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editor's note

We are pleased to be entering a new chapter in *Network*'s 14-year history with this issue, our first online-only edition of the magazine. As technology moves forwards, the Canadian Women's Health Network is moving forward as well and we are excited about the new opportunities that online publishing offers. In future issues, look for new features such as links to related articles and topics in our database, audio presentations by authors, and more!

This is also an exciting time for the entire CWHN, as we welcome new Executive Director Caryn Duncan. Caryn brings more than 20 years of experience in community organizations to the CWHN. She values the key role that the community sector plays in furthering social justice and equality, and is committed to addressing barriers to accessing health care in her work.

Prior to joining the CWHN, Caryn led the Vancouver Women's Health Collective as Executive Director, advocating for women's health care rights and for public health care in BC. A committed volunteer, Caryn served as the co-chair of the BC Health Coalition and was also a member of both the City of Vancouver Women's Task Force and the BC CEDAW Group (Convention to Eliminate All Forms of Discrimination Against Women). We are pleased to welcome Caryn to the CWHN and look forward to an exciting future under her leadership!

This Fall/Winter issue brings us exciting new perspectives in women's health, including work from the Centres of Excellence in Women's Health.

Jennifer Bernier of the Atlantic Centre for Excellence on Women's Health examines the health experiences of a marginalized population – criminalized women. From the National Network on Environments and

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Cover image: ThinkStockphotos/Hemera

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Women's Health, we get a fresh look at chemicals in our water as they question not just how individual chemicals added may affect people, but what happens when these chemicals combine. In a history of health indicators, the British Columbia Centre of Excellence on Women's Health takes a look back how women have been left out of health research, and how researchers are working to improve that today.

Finally, through an interview with founder Leonie Couture, CWHN Knowledge Exchange Director Jane Shulman gives an inside look at how Montreal women's organization HerStreet is helping homeless women regain their agency and their voices without judgement.

Signy Gerrard,
Director of Communications
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WHAT'S INSIDE

HerStreet

By Jane Shulman

It's 8:15 p.m. on a Monday night, and Léonie Couture's work day is far from over when she calls from her home to talk about Herstreet, the organization she started 16 years ago and still directs, that offers shelter, therapy and resources to homeless women in downtown Montreal. She had been too busy to talk at the office, writing a funding application that could secure a six-figure grant for Herstreet, so she offered to be interviewed outside office hours. In a soft and serious voice, she spends the next 90 minutes explaining the work that Herstreet does and talking about the women she sees on a daily basis – women she says many people would rather not see at all.

Couture has worked with women in distress for more than 25 years. Before founding Herstreet, she worked for five years at an organization that supports women who have experienced rape or incest. She found that some women were "too hurt to be helped," as they were dealing with issues of addiction, incest, violence, and were

unable to function in basic ways, like keeping weekly appointments with support workers at the group.

"I found that the core issue for most women who were experiencing severe difficulties was the violence they had endured in their lives," Couture explains. "It led to drugs, a loss of confidence in themselves, and so much suffering.

"As a feminist, I believed that we needed to find ways to that they could have access to help. They needed a place where they could go during the day if they wanted to talk, eat, or just be there, without any demands placed on them."

And so, in 1994, she founded Herstreet, a tiny organization with a clear mission: to accept women exactly as they are, and offer them help if they want it, but not force them to take it. Herstreet now has 50 employees, two houses that offer short and long-term lodging for women, a variety of therapeutic approaches, and operates on a $1.5 million annual budget with funding from the federal and provincial governments and private donors.

Herstreet has grown, but the mission is the same. Couture maintains workers and volunteers at Herstreet are trained to understand that behaviour deemed unacceptable in society, including loud or violent outbursts, are not to be quelled. Couture believes that these behaviours stem from the violence that women have experienced, and the excruciating physical and emotional suffering are the result.

"They have lived through enormous violence, and we want them to find their voice again," she says. For many people, including those who work with homeless women, the population at Herstreet is "too ugly – they don't want them because the way they express their pain can be really hard if they act paranoid or violent, and they are excluded from other shelters. For us it's just normal. Without judgment, we give them time to gradually tell their stories."

"We want them to find their voice again."

Herstreet's mandate is to put in place mechanisms where staff can reach out to women who have been robbed of their ability to connect with the outside world, and help them to develop different survival skills.

In the grand scheme of things, as long as a woman isn't posing a threat to another resident or a staff member, her behaviour will be accepted. That's not to say it's encouraged, Couture says, but it is essential that women feel as safe as they can, and know that no one at Herstreet is going to hurt them or insist that they change.

"If a woman is screaming for no apparent reason," Couture explains, "we're not going to stop her. When she is finished, we may approach her and ask if she wants to talk, and see if there are other ways she could express the pain she's experiencing, but we are not going to tell her that what she is doing is wrong."

The approach was a first in Montreal. There are other shelters that do excellent work for women, but none that operates quite like Herstreet. The mandate includes raising awareness about women and homelessness. Couture stresses that the degree of suffering of the women who find their way to Herstreet means that the goals are not to help them find a job.

"It's not poverty that puts women in the street – it's a consequence of being so badly hurt that she can't work. I find it funny when they say why aren't they working. Most never work," she says. Survival is the goal, and successes are celebrated wherever they can be found, small as they might seem.

To demonstrate her point, Couture tells the story of a women who lived in one of Herstreet's residences. For two years, Couture explains, she never once slept in the room. She slept on the floor just outside the room. Sleeping in a bedroom was terrifying because that is where the violence and trauma in her life began. No one at Herstreet questioned her

about sleeping in the hallway, or asked her to sleep in her room. Her behaviour was accepted and over time, understood. This was what she needed to do to feel safe enough to go to sleep. One night, out of the blue, she started sleeping in her room, but on the floor next to the bed, fully clothed. The woman needed to feel she could flee in the middle of the night if she was threatened, Couture notes.

