, and were often required to cover extra costs, such as travel expenses, when they needed to give birth in larger centres.

As with earlier strategic directions, we could examine many different factors that limit access to services, from privatization to discrimination. Some of these themes will be addressed later in the synthesis. For the purposes of this discussion, however, we will focus first on health care providers and the extent to which their approaches and practices either facilitate patient access or complicate it. Specifically, we will examine CEWHs documents that deal with sexual and reproductive health services for women with a history of sexual abuse or assault, and those that examine access to midwifery services. Second, we will consider the ways in which one factor, geography, can seriously compromise access to sexual and reproductive health services for women.

In addition to the brochure that provides advice to survivors of sexual abuse about how to manage medical examinations, the Prairie Women’s Health Centre of Excellence has supported a study of health care providers’ attitudes and practices, entitled *Women Survivors of Childhood Sexual Abuse: Knowledge and Preparation of Health Care Providers to Meet Client Needs*. The British Columbia Centre of Excellence for Women’s Health has also sponsored a study of the ethical dimensions of gathering forensic evidence from women who are unconscious following a sexual assault, entitled *In the Absence of Consent: Sexual Assault, Unconsciousness and Forensic Evidence*. These documents together address the ways in which health care providers and institutional mandates do not always meet the needs of women who have been subjected to coercive sex in the recent or distant past.

According to the authors of *Women Survivors*, victims of sexual abuse often avoid physical examinations and other medical procedures because the procedures themselves are invasive and because the attitudes of some practitioners are insensitive or oppressive. Tudiver et al. also found that levels of knowledge about sexual abuse among health care providers were quite varied, with some demonstrating considerable awareness and others having limited appreciation of the impact of abusive experiences. Although every practitioner interviewed felt that the issue of providing care to survivors of sexual abuse was important, few routinely asked their patients about a history of sexual abuse. These doctors (and other providers) are either not trained or not prepared to inquire fully into the sexual history of their patients, which then makes it impossible for them to create a safe and sensitive environment for necessary examinations.

The report recommends that health care providers adopt a policy of “universal precautions”, meaning that all clients be treated as if they might have a current or past history of abuse. While taking the patient’s history, for example, the doctor or nurse might ask open-ended questions, such as “Is there anything that would make this examination more comfortable for you?” or “Do you have any special concerns about this procedure?” This approach would demonstrate respect for all clients and offer them more control over the medical encounter, including the decision to disclose or guard their personal history. It would also reduce the trauma associated with medical examinations, making them more manageable for survivors of sexual abuse, and thereby improving the sexual and reproductive health of women in Canada.

*In the Absence of Consent* considers the care of women who are victims of sexual assault. The document explores the ethical and social implications of collecting forensic evidence from women who are unconscious and hospitalized following an attack. As of 2001, the policy of the Sexual Assault Service at British Columbia’s Women’s Hospital “does not endorse or permit medical/legal procedures for the collection, storage, and disclosure of any evidence from the non-consenting victim/patient while in the unconscious state, other than those deemed necessary in relation to her physical health and comfort” (Lee, 2001: 19). In other words, the collection of samples as forensic evidence in sexual assault cases is prohibited if the victim of the assault is unable to consent. Although the judicial system has a mandate to collect evidence in the interests of protecting both the individual and society as a whole, the authors contend that the rights and needs of the patient must not be subordinated to a legal imperative. Moreover, they maintain that it is the responsibility of health care providers to give priority to the immediate needs of patients.

We might reasonably ask if the collection of forensic evidence is not always in the interests of the victim as well as society. A woman who has suffered a sexual assault may feel, upon regaining consciousness, that the authorities *should* have collected any evidence that would help to bring her attacker to justice and protect other women from assault. She may feel especially distressed if her assailant escapes because *it is no longer possible* to collect evidence. Tudiver and her colleagues have taken this position into account, suggesting that surveys and interviews be conducted with sexual assault victims to find out what course of action they would have wanted their care providers to take. This research could then be used to inform policy for situations in which a patient is unconscious following an attack and unable to give or withhold her consent.

*In the Absence of Consent* and *Women Survivors* both draw attention to the differential treatment afforded to victims of sexual assault and abuse. It is no coincidence, commented one First Nations woman, that some women are met by a security guard rather than a triage nurse when they enter the Emergency Department at St Paul’s Hospital in Vancouver (Tudiver et al, 2000). Another First Nations woman concluded, “It’s not so bad for me, even though I’m Aboriginal, because I look and act normally, but for some women that come in dirty, they get a bad rap. It wouldn’t happen to you because you are white” (Lee 2001: 16). A similar conclusion is reached by the authors of a study of immigrant women in Quebec: they found that of the nineteen health care providers interviewed, most

knew very little about the lives of newly-arrived immigrant women or how the broader conditions of their lives in Canada might affect their perinatal and birthing experiences (CESAF, \*\*) These work of the CEWHs emphasize that attention must be paid to those members of Canadian society who are most vulnerable to attack and abuse, and most subject to discrimination within the health care system: women of colour, Aboriginal and immigrant women, women living in poverty, and women working in the sex trade.

The subject of midwifery provides a different but equally illuminating view of the issue of access in relation to women's sexual and reproductive health. In recent years, midwifery has become quite popular in Canada: many women prefer the care of a midwife during pregnancy and labour, and in the early weeks of looking after a newborn; some researchers and policy makers see midwifery as a less expensive alternative to physician care and hospital births, as well as a partial solution to the need for reproductive care in isolated and under-served regions (Davis-Murdoch, et al., 1999; Task Force, 1987; Manitoba Working Group, 1993). In keeping with this heightened interest, the CEWHs have supported several studies of midwifery in Canada. The British Columbia Centre of Excellence for Women's Health produced four reports dealing with the introduction of midwifery into the provincial health care system: 1) *A Difficult Labour: Experiences of Registering to be a Midwife in British Columbia* (2001); 2) *In Transition: Nurses Respond to Midwifery Integration* (2000); 3) *Pushing for Change: Challenges of Integrating Midwifery in the Health Care System* (2000); 4) *Reality, Opinion, and Uncertainty: Views on Midwifery in British Columbia's Health Care System* (1999). Two other documents focus on the experience of midwifery care: a graduate thesis subsidized by the Atlantic Centre of Excellence for Women's Health, entitled *Women Who Chose Midwifery Care in Nova Scotia: A Retrospective Survey and Selected In-Depth Interviews* (1999); and a report supported by the Prairie Women's Health Centre of Excellence, entitled *Midwifery Care: Women's Experiences, Hopes, and Reflections* (1999). These documents provide us with an opportunity to consider who wants midwifery care and why – as well as why many Canadians cannot get it.