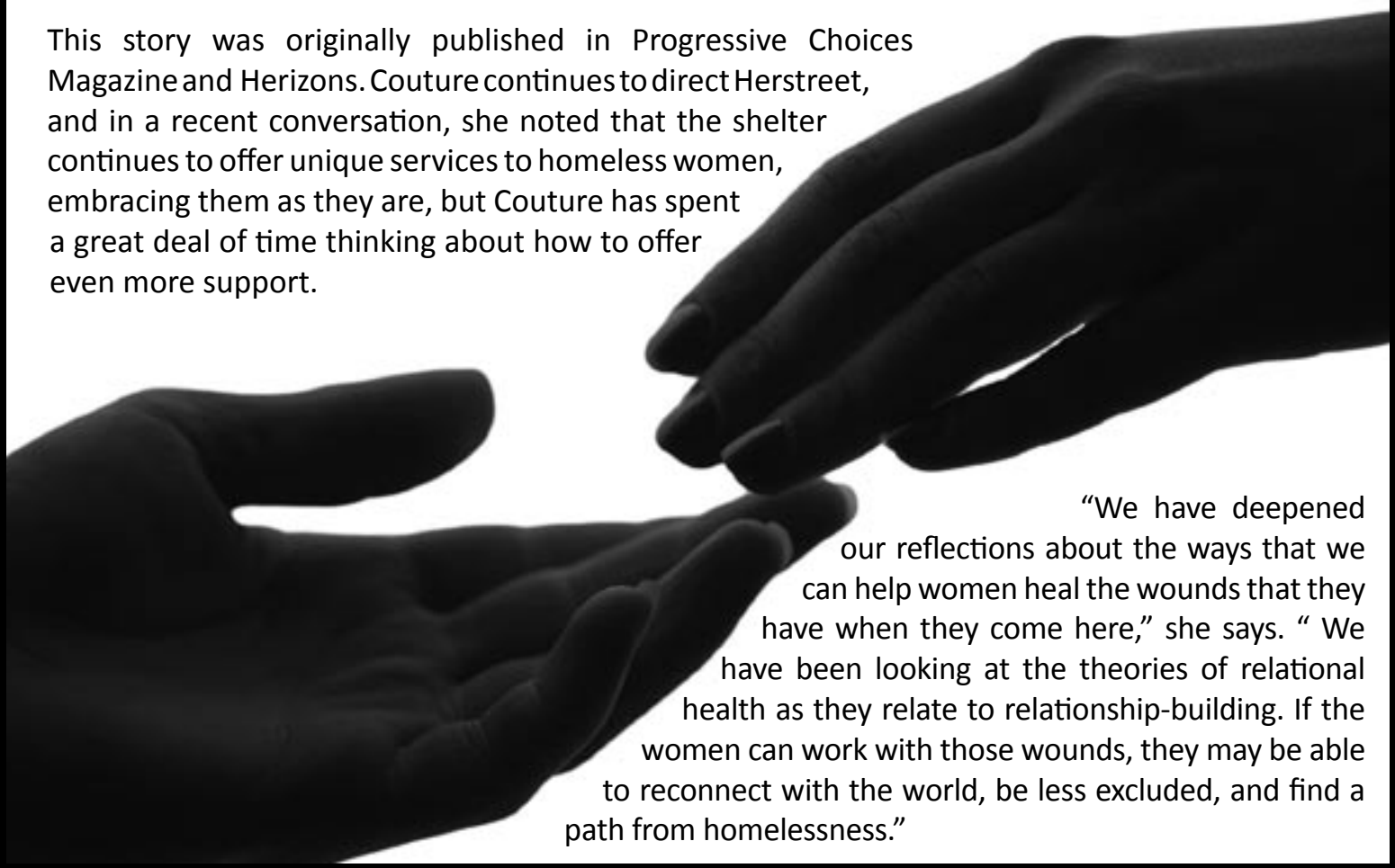
It is hard to imagine, as Couture recounts story after story of brutalized women who are in such dire situations, that we, as a society, don't seem to draw a parallel between the violence that we know is happening to girls and women behind closed doors in every neighborhood in the country, and the women we see on the street. Couture says the common thread is suffering, and Herstreet's goal is to offer an alternative, helping women to reclaim their agency.

Burnout seems a likely outcome of such emotionally demanding work, but Couture says that lots of training on remaining centered, a cohesive staff, and not losing sight of value of the work all help. Sometimes it's about remembering that everyone is hurt in some way, even though not everyone lands on the street. These are exceptional women who deserve support.

As we wrap up our marathon conversation, Couture looks to the future. "We're always in the process of creating things to compensate for reinsertion systems that don't work. We need to create them for more fragile people." For Couture, it's all about "changing the world," one step at a time.

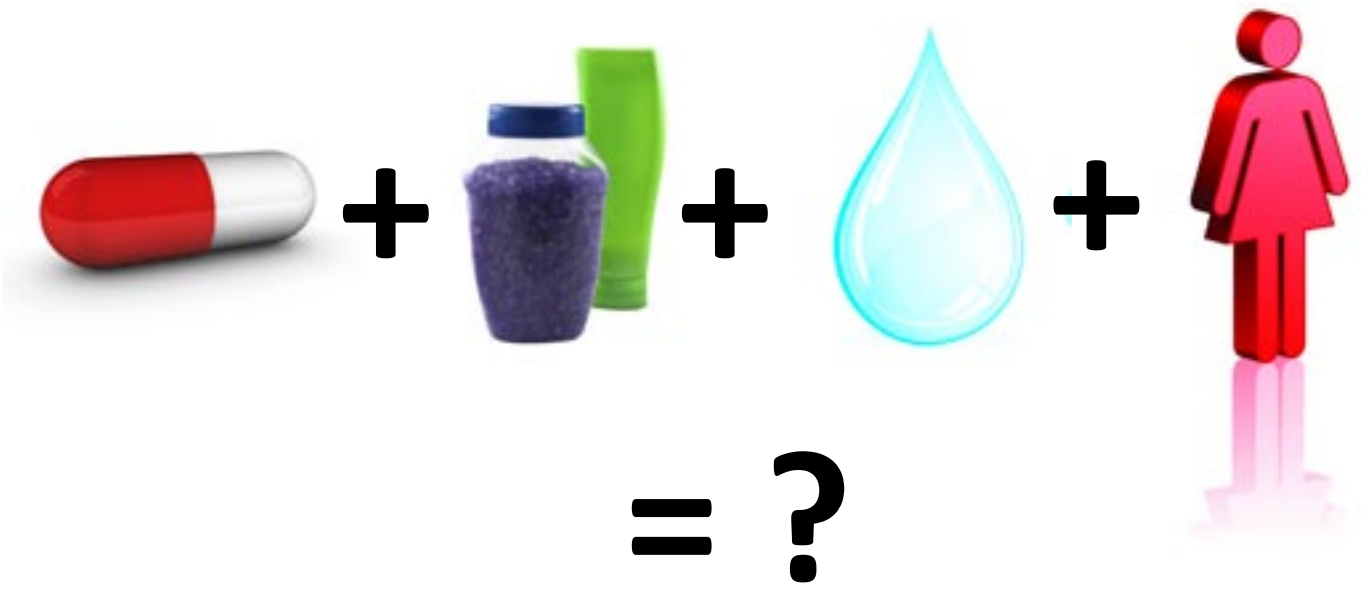
Jane Shulman is the Director of Knowledge Exchange at the Canadian Women's Health Network

This story was originally published in Progressive Choices Magazine and Herizons. Couture continues to direct Herstreet, and in a recent conversation, she noted that the shelter continues to offer unique services to homeless women, embracing them as they are, but Couture has spent a great deal of time thinking about how to offer even more support.



"We have deepened our reflections about the ways that we can help women heal the wounds that they have when they come here," she says. " We have been looking at the theories of relational health as they relate to relationship-building. If the women can work with those wounds, they may be able to reconnect with the world, be less excluded, and find a path from homelessness."

Images: ThinkStockphotos/Hemera



Disinfection & Downstream Effects:

Gender and the Implications of Pharmaceuticals and Personal Care Products in our Water

By Sharon Batt

Trace levels of pharmaceuticals and personal care products (PPCPs) are presently found in Canadian surface water and groundwater, and drinking water. Indeed, these compounds are starting to be acknowledged as pollutants that are persistent in our environment. Their 'persistence' is thought to derive not only from chemical properties that resist their breakdown in the environment, but from their continuous, and growing, release.

Because only a fraction of ingested drugs are completely broken down by the human body, a portion of these drugs and their metabolites enter our waterways daily, along with the compounds from the myriad of personal care products – shampoos, soaps, creams, gels, detergents – routinely washed down the drain. Pharmaceuticals also enter the environment via agriculture, aquaculture, hospital effluent and manufacturing plants. At present, neither wastewater nor drinking water treatment facilities are designed to completely remove these products, which results in their persistent release into Canada's lakes, rivers and streams. While the concentration of PPCPs in the environment is very low, researchers and policy makers in Canada and internationally have expressed a concern that these chemicals have the potential to harm ecosystems and human health over the long-term.

Box 1 lists the PPCPs that have been found in Canadian drinking water. Routine data are lacking however, since PPCPs are not included in current drinking water guidelines nor are they tested for in drinking water treatment facilities. Around the world, well over 30 different types of PPCPs have been found in drinking water.

Images: ThinkStockphotos/Hemera, istockPhoto

Not only may we be chronically exposed to trace levels of PPCPs in our water but the presence of PPCPs in drinking water creates another problem: PPCPs can react with the chemicals used to disinfect our water to form additional chemical by-products. Already, a wide range of disinfection by-products (over 600 have been identified) are created when disinfectants such as chlorine react with naturally-occurring organic matter found in water. While the evidence is inconclusive, studies have linked exposure to disinfection by-products to a range of adverse health effects including certain forms of cancer and reproductive health outcomes. Emerging research shows that PPCPs, too, can react with the same disinfectants. For example, new chemical by-products, often of unknown properties and toxicity, are created when disinfectants mix with common PPCPs, such as the estrogenic steroids used in contraceptives, anti-inflammatory agents such as ibuprofen, the antibacterial agent triclosan, and ultraviolet (UV) filters.

Clearly, disinfection promotes public health by killing pathogens in drinking water. And yet, the formation of disinfection by-products, particularly those derived from PPCPs points to the limitations of technological solutions for controlling contaminants in drinking water.

What does a sex and gender analysis (SGBA) of the problem reveal?

Important questions of sex and gender do not feature in current analyses of PPCPs in the environment, despite the obviously gendered patterns of use for many pharmaceuticals (e.g., contraceptives, hormone therapy, anti-depressants) and personal care products (cosmetics, sunscreens, perfumes), and the possible sex and gender-related disparities in health effects of exposures to trace levels of these contaminants and disinfection by-products, in drinking water.

Gendered use of PPCPs

Many of the PPCPs detected in the environment are used in different

PPCPs found in Canadian drinking water samples

- *Acetaminophen* - Analgesic (pain reliever)
- *Benzafibrate* – Cholesterol lowering drug
- *Carbamazepine* – Anti-convulsant
- *Enrofloxacin* - Antibiotic
- *Gemfibrozil* – Lipid lowering drug
- *Ibuprofen* - Non-steroidal anti-inflammatory drug
- *Lincomycin* - Antibiotic
- *Ketoprofen* - Non-steroidal anti-inflammatory drug
- *Meclocyclin* - Antibiotic
- *Naproxen* - Non-steroidal anti-inflammatory drug
- *Norfloxacin* -Antibiotic
- *Roxithromycin* - Antibiotic
- *Sulfamethoxazole* - Antibiotic
- *Tetracycline* - Antibiotic
- *Trimethoprim* -Antibiotic
- *Triclosan* – Antibacterial agent
- *Tylosin* -Antibiotic

ways, and in vastly different quantities, by men and women. This is true both for pharmaceuticals and for personal care products. Women consume more pharmaceuticals than men, for reasons that are both biological and social. Contraceptives, fertility drugs and menopausal hormones are prescribed exclusively to women, and many women are on some form of hormonal medication throughout their lives, from puberty onwards. Women are also diagnosed with psychiatric problems such as depression and anxiety more often than men and are more likely than men to be prescribed anti-depressants for similar symptoms of emotional distress.