The two studies dealing with the experience of midwifery – one in Nova Scotia and the other in the prairies – highlight the appeal of this approach to managing pregnancy and childbirth. Both concluded that women preferred midwifery to physician care for several reasons. The authors of *Women Who Choose Midwifery* pointed out that Nova Scotian women utilizing the services of a midwife were highly motivated to adopt a non-medical approach to care because many believed that pregnancy and childbirth are natural events. They also tended to see birth as an experience that affects self-esteem. The authors of *Midwifery Care* found that women were often more comfortable with midwives because these practitioners afforded them more time and attention than doctors could or did. Midwives allowed them to ask questions and explore issues of importance to them in an atmosphere that was both relaxed and unhurried. They also appreciated care in their homes and, like the Nova Scotian women, the holistic and low-tech approach to pregnancy and childbirth offered by midwives. Women who chose midwifery ultimately felt empowered because care was consultative, rather than prescriptive. Midwives furnished them with information, suggestions, and support, enabling them to make their own decisions. As one woman concluded, "My body is strong, my body is powerful and it has the ability to

do these things. I don't need to trust other people to tell me what's right and wrong for me and my family. I can do this!" (Moon, et al. 1999: 8).

Despite considerable evidence that midwifery is both safe and popular, access to this service remains uneven and limited across the country (Burtch, 1994; Wiegers, et al., 1996; Davies, et al., 1996 ; Shroff, 1997). Only Ontario, British Columbia, Manitoba, and Quebec have passed legislation that regulates and funds midwifery care – which means consumers do not have to pay for the service – and gives midwives full hospital privileges. In Alberta, midwifery is regulated to the extent that there are provincial standards of practice, clinical guidelines, and professional qualifications, but the province does not support midwives through provision of funding or hospital admitting privileges. Other provinces, such as Nova Scotia, are considering the integration of midwifery care into the existing health care system. In the absence of legislation, midwives can still attend home births, but clients must pay for this service out-of-pocket (Spicer, 1999). Uneven coverage of midwifery means that many women who might prefer the care of a midwife cannot afford it. Indeed, as the author of *Women Who Choose Midwifery* demonstrates, Nova Scotian women who turned to a midwife tended to be older and well-educated, and therefore presumably better able to bear the expense of uninsured services.

The other 4 documents explore midwifery's transition from an unregulated practice to a self-regulated profession providing a publicly insured service in British Columbia. They also bring us face-to-face with the political and professional dimensions of access to health care in Canada. In the weeks and months leading up to the regulation of midwifery in BC, the authors of *Reality, Opinion, and Uncertainty* observed considerable anxiety among doctors and nurses. Physicians wondered how midwives would be paid, how they themselves would be paid for maternity services, and how their role as medical practitioners would be altered by the acceptance of midwifery. Nurses also expressed concern about their role in midwife-assisted hospital births.

After the introduction of midwifery, nurses continued to be concerned about the security of their jobs and the safety of mothers and newborns. The study *In Transition* reveals that perinatal nurses were particularly concerned about the medical risks of home birthing as well as the impact on their jobs if home births became more common.

All the reports indicate that physicians and nurses who are unfamiliar with midwifery training and practice are less likely to regard it as a legitimate model of care. Community-based nurses, who would typically have more experience with midwifery and home birthing, had more favourable opinions of midwifery, as compared with hospital-based perinatal nurses who had limited exposure to midwives and who were more vested in the medical management of pregnancy and labour (Kornelson, Dahinten, & Carty:2000). Moreover, the authors of *Pushing for Change* discovered that two years after the regulation of midwifery, some physicians and nurses still refused to work with midwives and actively opposed home births. In some cases, doctors and nurses refused even to accept patients who chose a midwife as their primary caregiver during pregnancy. Although midwives have managed to convince some doctors and nurses of their ability to provide excellent care, professional acceptance and recognition have been slow to materialize. In the meantime, rivalry and territoriality have “the potential



to weaken the profession of midwifery and challenge the long-term availability of accessible midwifery care”(Kornelson, 2001:14).

According to Kornelson and Carty, “many of the challenges faced by midwives in BC are endemic to any new profession struggling to secure its place alongside other, well-established professions”(Kornelson & Carty 2001:3). While it is true that midwives faced considerable opposition from other health care providers, their own ranks were divided by differences of training, ethnicity, language, and geography. *A Difficult Labour* revealed that a significant number of first-time registrants with the College of Midwives of British Columbia were unhappy with the process. Midwives, striving to establish or develop careers and practices, reported that registration had “a profound negative emotional and financial impact on their lives”(Kornelson & Carty 2001:1). Hospital-based midwives believed that home-based midwives were favoured in the registration process, a conclusion supported by some of the home-based midwives. Midwives with nursing training sometimes perceived a bias against them, but so did some direct entry (lay) midwives. Rural applicants felt disadvantaged by the registration process because they had difficulty meeting the quota of 10 deliveries per year and finding supervisors or qualified second attendants to provide back-up at home births. Immigrant midwives and those whose first language was not English also felt the registration process was discriminatory. Some had to repeat the examinations, at considerable additional cost, due to unfamiliarity with the language or Canadian content. Furthermore, many newly arrived immigrant women were uncomfortable being asked about the number of home births they had attended over the past 3 years; they knew the practice of midwifery was illegal and the possibility of prosecution had more profound consequences for them than it would for Canadian citizens. In other words, midwives could not agree about or fully support the process by which their own College elected to evaluate their skills. Divisions with the profession as well as challenges from other professions may well limit access to midwifery care for many Canadian women.