Personal care products (PCPs) are distinct from pharmaceuticals in a number of ways. PCPs are generally meant to be safely used by healthy people. PCPs include such a large and varied range of products that discussing gendered use in relation to particular chemical ingredients is not self-eviden. Some popular products are clearly used predominantly by women, however. For example, the overwhelming majority of users of ultraviolet (UV) filters - the chemicals used in the production of sunscreens - are women; the same is true for many other products (creams, lotions, cosmetics, etc) that now commonly contain UV filtering compounds. Synthetic musks – the chemicals used as fragrance materials in a wide range of consumer products including perfumes, soaps, lotions, shampoos, and laundry detergents - also have distinctly gendered patterns of use.

Gendered exposures to PPCPs

Assessing gendered exposures to PPCPs in drinking water is difficult given the paucity of data available on PPCPs in the environment broadly, and gender based data specifically. Do women drink more or less water than men? Are women's places of residence – clearly a factor in determining drinking water quality – distributed differently than men's? Answers to such questions would provide better insight into gender differences in exposure. The exposure of pregnant women to PPCPs in drinking water is one area where some data are available. For example, the recommendation that pregnant women drink two litres of water of per day, if followed, might expose this group to more contaminants than someone drinking less over an equivalent period. Indeed, one estimate found that following the two litre/day guideline might expose a pregnant woman to five drugs of particular concern during her pregnancy.

What is a sex and gender based analysis (SGBA)?

A SGBA takes into account biological and social differences between women and men, in order to uncover the potentially disparate implications for health.*

Sex and gender shape our *use* of PPCPs, our *exposure*s to PPCPs and DBPs in drinking water, and also the *effects* of these exposures on our bodies and on our health. Other variables are also important. Thus, heath disparities may arise from sex and/or gender differences as they intersect with social factors such as income, geography, race, ethnicity, and language,

*Barbara Clow et al., *Rising to the Challenge: Sex-and gender-based analysis for health planning, policy and research in Canada* Halifax: Atlantic Centre of Excellence for Women's Health (2009).

Gendered health effects of PPCPs in drinking water

Many PPCPs, including oral contraceptives, hormone therapies, anti-epileptics, anti-inflammatory drugs, some anti-depressants, UV filters, and synthetic musk fragrances, are considered endocrine disruptors. At this stage, evidence of gendered health effects of PPCPs is drawn primarily from research examining the impact of endocrine-disrupting chemicals on aquatic species. A common finding among such studies is the feminization of male fish, which manifests as arrested testicular development and the production of early-stage eggs in their testes. When researchers added low concentrations of ethinylestradiol to a Northern Ontario lake, for instance, male fathead minnows were feminized and egg formation in females was altered, leading to near-extinction of the species in that lake. Intersex fish have attracted attention because reproductive changes observed in fish are comparable to effects, such as testicular dysgenesis syndrome, observed in humans. Clues to possible effects can also be gleaned from research on pesticides and industrial contaminants which suggests that ongoing in utero and early childhood exposures to compounds classified as endocrine disruptors may well have gendered health effects.

Women consume more pharmaceuticals than men, for reasons that are both biological and social.

Why worry about trace levels?

Compared to the daily therapeutic dosages of a pharmaceutical drug, the concentrations of any particular drug present in the aquatic environment is very low. As a result, some analysts conclude that the risk to human health from the trace amounts detected in Canadian drinking water samples is negligible because "an individual would have to consume thousands of glasses of drinking water a day to reach the maximum acceptable daily intake". Research on the category of substances known as endocrine disruptors suggests otherwise.

Based on understandings from the new field of epigenetics, endocrine disrupting compounds interact with the body's endocrine signalling systems in a way that makes not only dosage but also timing critical in determining the effects of exposure. Epigenetic alterations reprogram the regulation of vital cellular functions, allowing the organism's organ systems to adapt to stresses in the environment, including exposures to hormones, drugs or toxins, and thereby prepare the organism for meeting similar demands in later life. This reprogramming or imprinting takes place at critical periods or "windows" in the development of organ systems. In humans, these periods occur during fetal development, childhood and, for the reproductive and central nervous systems, continue into late adolescence. Synthetic chemicals that mimic internal cues have the capacity to confuse this adaptive system, increasing the risk of diseases later in life. Thus, exposure to chronic low levels of endocrine disruptors in the environment might well have human health effects; stage of development would be highly relevant; and significant interactions among substances might be expected.

Concerns about the human health effects of PPCPs in the environment are not restricted to endocrine disruptors, however. All pharmaceutically active compounds are developed to target specific biological activity and are not meant for dispersion into the environment. It is for good reasons that many pharmaceuticals are available only with a prescription, specifically because they are not appropriate for everyone, or for widespread or long-term use. In contrast to pharmaceuticals, personal care products are not designed for human consumption at all. Very little is known about the potential health effects of chronic ingestion of these compounds; as with pharmaceuticals,

however, their presence in drinking water, even at very low levels, raises important questions for long-term population health.