Together, these reports demonstrate the need for further education of health care providers and policy makers – both about the needs of diverse groups of patients and about the potential of new or renewed approaches to care. These are necessary steps in the effort to ensure equitable access to appropriate services that will protect and promote the sexual and reproductive health of women.

### **3.2.4 Physical Environment**

Fifty years ago, American scientist and ecologist Rachel Carson warned of the dangers of contaminants in the physical environment. Her research demonstrated that pesticides used to improve agricultural yields were polluting the waterways of the world (Carson, 2002). Testifying before the US Congress in 1963, Carson called for new policies to protect both human health and the environment (Lear, 1997). Other developments in the decades after World War II revealed the darker side of science, including threats to women’s sexual and reproductive health. In the 1960s, for example, thousands of mothers who had ingested thalidomide, a sleeping pill, gave birth to children with profound disabilities, ranging from hearing loss and hemangiomas to cardiac defects and missing or malformed limbs (Clow, in press; Stephens and Bryner, 2001). Woman prescribed diethylstilboestrol (DES) for miscarriage found

themselves at increased risk of breast cancer and other diseases, while their daughters and sons frequently developed serious reproductive health problems (Apfel & Fisher, 1984; Merkin, 1976). In addition to iatrogenic conditions, those caused by medical intervention, a host of illnesses have spread and worsened as a result of increased levels of environmental toxins. Asthma and lung cancer, for example, are clearly associated with air pollutants. Women and men are also exposed to a wide array of chemicals and physical and biological agents in their workplaces, many of which can damage their sexual and reproductive health. Occupational exposure to certain substances can reduce libido and fertility or result in menstrual dysfunction. Maternal exposure after conception may lead to perinatal death, low birth weight, birth defects, developmental or behavioural disabilities, and cancer (US Dept. of Labour, 2002).

Despite the mounting evidence that environmental contaminants adversely affect our sexual and reproductive health, this area of investigation remains relatively underdeveloped, especially by comparison with research on the effects of “lifestyle”. Social attitudes, such as those that vilify homosexuality, may underpin this emphasis on individual behaviour and personal choices, but some researchers have also argued that greed is equally if not more responsible for political and corporate decisions that threaten sexual and reproductive health (Procter, 1995; Breslow, 1992; Waitzkin, 1984; Doyal, 1983; Epstein, 1978, 1990; Renaud, 1978; Navarro, 1976). The recent debate over hormone replacement therapy (HRT) is a case in point. Some physicians, agencies, and companies have continued to support the use of estrogen and progestin therapy in postmenopausal women despite compelling evidence that the risks of treatment outweigh the potential benefits for most healthy women (Writing Group for the Women’s Health Initiative Investigators, 2002).

The determinants of health model acts as a powerful corrective – both to the emphasis on personal over collective responsibility for illness and to the emphasis on medical over social and environmental solutions for illness. In these ways, it is especially valuable for deepening our appreciation of the dangers to reproductive and sexual health that reside in our physical environments and devising realistic remedies. The work of the CEWHs contributes to a growing body of research that employs this model of analysis to investigate the ways in which chemicals, drugs, and physical and biological agents threaten our health. Three documents, in particular, are germane to this discussion of women’s sexual and reproductive health: *Estrogen Through the Life Cycle* (1998); *Taking Action for a Healthy Future: A Guide for Educational Workshops* (1999), and *Risks, Rights, and Regulation: Communicating About Risks and Breastfeeding* (2000), all of which were supported, fittingly, by the National Network on Environments and Women’s Health.

*Estrogen Through the Life Cycle* is a short booklet that aims to inform women about how estrogens act in the body and how women may be exposed to too much estrogen or the wrong kind of estrogen. Natural estrogen is integral to the healthy functioning of a woman’s reproductive system, from the onset of puberty through pregnancy to menopause. Women cannot have children without an appropriate supply of estrogen. But the authors of the booklet warn that many common drugs and widely-used chemicals have estrogenic properties that can negatively affect women’s health and the health of their

offspring. They are linked with dramatic increases in infertility, genital malformations, hormone-sensitive breast cancers, hyperactivity, and other neurological disorders. These same chemicals and drugs affect men in similar ways. The document also discusses various forms of synthetic estrogens, such as birth control pills and hormone replacement therapy, both of which have the potential to cause serious illnesses. Women who use birth control pills to avoid pregnancy "have a greater tendency towards liver dysfunction and to more allergies. Vitamin A levels may be raised in the blood; vitamins B12 and C...lowered" (Day & Hawkins 1999:4). According to the authors, some early researchers were shocked to see the Pill marketed as a safe form of contraception when dozens of studies had already confirmed dangerous side effects, such as increased risk of heart attack and stroke, diabetes, gallbladder disease and liver cancer. Early or prolonged use of the Pill, which some reproductive specialists have claimed preserves a woman's fertility, is associated with up to 10 times greater risk of breast cancer. Moreover, recent changes to birth control pills have actually increased the side effects. Nausea, vomiting, headaches, breast tenderness, weight gain, changes in sex drive, depression, blood clots, and increased incidence of vaginitis are commonly associated with use of the Pill and risks of both minor and serious side effects are accentuated for women who smoke while taking oral contraceptives.

Day and Hawkins describe the impact of xenoestrogens or pseudoestrogens, which can be found in a wide array of common products, from processed food and preservatives to food packaging. These "toxic manmade chemicals ... confuse estrogen receptor sites in the body and interfere with natural biochemical messages"(Day & Hawkins 1999:5). They have been linked to altered sexual behaviour, genital malformations, cancers of the breast, ovaries, and uterus, fibrocystic disease of the breast, polycystic ovarian syndrome, endometriosis, uterine fibroids, and pelvic inflammatory disease. Furthermore, women's overexposure to these xenoestrogens can cause reproductive abnormalities in their offspring, including masculinization of females and the feminization of males.