Looking upstream: a neglected part of the solution

For some, the solution to PPCPs in drinking water rests with improved water treatment systems. While such technologies are an important element to control the levels of PPCPs in drinking water, they cannot be the only strategy, for several reasons. First, advanced treatment technologies such as ozonation are costly, and are therefore likely to remain inaccessible to most Canadians who continue to rely on chlorine to disinfect their water. Second, even the best technologies are unable to completely remove all contaminants, and worse, as noted above they can create additional by-products, seldom accounted for when assessing the merits of such treatments. Ozonation of the anti-convulsant drug carbamazepine, for instance, has been found to yield three new and previously unreported by-products. Given that new PPCPs are constantly becoming available in the marketplace, it becomes questionable whether treatment technologies will be able to keep pace.

Rather, such "end of pipe" solutions should be coupled with strategies for reducing the load of PPCPs entering into the environment in the first place. Taking a preventative or "upstream" approach recognizes that while the risks posed by such substances may not be entirely known, it is better to err on the side of caution. Moreover, many upstream steps could be implemented immediately and relatively cheaply, when compared to the longer term investments required for broad scale improvements to drinking water treatment plants.

...even the best technologies are unable to completely remove all contaminants, and worse, they can create additional by-products

While many PPCPs serve essential, life-affirming ends, there are also cases where the use of some products could be curtailed or eliminated altogether. One example is the proliferation of antibacterial products such as hand soaps, many of which contain triclosan – a substance now found widely in the environment, including in drinking water. Despite their popularity, the use of antibacterial products for regular hand washing is not recommended by Health Canada, the Canadian Medical Association, or the Canadian Paediatric Society.

And yet, current PPCP use and promotion trends point in the opposite direction. Canadians are consuming more and more drugs each year. For their part, pharmaceutical companies are delivering drugs in more aggressive and ever inventive ways, often with specific campaigns that target women and exploit gender roles.

Some upstream strategies to consider might include:

• Reducing pharmaceutical use by strengthening the direct-to-consumer advertising ban in Canada. At present, enforcement is woefully inadequate;
• Stemming the tide of pharmaceutical inputs to aquatic systems by broadening consumer pharmaceutical take-back programs. Programs exist in a handful of provinces. More should follow suit;
• Better education of consumers, including young people, patients, physicians and pharmacists about the environmental consequences of improper disposal and misuse of PPCPs; and
• Judiciously curbing the use and promotion of some PPCPs.

Clearly, practical and realistic steps can be taken immediately to curb the release of PPCPs into the environment. A sex and gender based analysis reveals that attention to the impact on women is a critical aspect in such efforts.

Sharon Batt is a founding member of Breast Cancer Action Montreal and author of Patient no More: The Politics of Breast Cancer.

CWHN Webinar Series

Last year, the Canadian Women's Health Network (CWHN) launched its new series of webinars. The interactive lecture format allows presenters to speak to and take questions from a nationwide audience online, and allows audience members to interact and discuss presentation material with each other. Sessions are also recorded and available on CWHN's website for later viewing by those who couldn't attend the webinar.

Maternal Health Internationally - What's Really Needed?

Recorded June 16, 2010

Shortly before the much-hyped G8 and G20 summits in Toronto, the Canadian Women's Health Network welcomed Katherine McDonald, Executive Director of Action Canada for Population and Development, to discuss what the evidence shows about maternal health internationally.

McDonald addressed the costs and benefits of investing in maternal health, family planning and newborn care around the world. Using powerful examples, she illustrated how addressing the full spectrum of care, from family planning through to infant care, has far reaching benefits to women and communities, both health and social. Bringing reliable evidence to a passionate debate, she discussed what we need to do to address gaps in family planning, address gaps in maternal and newborn care, and why funding the complete spectrum of care leads to better outcomes for both mothers and children, and uses funds most efficiently.

Creating Climate Change for the Medical Workplace: Lessons on physician work-life balance from around the world

Recorded April 29, 2010

Members of the Federation of Medical Women of Canada joined CWHN to discuss the challenges of finding balance in medical workplaces.

Despite the fact that women now make up half of all physicians in Canada under 35, and up to 70% of students in some med schools, there are still gender issues. Presenters addressed the questions of which specialties women are choosing, working hours and issues of work-life balance. Reflecting on their 2008 Needs Assessment, the FMWC discussed three priorities to make the most of both the women and men who make up our medical workforce – of improved workplace flexibility, increased physician resources in Canada, and the need for more female faculty and women advancing into leadership positions.

Check www.cwhn.ca or subscribe to Brigit's Notes, CWHN's monthly newsletter, for the announcement of upcoming webinars.

Breaking down the walls:

Building a case for community-based alternatives to incarceration that better meet the needs of criminalized women

By Jennifer Bernier, PhD

In the current socio-political climate in Canada, we are seeing government campaigns to increase spending on incarceration. Instead of building more jails and prisons, what we need to do is examine the underpinnings of those already in existence and create alternatives that better meet the needs of those who become entangled within the correctional system. In Canada, a dual correctional system divides responsibility between the federal and provincial governments. Individuals sentenced to two or more years fall under federal jurisdiction while those who receive a sentence of less than two years fall under provincial or territorial jurisdictions. This divide has resulted in relatively consistent services at the federal level and non-standardized policies, procedures, practices, and programming at the provincial level. Having a single governing body at the federal level has also made it easier to identify and address issues related to federal prisons, including the experiences of federally sentenced women and men. In contrast, little is known about the provincial correctional system.

Despite the fact that the provincial correctional system incarcerates the largest number of individuals in Canada, the individual and collective experiences of those

incarcerated within provincial jails have been largely overlooked, especially in regard to women. Unlike the federal system, which has correctional facilities specifically for women, provincially sentenced women are routinely incarcerated in jails constructed for and largely inhabited by men. There is little information that describes what it is like for women to be housed in provincial facilities or their experiences of returning to the community. This lack of knowledge is problematic given that women have the fastest rising rates of imprisonment in the world, far exceeding rates for men. As more and more women are incarcerated, more will return to the community. Gaining a greater appreciation for the factors that influence experiences of incarceration, as well as facilitate or impede reintegration is paramount for providing women with the support they need.

To begin to address this gap in knowledge I conducted a qualitative study, speaking with 32 women across Atlantic Canada who were either incarcerated at the time or had previously been incarcerated in a provincial correctional facility. These women spoke candidly about their incarceration and reintegration experiences. They discussed the jail environment and how detrimental it was to their healing and rehabilitation. Participants argued that few supports were available in Atlantic jails and communities to help women address the underlying issues that led to their criminalization. These women described what supports women needed in jail and as they made the difficult transition from incarceration to the community. It is evident from the women's stories that, in its current form, the provincial correctional system is failing to adequately meet the needs of the women.

We know that criminalized women are amongst the most marginalized groups in society. They often come from vulnerable social and economic situations. The women who participated in this study, like many other women in jail, were either unemployed or working in unstable jobs, surviving on low incomes prior to and following incarceration. The majority were lone mothers. Most of the women I spoke with had experienced histories of trauma and/or violence that typically started in their childhood and continued into their adult lives. Substance abuse and mental illness were also pervasive. A disproportionate number were Aboriginal people who had experienced historical, cultural, and personal oppression. Unlike

Why use the term "criminalized" as opposed to "criminal" or "offender?"

Many feminist scholars and advocates no longer use the terms "criminal" or "offender," because such labels individualize and pathologize those who become entangled within the criminal justice system. Instead, the term "criminalized" is being used to bring attention to the social, political, economic, cultural, and psychological processes that influence crime and criminality. It implies that there are things about women's and men's lives that effect how they are treated by society and the criminal justice system. These factors, which include gender, race, education, employment, income, housing, and other social determinants of health, contribute to the reasons why women and men commit crime and influence how acts become defined as crimes.

findings from previous studies, however, which have identified criminalized women as being under-educated, most of the women I spoke with had finished high school and a large percentage had attended college or university. This finding suggested that for the women in this study, education did not translate into economic security and often forced them into precarious living situations.

The study found that there were very few programmes or services available in the provincial correctional system to address the social and economic issues women face. Health services were lacking in Atlantic provincial jails. Physicians were typically only available onsite once per week, which resulted in lengthy wait lists. According to the women who participated in this study, when women did seek medical attention there was a general lack of respect and confidentiality regarding their medical issues by both medical and correctional staff, the latter being mandated to be present during medical appointments. Mental health and addiction supports were insufficient to address the needs of women. Mental health and addiction counsellors were usually onsite once per week and it was common for women to only be allowed to see one or the other. Addiction programs such as Alcoholics and Narcotics Anonymous were most often co-ed with a larger number of spaces reserved for male prisoners. In addition, few employment programs were offered through the provincial system and, unlike federal prisons where women get paid for working in the institution, provincially sentenced women were not financially compensated for kitchen, laundry, or cleaning duties. The women in this study rarely received any kind of release support to help them set up necessities such as housing, social assistance, social support, and programming prior to exiting the provincial system. The only program that was offered consistently across the correctional facilities was education and most of the women who participated in this study had education levels that surpassed what was being offered at the jail. In many cases, the lack of programming, services, and supports available to women in provincial jails meant that they often returned to the community in even worse social and economic situations than when they entered the correctional system.

Of the programs, services, and supports that were offered for women at the jails, the vast majority were provided by non-profit community groups

Of the programs, services, and supports that were offered for women at the jails, the vast majority were provided by non-profit community groups, such as the Elizabeth Fry Society and various faith-based organizations. In fact, external organizations played the biggest role in service provision and in addressing the social determinants of health – the factors most often responsible for women's criminalization and subsequent incarceration. In the jails where such groups were absent, women said they had very little support.

The jail environment itself was described as being harmful to women's overall well-being. Gender disparities were particularly noticeable given that the majority of women who participated in this study were housed in the same facilities as men. According to these women, female prisoners were housed in smaller units than men and regularly experienced overcrowding. At one of the jails, participants spoke of having to routinely sleep on the library floor because there were not enough beds. Women were also more likely than male prisoners to have their movement restricted, meaning they

had less access to public areas in the jail such as the cafeteria and the "yard." It was common for women to report long periods of time – up to several consecutive weeks – where they had not been let outside for fresh air. These gender inequities were often explained as being a result of the fact that women comprised a smaller proportion of the jail population than men. Whether or not women represent a smaller number, these practices violated their basic human rights. As another example of gender disparities in the provincial system, the women in this study said that when correctional programming was available, men were frequently given priority to attend. For example, male prisoners had more assigned seats in school and in such programs as Alcoholics and Narcotics Anonymous. It was unclear whether access to programming was based on the proportion of the female and male population. Regardless, restricting participation meant that many women who wanted to attend were not able to get the programming they wanted.

Unlike the federal system, which has the financial resources available to provide programming, services, and supports, the provincial correctional system lacks the necessary funding to properly support prisoners. The fact that women and men in the provincial system serve less time than those incarcerated in federal prisons also plays a role in service implementation. There is no doubt that a lack of resources and shorter time spans makes it challenging for provincial jails to offer the necessary programs, services, and support to address the underlying issues that lead to criminalization.

What this study shows is a system that is already unable to support those under its care. It is unlikely that building more jails will be the answer. Instead, we need to invest in alternatives that better meet the needs of criminalized women. Few women entangled in the correctional system present a danger to the community. The vast majority commit minor property offences, such as theft – attesting to the

Physical Health Needs of Criminalized Women and Men in the Provincial Correctional System:

The Atlantic Centre of Excellence is currently conducting a project that builds on one of the findings from the study that this article is based, which showed that provincially sentenced women suffer from a host of physical ailments and have little access to health services while in custody. The current study will survey incarcerated women and men and interview them in a group setting to learn more about the physical health status and needs of women and men in provincial jails, as well as sex and gender differences in their access to and use of health services.