Having outlined the nature and dangers of synthetic hormones and estrogenic substances, the authors suggest steps for reducing hormone exposure and disruption of normal body function. Attention to diet, for example, helps to redress hormonal imbalances and allay other health conditions. Societies with a high soy diet are known to have more limited osteoporosis rates among women. Dietary intake of phytoestrogens – natural compounds found in hundreds of food plants – also seems to protect against breast and reproductive cancers and osteoporosis and can be used to treat the symptoms of menopause.

Over-exposure to estrogen can be moderated to some extent through diet, but xenoestrogens are far more difficult to avoid and their effects are hard to reverse. As a result, Day and Hawkins recommend finding ways to limit the amounts of hazardous chemicals released into the environment. Canadians can lobby politicians and industry to establish processes that will protect both the environment and women's sexual and reproductive health. The *Women's Health Strategy* includes an environmental health component, consisting of accelerated screening and assessment of new and existing substances as well as improvements in the management, control, and tracking of toxic substances (Health Canada 1999:30).

Although most of us recognize the dangers posed by drugs and chemicals in our environment, few of us would consider breast milk a potentially harmful substance. Indeed, popular and professional advice manuals and educational literature are replete with assurances that breast milk is the best food for baby (Eisenburg, Hathaway, & Murkoff, 1996). Yet the authors of *Taking Action* and *Rights, Risks, and Regulation* point out how difficult it is for women to make informed choices about breast feeding when the “experts” disagree. In the past, environmental groups have accused breast feeding advocates of failing to provide mothers with the “whole truth” about the issue of contaminated breast milk. While those in favour of breast feeding promote breast milk as a way to reduce the risk of cancer, environmentalists warn about possible carcinogens in breast milk. Contradictory messages from the mass media do not help: in some cases breast milk is presented as poison, in others as wholesome food for babies. Much of the time, little attention is paid to the greater risk of exposure to contaminants associated with other infant feeding substances, such as prepared baby formula, cow’s milk, soy-based products, and products re-constituted with water.

Both documents demonstrate the need for research and policy to clarify the reality and role of environmental contaminants in breast milk. On the research side, we have little reliable information about how exposure to environmental toxins affects infants, breast fed infants, and adults. We also need to examine the ways in which environmentalists, breast feeding advocates, and women’s health care providers approach the issue of contaminated breast milk in order to develop a common understanding and vocabulary that will not confuse women further or undermine the objectives of these different groups. In the meantime, governments should establish educational strategies that will help mothers make informed choices, such as eating lower on the food chain, washing and peeling fruits and vegetables, avoiding consumption of Great Lakes fish, reducing exposure to pesticides, etc. We also need to reassure women that breast milk is the lowest risk and most nutritious food for their babies. Political and legislative action must also include tougher approaches to cleaning up the environment, rigorous workplace safety standards suitable for pregnant and lactating women, and international conventions, such as the WHO/UNICEF code, to govern the marketing of breast milk substitutes.

Immediate action to safeguard the sexual and reproductive health of women in Canada is imperative. Although we do not understand the extent of every environmental threat, as *Framework* indicates “there is enough evidence to maintain vigilance in testing new and existing chemicals” and in monitoring drugs and devices with the potential to affect sexuality and reproduction (p.13). The *Women’s Health Strategy* makes explicit the federal government’s commitment to regulate reproductive and genetic technologies, pharmaceutical products, and chemicals that might threaten women’s health (p.18). These are important first steps in the effort to improve sexual and reproductive health by rejuvenating the physical environment.

### **3.2.5 Families and Communities**

As the value of a determinants of health approach has become apparent, new conceptual tools have been deployed to study newly recognized influences on health and illness. In addition to evaluating the role of gender, culture, age or geography, researchers have begun to investigate the significance of

family and community well-being for the health of Canadians. Safe, clean parks and playgrounds, for example, can contribute to the physical fitness of children and to improved air quality. Available, accessible services, such as recreation facilities, schools and libraries, police and fire departments, and health clinics, are equally important to the health of communities. Families and individuals also benefit from supportive neighbours and safe neighbourhoods. Features of family and community life that have the potential to enhance health, such as cohesiveness and resiliency, or detract from health, such as marginalization, are frequently grouped under the concept of “social capital” (Calvert, 1997; Cattell, 2001; Geronimus, 2000; Gitall & Vidal, 1998; Lochner, Kawachi, & Kennedy, 42; Putnam, 1995; Veenstra & Lomas, 1999). According to Lomas, social capital involves the “way we organize our society, the extent to which we encourage interaction among the citizenry and the degree to which we trust and associate with each other in caring communities [and] “it is probably the most important determinant of health” (Lomas, 1998).

The distinction between social capital and “societal values”, as outlined in *Framework*, is far from clear because the document clusters social values and social supports with education, employment, and income under the broader category of social and economic environments – which is itself a strategic direction for action (pp.10-12). *Framework* also focuses on the role of government in mobilizing families and communities through education and integration of services. For example, the report recommends that preconception, prenatal, pregnancy, and postpartum services be integrated to “ensure essential assistance and support for mothers, fathers, and babies”(p.33). It further counsels improvements to workplace benefits and supports to help parents balance work and family life. A variety of educational strategies are also proposed to increase family and community capacity, including school-based programmes, support for self-help groups, and continuing education for professionals.

The issue of social capital is implicit in many of the CEWHs reports, but it is seldom named or discussed systematically. For instance, in the *Women’s Self-care* book introduced under the theme of personal choices, readers are urged to consult with others before making a decision about sexual intimacy; this advice begs the question of whether or not women and girls have social networks that are adequate to the task of advising them about sexuality or reproduction. At the same time, some documents mirror *Framework’s* emphasis on education as an effective response to sexual and reproductive health concerns. *Adolescent Sexual Health*, a report mentioned earlier in relation to the theme of social values, describes how a multi-component educational initiative in Amherst, Nova Scotia produced significant changes in the knowledge, attitudes, and behaviour of high school students. Between 1996 and 1999, for instance, girls aged 14-15 and 17-19 reported greater support from parents, partners, friends, and the community for the use of condoms. Pregnancy rates declined in the same period while the proportion of younger females not using contraception at last intercourse decreased from 32 % to 14 % (Langille, 2000: 13).

Among the work of the CEWHs, the most explicit discussion of social capital in relation to sexual and reproductive health can be found in a report released by Le Centre d’excellence pour la santé des femmes, entitled *Les mere immigrantes: pareilles pas pareilles!* The study analyses the experiences

of women who had been living in Quebec for less than 6 months and who had borne a child during the preceding 3 to 12 months. The authors asked 3 main questions: How does pre-migration experience influence women's potential to integrate into Quebecois society? How does the integration process itself affect women's perinatal and mothering experiences? Is there an association between women's vulnerability in the perinatal period and their migration experience?

According to this research, recently-arrived immigrant women are frequently impoverished and subject to both social isolation and emotional difficulties. Experiences with pregnancy varied according to their reasons for migration (as war, persecution, or other), their language skills (English or French), and whether or not they were separated from family. Younger women who speak some French or English, have some college or university education, and have given birth in Canada are generally at "lower risk" for pregnancy complications. In contrast, mothers who speak English but not French, have upper post-secondary education, and who have not received recognition of their professional qualifications in Canada face higher risks during pregnancy, including premature birth, low birth weight, anemia, difficult labour, bleeding, and hypertension.

Recently arrived women also believe that life in their home countries would have been easier in some ways because their cultures are more child-centred as opposed to western societies, where an individualistic ethos prevails over an orientation toward family and community. As one woman commented: "La-bas je serais entouree par ma famille, par la famille de mon mari, c'est tres different ... Les enfants grandiraient dans une ambiance pleine d'amour, d'affection et de chaleur humaine, ce qui n'est pas le cas actuellement"(p.117).

Although the study does not delve as fully into the issue of cultural context as it might have done, it speaks directly to problems that can arise from inadequate social capital. Women who are stripped of supportive family networks through immigration and who are unable to establish new support structures because of time, financial, language, or cultural constraints are more likely to experience health problems, such as depression, and to suffer complications during pregnancy. They are also less likely to get timely, appropriate care. Both of these conclusions could easily be extrapolated to other vulnerable and marginalized populations. As we will see in the next section, impoverished women, Aboriginal women, and addicted women consistently find that their personal and social resources are leached away by relentless discrimination and isolation.

This research project makes clear that education of families and communities, and integration of services – while necessary – are not sufficient to improve the sexual and reproductive health of all women in Canada. Our culture is decidedly anti-immigrant, despite the fact that most of us live in this country as a result of migration in the recent or distant past. Until such time as we engage in fundamental re-evaluation of our social values and social structures, it will be difficult to fortify the social capital of Canadians or strengthen the capacity of families and communities to improve the sexual and reproductive health of their members.

### **3.2.6 Social and Economic Conditions**

The relationship between income and health was one of the first and most enduring research priorities to develop out of a determinants of health approach. In the past three decades, numerous American studies have demonstrated that middle and upper class women and men are more likely to enjoy good health than those living in straitened economic circumstances (Antonovsky, Zola, & Kosa, 1969; Backlund, Sorlie, & Johnson, 1996; Davis, 1978; Ewig and Krasner, 1989; Hay, 1994; Lynch, 1996; Pappas et al, 1993; Townson, 1994; Wagstaff & van Doorslaer, 2000). In Canada, the relationship between income and health seems to be less predictable. According to Veenstra, “health researchers have yet to report a meaningful relationship between income inequality and population health within Canada” (Veenstra, 2002). He suggests that the impact of income inequities may be “psycho-social”, meaning that when people recognize they are at an economic disadvantage compared with others, it can have a deleterious effect on their health. Other researchers have argued that while income and health are not as directly correlated in Canada as in the US, there is no doubt that inequities contribute to illness (Ross, et al, 2000; Agbayewa, Marion, & Wiggins, 1998, Humphries & van Doorslaer, 2000). Raphael, for instance, has amply demonstrated that heart disease results primarily from low income and social exclusion, rather than from lifestyle (Raphael, 2001).

Social conditions that detract from health, such as discrimination, have also garnered attention from the research community and, in contrast to economic indicators, there seems to be less dispute about the significance of social inequalities as predictors of illness (Wilkinson, 2000). (Aday, 1993; Anderson, 1998; Doyal, 1995; Foster, 1995; Gates, Lackey, & Brown, 2001; Graham, et al, 2001; Mingo, Herman, & Jasperse, 2000; Raphael, 2001, 2002; Thomas, 2001; Zong & Li, 1994). Many studies have documented the relationship between gender and health, for example, with women being at a decided disadvantage. (Barksdale, et al., 1999; Davidson, et al., 2001; Dresser, 1992; Matthews, Manor, and Power, 1999; McDonough and Walters, 2001; Rosser, 1994). Many common life-threatening conditions, such as heart attacks, are consistently under-diagnosed in women and may be treated inappropriately even when they are diagnosed (Schaubel, et al., 2000; Schulman, et al., 1999). In addition to class and gender, race and ethnicity have been strongly correlated with health status and access to services (Barbee and Bauer, 1988; Blake and Darling, 2000; Bolaria and Bolaria, 1994; Brancati, et al., 2000; Dana, 2002; Fisher, et al., 1996; Graham, et al., 2001; LeClere, Rogers, and Peters, 1997; Schulz, et al., 2000; Utsey, et al., 2000). People of colour are most at risk of poor health and are most likely to receive poor or inappropriate care. African Americans, for example, are twice as likely as white Americans to develop adult-onset diabetes, and to face serious sequelae of the disease, including amputation and blindness (National Institutes of Health, 1992; Brancati, et al., 2000). Most vulnerable of all are those who experience intersecting inequities, such as poverty compounded by gender and ethnic discrimination. Women of colour routinely experience this “triple jeopardy,” and its pernicious influence on their health (Bernard, 2001). In the case of HIV, African American women are approximately 3 times more likely to be infected than African American men and 8 times more likely than white Americans (Enang, 2002).