For more information, visit:
Atlantic Centre of Excellence for Women's Health
www.acewh.dal.ca

fact that women are increasingly being criminalized for their social, political, economic, and cultural marginalization. Instead of building more correctional facilities, we need to focus on community-based programming, services, support, treatment options, and early interventions for prevention. This study found that the bulk of programming in the provincial system is already being provided by community-based non-profit organizations. By investing in these organizations instead of constructing more jails, women would be able to receive more support on the inside that addressed the underlying issues that led to their criminalization and worked to impede reintegration. But it is not just about addressing issues in the current system, we also need to work towards building an alternative infrastructure where criminalized populations receive all necessary programming, services, support, and treatment in the community – not in jails.

Jennifer Bernier recently graduated with a PhD in Community Psychology from Wilfrid Laurier University. This article is based on her doctoral research which examined the incarceration and reintegration experiences of provincially sentenced women in Atlantic Canada. Jennifer is currently the Gender-based Analysis Coordinator at the Atlantic Centre of Excellence for Women's Health.

Marginalization *through* Aggregation

By Steve Chasey and Ann Pederson

Cardiovascular disease is the second highest cause of mortality in Canada, eclipsed only by cancer as the highest cause of death for Canadians. When the aggregate CVD numbers are compared for women and for men, the sexes appear to have similar experiences of CVD – in 2000, 50.5% of all cardiovascular deaths in Canada were women and 49.5% were men. However, aggregation masks dramatic differences for men and for women in terms of cardiovascular disease. Applying a sex- and gender-based analysis reveals that historically, men have had higher mortality rates from CVD, leading to the perception that CVD is a disease mainly afflicting middle-aged men. Therefore, until recently research has often only included men, leading to a male bias in our knowledge about CVD treatment and symptoms. But research has since demonstrated that the symptoms of CVD for men and women can be different, and many groups, including The Heart and Stroke Foundation of Canada, are launching education campaigns on the topic. These emerging sex-specific findings have been possible because CVD-related research has begun to include both men and women and disaggregate data by sex, with some researchers even beginning to develop sex-sensitive indicators of CVD. In other words, aggregation has been challenged, and sources of marginalization that once were invisible are now plain to see. This new line of research will improve cardiovascular care across the Canadian population.

Cardiovascular disease is only one example of how critical issues for women's health can be lost through data aggregation, a lack of sex- and gender-based analysis, (SGBA) or not collecting data broken down by sex in the first place. There is a fundamental question underlying this issue – how can our surveillance systems collect, process, and report on the data that are important to women's health?

Some argue that a female-specific set of health indicators (a single set of measurements that captures the status of women's health) is needed. Others argue for making mainstream health indicators more gender-sensitive (improving how our current systems monitor issues that vary for men and women) by improving current indicators and complementing them with measures that better capture women's and men's health. Progress in both of these streams has been captured within Canadian Women's Health Indicators: An Introduction, Environmental Scan, and Framework Evaluation, a report recently released by the British Columbia Centre of Excellence for Women's Health. The report traces the evolution of women's health indicators over the past 20 years, highlighting the recent and ongoing work of several key Canadian women's health organizations. The full report can be viewed or downloaded here.

Gaps in Canada's ability to report on women's health began to receive attention in the mid 1990s. In 1998, the Laboratory Centre for Disease Control at Health Canada noted a lack of data concerning women as a gap in their surveillance. In response, Health Canada assembled an Advisory Committee on Women's Health Surveillance to oversee the development of women's health surveillance in Canada. The committee was informed by the efforts of women's health researchers working at the national, provincial, and local levels and their recommendations have helped shape future efforts. These include development of frameworks for women's health indicators, attempts to develop sex-specific and gender-sensitive sets of indicators, and a range of other initiatives driven by Canadian women's health researchers and other interested parties.

The POWER Study (Project for an Ontario Women's Health Evidence-Based Report) is one such organization pushing for change. Throughout this multi-year project, the POWER team has been producing the POWER Report which examines current health information to uncover the differences between men and women and between various groups of women. Its goals are to examine gender differences on a comprehensive set of evidence-based indicators as well as differences among women associated with socioeconomic status, ethnicity, and geography. The POWER report provides an in-depth look at numerous health domains representing the leading causes of morbidity and mortality among women including: burden of illness, cancer, depression, cardiovascular disease and access to health care. Individual reports on these specific health domains provide an in-depth analysis of women's health data, and include a strong diversity component, highlighting the health of specific subpopulations in Ontario. The POWER Study is using performance measurement and reporting on gender and socioeconomic inequities in health and health care as a tool for knowledge translation.

How can our surveillance systems collect, process, and report on the data that are important to women's health?

The Prairie Women's Health Centre of Excellence (PWHCE) in Manitoba has also recently undertaken a series of projects that strengthen our understanding of both how a female-specific set of health indicators and a gender-sensitive set of health indicators would improve our understanding of women's health. In 2007, the PWHCE conducted the a field test of a set of women's health indicators proposed by the World Health Organization using Manitoba data, with the goal of assessing the feasibility of using the core set in a province of Canada. Similar field tests were undertaken in Tanzania and China. PWHCE noted that in order for the core set of indicators to properly capture the experiences of Manitoba women, data would need

to be not only sex-disaggregated, but also account for diversity. Their report notes that Manitoba women have different geographical, ethnic, and socioeconomic backgrounds and that therefore indicator analysis must examine the health implications of these differences.

In 2008, building on the feasibility study of the WHO core set of women's health indicators, PWHCE released their gender-based analysis of over 140 women's health indicators, using a variety of sources of data for Manitoba (available at www.pwhce.ca). Whereas the feasibility study approached a core set of indicators of women's health, the Profile of Women's Health applied a sex- and gender-based analysis to mainstream data sources in Manitoba in order to develop a comprehensive picture of women's health. The report was one of the first to provide an in-depth, provincial analysis; local-level results contain profound implications for service delivery, policy and research such as concrete recommendations on how to support the development of a health system that is sensitive and responsive to women's needs.