Both *Framework* and *Strategy* recognize the role of social and economic conditions in health, and both support initiatives to reduce disparities, particularly economic disparities. The main thrust of the

*Women's Health Strategy* is to expose and eliminate discrimination for diverse populations of Canadian women and, in so doing, to improve their health. In this way, *Strategy* speaks to the pressing need for social change. By comparison, *Framework* is quite disappointing in that it recommends symptomatic relief rather than a cure for social inequalities: marginalized groups of women are offered better access to education and services to improve their sexual and reproductive health, rather than fundamental changes to gender relations in our society.

All of the CEWHs have supported or undertaken research on the impact of social and economic conditions on women's sexual and reproductive health: *Evaluation Report of the Sheway Project for High-risk Pregnant and Parenting Women* (2000), from the BC Centre; *A Study of the Service Needs of Pregnant Addicted Women in Manitoba* (2000), from the Prairie Centre; *Marginalized Voices from the Downtown Eastside: Aboriginal Women Speak About their Health* (2000), from the National Network on the Environment and Women's Health; *Aboriginal Women and Maternity: Fetal Alcohol Syndrome* (1998), from the Quebec Centre; and *Early Maternity Discharge and Low-Income Women: A Grounded Theory Study* (1999), from the Atlantic Centre. By exploring the needs and experiences of women facing multiple social and economic barriers to health and care, this body of work demonstrates the need for policies and programmes to counter systemic inequities.

*Low-Income Women* is a graduate thesis that seeks to explain the challenges faced by low-income women – the working poor – related to early maternity discharge policies. According to the author, the women in this study had been raised in limited-income homes, with the result that they had already developed coping strategies before they became pregnant. In other words, they knew how to “make do”. Many of these women also had well-developed systems of social support, consisting of family and friends, which also helped to blunt the impact of low incomes. The author consequently concludes that “for these women low-income status was not a major concern” (p.82). Yet it is clear that in some ways at least, their economic circumstances influenced the choices of these women once they were admitted to hospital. For example, they were given beds in wards, rather than in private or semi-private rooms, because they did not have private insurance to cover the additional costs. Some women consequently felt uncomfortable having their babies in their rooms, particularly if one of their roommates had lost a child or was especially ill following delivery. Moreover, the women felt unable to ask questions of the nurses, who appeared too busy to help, or to challenge decisions about their readiness for early discharge. Although many mothers might experience similar problems, regardless of their economic status, low-income women typically have less access to information that will help them manage birthing, breast feeding, and infant care (p.86).

If women with a low income face barriers to effective and appropriate maternity care, conditions are much worse for Aboriginal women, particularly if they are also dealing with addictions while they are pregnant. Many of the CEWHs reports that deal with pregnancy capture the pernicious effects of intersecting inequalities. For example pregnant women with addictions share many characteristics that predispose them to ill health and poor care, including poverty, inadequate social supports, diminished self-esteem, and histories of physical violence and abuse. As one woman commented,



[W]ith an addiction it's really hard to put anything else above that addiction, especially ourselves. Even though we're carrying a baby, yes, but we have such low self-esteem in most cases or such low respect for ourselves that it really doesn't matter. Sure this is my body but it's only here in vision. It's really gone somewhere ... It's here to get your attention so you'll pick me up but you know but other than that I don't really care what you're going to do to it. I'm just thinking you're giving me money, I'm going to go get high. That's basically what it is and it's a sad thing to think, but yeah, most addicts do think that way (*Service Needs of Pregnant Addicted Women*, 2000: 44).

Women who misuse substances, such as alcohol, drugs, or solvents, often do so to as a means to cope with or protest difficulties in their relations with male partners, family members, or service providers. Pregnancy does not change these conditions. One woman, who had also been raped, was rejected by her boyfriend when he found out she was pregnant with their child. “I became a hooker when I was 22”, she said, “‘cause I thought, What the hell, my boyfriend don't love me no more. Nobody gives a shit. The hell with everybody. I'll just go to work and make some money”(*Service Needs of Pregnant Addicted Women*, 2000: 45).

*Aboriginal Women and Maternity* examines substance abuse during pregnancy as a health concern for Aboriginal women in Quebec, with particular emphasis on the prevention of fetal alcohol syndrome (FAS) and fetal alcohol effects (FAE). As for many other pregnant addicted women, Aboriginal women face a combination of social and economic disadvantages, including poverty and sexual, emotional, and physical abuse. But the plight of Aboriginal women is intensified by experiences of discrimination that span many generations, including loss or rejection of culture, loss of home lands, residential school trauma, and death or loss of parents and siblings through substance abuse. Those at greatest risk of using substances while pregnant are under 25 years of age and/or have previously had children removed from their custody because of addiction problems.

According to this same report, the health system is failing to provide services required by addicted, pregnant Aboriginal women. They face long waiting lists for services, inadequate childcare for the duration of treatment programmes, policies that prohibit them from accessing services while intoxicated, and judgmental treatment from health care providers. The authors conclude that prevention and treatment models have been too narrow in focus to adequately deal with the complexity of pregnancy and addiction among Aboriginal women. Care should be delivered in a relaxed atmosphere and should consist of an integrated network of support and services. Moreover, services are most effective when they are non-judgmental and sensitive to women's cultural, social, emotional, and practical circumstances. One of the biggest obstacles to effective care is the fear among pregnant, addicted Aboriginal women that their children may be apprehended by social services staff.

The *Sheway Project* in Vancouver is an example of a successful, sensitive programme for women with addictions, with special reference to the needs of Aboriginal women. Because the project is located in Vancouver's Downtown Eastside, it is easily accessible to its clientele. It offers a full range of services

to women, from hot nutritious lunches, recreational facilities, and diapers to medications, prenatal care, and emergency supplies. In addition the staff provide addiction counselling, training in parenting skills, assistance to access financial services, and advocacy in the legal system. The atmosphere is non-threatening and the philosophy is one of women's self-determination. As the authors of *Marginalized Voices* conclude, "Aboriginal women ... hold the key to a healthier way of life for themselves and their children"(Benoit et al, 2001:37). The Sheway Project thus embodies the main elements of effective programming for pregnant women who engage in high-risk behaviours.