The British Columbia Centre of Excellence for Women's Health (BCCEWH) in Vancouver has also been a key organization in advancing the surveillance of women's health in Canada. Since 2006, BCCEWH has partnered with women's health organizations from across Canada in order to develop The Source, a pan-Canadian resource for women's health surveillance. The Source provides an SGBA, data sources, and reports on over 70 indicators of women's health broken down into categories of health determinants, health status, and health services. The Source contains descriptions of sex-specific, gender-sensitive, and qualitative indicators, including analysis of each in terms of sex, gender, and diversity.

These initiatives, which have been influenced by and have contributed to similar international efforts, have all provided insight into how to move forward with Canadian women's health surveillance. While the debate continues between the utility of a sex-specific set of indicators versus making standard indicator sets more gender-sensitive, a different trend has also begun to emerge. A number of organizations, including the World Health Organization, have begun to explore an equity-focused set of indicators that measure not only issues of sex and gender, but also other population characteristics that have historically led to marginalization and/or health inequity. Socio-economic status, geography, language, race, religion, and other factors all fall into this category.

The development of effective indicators to monitor marginalizing social and material forces may assist in the future advancement of women's health surveillance. Many of the questions equity indicators seek to answer – such as how is health affected for different population groups – are the same types of questions asked in sex- and gender-based analysis. Fundamentally both techniques are concerned that summarizing data across a population can potentially mask important differences for specific subgroups. If the differences for these groups cannot be seen in the data, they will continue to be invisible in research, policy and practice. In order to develop the most effective techniques to avoid marginalizing at-risk groups, future research should explore the overlap between equity, sex, and gender, and create suggestions on how these techniques can complement and support each other.

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Steve Chasey is the Manager of Data and Surveillance at the British Columbia Centre of Excellence for Women`s Health. Ann Pederson is the Director of the British Columbia Centre of Excellence for Women`s Health.

WHAT WE'RE READING recommended resources

Sex, Lies, and Pharmaceuticals: How Drug Companies Plan to Profit from Female Sexual Dysfunction

By Ray Moynihan and Barbara Mintzes (Greystone Books, 2010)

A provocative exposé of the lucrative industry built around a newly constructed disorder.

Set against a backdrop of virtual intercourse, online porn, and burgeoning Viagra sales, this compelling new book reveals how women's sexual difficulties are being repackaged as symptoms of a new disease—female sexual dysfunction, or FSD.

Award-winning journalist Ray Moynihan and drug assessment specialist Barbara Mintzes go inside the corridors of medical power to reveal how doctors, psychologists, and PR specialists are now working with global drug companies to promote awareness of this potentially lucrative condition and the drugs being hailed as its cure-all.

Sex, Lies, and Pharmaceuticals explores the controversy about whether common sexual difficulties should be treated as medical conditions like FSD, which may be a dangerous distraction from the real problems in sexual relationships.

The book also offers practical information about the risks and benefits of the latest pills and canvasses other approaches to understanding common sexual problems.

For more from Barbara Mintzes, check out our webinar series. In a presentation on on Sex, Lies, and Pharmaceuticals, Barbara discusses the book, what we might expect to see if a FSD drug ever makes it to market, and participates in a lively audience discussion.

Maternity Rolls: Pregnancy, Childbirth, and Disability

Heather Kuttai (Fernwood Publishing, 2010)

Though much has been writeen about women's experiences with pregnancy and childbirth, the experiences of women with disabilities have gone largely untold. Heather Kuttai, a spinal cord injured mother of two, argues that this silence results from a prevailing belief that living with a disability means living without sexuality. Kuttai reveals how this pervasive attitude affected her perception of herself as she matured into adulthood, and how, through pregnancy and childbirth, she was finally able to see herself as a "real woman and whole person."

Valuing Care Work: Comparative Perspectives

Edited by Cecilia Benoit and Helga Hallgrimsdottir (University of Toronto Press, 2011)

There are many forms of paid and unpaid labour encompassed in health care systems, including home care for the eldery or disabled, community health services, and the care family members provide for loved ones. Valuing Care Work is an international comparitive study that examines economic organizations as well as intimate settings to show how personal service work is shaped by broader welfare state developments.

Gender, Health, and Popular Culture: Historical Perspectives

Edited by Cheryl Krasnick Warsh
Wilfrid Laurier University Press (2011)

Health is a gendered concept in Western cultures, customarily associated with strength in men and beauty in women. Educated or self-styled experts, ranging from physicians to newspaper columnists to advertisers, offer advice on achieving optimal health. Historically, gendered concepts of health were transmitted through visual representations of the ideal female and male bodies, with media images resulting in the absorption of universal standards of beauty and health and generalized desires to achieve them. .Seemingly "objective" public health advisories are shown to be as influenced by commercial interests, class, gender, and other social differentiations as marketing approaches, and the message presented is mediated to varying degrees by those receiving it.

Women Who Care: Women's Stories of Health Care and Caring

Edited by Nili Kaplan - Myrth, Lori Hanson and Patricia Thille
(Nimbus Publishing, 2010)

In her third year of medical training – discouraged by how little focus there was on caring – a young woman was faced with a decision: she could throw her hands up and quit or she could risk speaking up and work toward change. She decided to send out a call for submissions, asking women to share their experiences of health care and caring. Her inbox immediately overflowed with stories from women across Canada. Together, this amazing group of women wrote Women Who Care. Most women have stories to tell about their experiences of health care. They care for themselves through personal health and illness; they seek care from others; they become lay caregivers to their children, partners, aging parents and extended families. Some work as health care professionals – physicians, nurses, midwives, physiotherapists, social workers, psychologists. Others work in community centres and shelters, or as health administrators, health policy-makers, women's health researchers, and as feminist leaders and activists in women's health. Women Who Care is a collection of women's stories about caring. Through prose and poetry, this book captures the personal and professional values and expectations of women caregivers at each stage in their lives and careers. It examines women's experiences as the providers and recipients of health care.