### **3.2.7 Research, Evaluation, and Information**

The final strategic direction in *Framework* reiterates the need for further research, policy and programme evaluation, and knowledge translation with respect to sexual and reproductive health. The Centres of Excellence for Women Health Programme was originally established, in part, to facilitate these objectives. Each of the CEWHs has generated new knowledge to help inform policy development within the Women's Health Bureau and Health Canada as well as within other federal, provincial, and territorial agencies. Moreover, the CEWHs have helped to identify new and emerging challenges to women's health, and have provided essential gender-based analysis of these phenomenon. Two documents in particular expose the grave threats to women's sexual and reproductive health posed by unrestrained or unexamined biomedical innovation at the end of the 20<sup>th</sup> century: *The Ethical and Human Rights Implications of Prenatal Technologies* ( 2002), released by the Prairie Centre, and *The Hazards of Human Developmental Gene Modification* (2000), sponsored by the National Network.

During the last two decades, prenatal screening has gradually become routine in the medical management of pregnancy, with maternal serum tests, ultrasound, and amniocentesis or chorionic villus sampling being recommended for women at "high-risk" of bearing a disabled child. Women deemed high-risk – "senior" mothers and those with a family history of genetic disorders – may be pressured to submit to testing in order to better prepare them for delivery and parenting if necessary their child is disabled. At the same time, prenatal testing theoretically allows mothers to choose abortion if testing reveals any "abnormalities" in the fetus and if the parents feel unable to care for a disabled child.

Although prenatal screening appears to foster informed choices about reproduction, the authors of *Prenatal Technologies* contend that it most often operates in the health care system as a device for reducing the incidence of birth defects, rather than as a tool for informed family planning. Not only does this tend to reify historic constructions of disability as tragic and burdensome, but also it may seriously compromise autonomy. A woman may feel coerced into aborting a fetus out of fear that her community will withhold support if she makes a seemingly irresponsible or unacceptable choice to keep the baby. The report suggests that discrimination against disabled individuals and restrictions to women's choices will deepen as screening technologies become more widely used.

Similar concerns are raised by the author of *Gene Modification*, who claims that human developmental germ-line modification is dangerous for the pregnant woman, the fetus, and even subsequent generations. Genes introduced in utero can attack a woman's own tissues, including her eggs, and create a heightened risk of some diseases, such as cancer. Although gene modification has never been tested on humans, studies in mice reveal serious developmental problems that are likely to affect the human fetus as well. Moreover, while the benefits for the unborn fetus are uncertain, there appear to be no benefits whatsoever for the woman who submits to this procedure. Nonetheless, gene modification is being proposed as a way to prevent disease and to enhance the life chances of offspring by "designing" appearance and abilities.

The author cautions that women may be pressured into accepting experimental genetic procedures "for the sake of the children". Indeed, he suggests that abortion rights may vanish if a mother is expected to "fix" the fetus in utero, regardless of any dangers the technology may pose to herself or the child. Although such warnings may seem premature or incredible – science fiction rather than science – support for genetic technology is congruent with aggressive attempts in the US to reverse abortion rights and with commercial and political agendas informed by new eugenic ideologies (Miller et al, 2000: 52).

In an era of ostensible enthusiasm for biotechnology, *Prenatal Technologies* and *Gene Modification* alert us to important questions about who develops biotechnology, who pays for it, who benefits from it and in what ways, who monitors and regulates biomedical research, and who will be disadvantaged when new technologies are deployed or withheld. Moreover, the work of the CEWHs underscores the need for more research on how Canadians feel about biotechnology. Attitudes to infertility treatments, discussed earlier, reveal that many women would prefer low-tech solutions to reproductive problems (Feldberg, et al., 2001). Debates about genetically-modified foods likewise suggest that Canadians are not so thoroughly enamoured with biomedicine as we have been led to believe.

#### **4. GAPS AND RECOMMENDATIONS**

Given the scope of this synthesis, the CEWHs research on women's sexual and reproductive health is surprisingly diverse. Together these documents span much of the life course – from adolescence through the reproductive years – and raise many crucial issues, such as the need for more knowledge, genuine opportunities to make choices, safety and security for women, and greater awareness of and sensitivity to women's issues among policy makers and service providers.

At the same time, there are some obvious holes in this body of literature. For instance, there is little discussion of menopause as a sexual and reproductive health concern and there is no analysis of the sexual and reproductive health needs of women who do not or cannot reproduce. The absence of research on specific topics does not necessarily indicate indifference or oversight. Some subjects, such as menopause, have been and are being actively studied by a great many investigators outside of the CEWHs; a decision not to pursue research in one area may be strategic. With other issues and topics,

however, the field of research is much more sparse, with the result that it is harder to explain the lack of attention to them among the work supported or produced by the CEWHs. The sexual and reproductive health concerns of childless women or adoptive mothers is a case in point. If women who do not bear and breast feed children are at higher risk of uterine and breast cancer, then should “best practices” for these women include earlier or more frequent screening? Similarly, what are the sexual health needs of women who cannot or can no longer get pregnant?

We might devote a good deal of time to a detailed explication of the gaps in this literature: criticism is always easier than creation. Rather than cataloguing real or perceived deficiencies in this work, it is more fruitful to discuss potential new approaches and areas of study. Many aspects of women’s sexual and reproductive health are crying out for investigation, but we will focus here on only five subjects.

#### **4.1 Healthy Sexuality**

As mentioned in section 2, women’s sexual health has often taken a back seat to their reproductive health. This emphasis persists in both of the Health Canada documents, *Framework* and *Strategy*, as well as in the work of the CEWHs. The introduction to *Framework* stresses that “healthy sexuality is a positive and life affirming part of being human”, but the remainder of the report pays little attention to what constitutes healthy sexuality and how best to foster healthy sexuality among Canadians. *Strategy* aims to improve women’s health, but with the exception of sexually transmitted infections and the effects of abuse, it also largely avoids the issue of healthy sexuality. The reports produced by the CEWHs touch on some related issues, such as the significance of sexual orientation, and the impact of power differentials between women and men, boys and girls, including overt violence against women. But as with *Framework* and *Strategy* these documents deal mainly with “unhealthy” influences on sexuality rather than examining the nature of healthy sexuality and better methods of promoting healthy sexuality. Admittedly, this is a subject rife with complications because it is extremely difficult to define. Does healthy sexuality consist of mutually gratifying, consensual acts of intimacy? If so, would celibacy be considered a healthy sexual choice? Does healthy sexuality also include a healthy body image? If so, who sets the standard of physical health and healthy self-perception? Is self-esteem part of healthy sexuality or simply a necessary pre-condition? If we hope to “move beyond maternity” in our discussions of women’s sexual and reproductive health – and in the formulation of “healthy” public policy, we must be willing to ask these hard questions and find answers to them.

#### **4.2. Diversity and Discrimination**

Many of the documents reviewed in this synthesis touch upon the experiences of diverse groups of Canadian women: lesbians, Native women, women of colour, recently arrived immigrant women, women addicted to drugs and alcohol, women living in poverty, women residing in rural and remote communities. The work of the CEWHs thus serves as an important reminder that women do not constitute a homogeneous group with a single set of circumstances, expectations, or sexual and reproductive health care needs. These studies are especially valuable in this regard because they

contribute Canadian content to areas of research that have traditionally been dominated by American researchers. It is relatively easy, for example, to investigate the health status and health care needs of African-American women, but virtually impossible to find comparable evidence about the health of African-Canadian women.

At the same time, these reports help to flesh out the perspectives presented in *Framework* and *Strategy*. Both Health Canada documents refer to the health implications of cultural, economic, and social differences among Canadian women, but the specific issues of diversity and discrimination are often eclipsed by relatively general discussions of the need for gender-based analysis of health conditions and health services, or by vague recommendations for greater sensitivity to the needs of women facing social, economic, or geographic barriers to health care. The studies supported by the CEWHs provide concrete examples of the impact of diversity and discrimination on women's sexual and reproductive health, and compelling evidence of the need for new approaches to health policy, research, practice, and service delivery.

Nonetheless, the work of the CEWHs would benefit from more explicit attention to various forms of discrimination. As with *Framework* and *Strategy*, these documents tend to focus on the negative experiences of specific groups of women without naming or examining the root problems plaguing them. For instance, in the many studies dealing with the needs and experiences of Native women and women of colour, racism is always implied and sometimes discussed, but seldom tackled directly as a subject for investigation. Similarly, reports on prenatal screening and genetic modification refer only tangentially to the prejudicial attitudes towards the disabled that underlie and are perpetuated by these technologies. New research being conducted by the CEWHs promises to advance our understanding of the effects of discrimination for lesbians seeking assistance with conception, for women with disabilities who are trying to protect their sexual and reproductive health, and for women at risk of HIV infection due to sexual violence (See annotated bibliography). But further work that deals expressly with specific forms of discrimination, such as homophobia and racism, is crucial for better health and care as well as for a more equitable and just society in Canada.

### **4.3 Health Protection**

Several of the studies supported by the CEWHs deal with the impact of environmental contaminants on the sexual and reproductive health of women in Canada. Moreover, some of these reports help to expand the definition of environmental hazards to include not only industrial toxins, but also the unanticipated effects of biomedical interventions. In this era of global warming, oil spills, and pharmaceutical disasters, we need more research on the relationship between environmental hazards and the sexual and reproductive health of Canadians. As with the issue of discrimination, the CEWHs are already moving in this direction, supporting an ongoing investigation of the dangers of breast implants (See annotated bibliography). This area of research should be nurtured and expanded to provide evidence for effective and appropriate policy formulation.

#### **4.4 Monitoring and Evaluation**

In 1999, *Women's Health Strategy* declared Health Canada's intention to "integrate gender into all its programs and policies by conducting gender-based analysis" (p.4). Then Minister of Health Allan Rock also described the Canadian Women's Health Network and the Centres of Excellence for Women's Health as "two important pillars of the *Strategy*"(p.2). While the CEWHs have responded to this federal mandate by generating new knowledge on women's health needs and experiences, it is more difficult to gauge the state of Health Canada's efforts to mainstream gender into its policies and programmes. Recent analyses of the Canadian health care system, however, are not encouraging; the Senate Report, *The Health of Canadians*, and the Report of the Royal Commission on Future of Health Care in Canada, *Building on Values*, demonstrate an enduring ignorance of or indifference to health care issues affecting women. Reform of the health care system that neglects gender will have a profoundly negative effect on the sexual and reproductive health of women in Canada. Consequently, research to evaluate the methods and tools developed to incorporate gender into policy and programming in this country – and the results of these efforts – would be a valuable area of activity for the CEWHs.

#### **4.5 Structural and Societal Change**

Finally, we not only need to understand Canadian values and structures in relation to the sexual and reproductive health of women, but also we need to find ways to transform values and structures that are hazardous to our sexual and reproductive health. Some of the research presently being carried out by the CEWHs will deepen our understanding of the role of specific values in determining health research, health policy, and health service provision. One study, for example, investigates the implications of popular, policy, and legal definitions of mothering that subordinate the needs of the woman to "the best interest of the child". Another project focusses on understanding perceptions of disability and risk in our society, and their impact on the health and well-being of pregnant women. Undoubtedly, this is important work, but like much other health research in Canada, it concentrates on one half of the problem while largely ignoring the other. How do we move from understanding social values to changing them? How do we expose *and then alter* structures that undermine the sexual and reproductive health of women? Research of this nature and significance is daunting, but also critical if women in Canada are to enjoy greater sexual and reproductive health in the future, and the CEWHs are well-placed to take the lead in this area.