Canadian Women's Health
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Women and disaster

Casting light
Taking on body image and the media

The POWER of equity
Gender and heart health

Got a cervix? Get a Pap
Encouraging lesbian, bisexual, and trans people to get tested

Canadian Women's Health Network
Le Réseau canadien pour la santé des femmes

editor's note

Recent tragedies in Haiti and other countries have brought disasters to the front pages of the news, and we bring our focus to it our first article of the Spring/Summer issue of Network. Through the work of Elaine Enarson and the Women and Health Care Reform working group, we look at why it is essential to consider sex and gender when we think about emergency preparedness and recovery, touching on both the particular vulnerabilities and strengths of women in disaster situations.

Two recent public awareness campaigns that aim to get women and girls thinking about their own health make the pages of this issue.

In *Got a cervix? Get a Pap* Canadian Women's Health Network (CWHN) Director of Knowledge Exchange Jane Shulman discusses a new campaign pushing the importance of a Pap tests if you are lesbian, bisexual or trans. She speaks with members of the Queer Women`s Health Initiative about their work on the ``Check it Out`` campaign to help spread the word and combat common misconceptions among both queer communities and health providers.

The National Eating Disorders Information Centre is also catching the attention of girls and women with its campaign on body image and the media. In *Casting Light*, we look at how women`s self-image can be affected by hyper-thin ideals of beauty, and how the in-your-face campaign is targeting both the consumers and creators of the images and pushing for a more diverse and healthy standard.

Alcohol use and abuse among young women is examined in work from the British Columbia Centre of Excellence for Women`s Health. Trends, specific health risks and consequences for young women, influences and prevention strategies found through a literature review are all addressed.

Also from the Centres of Excellence, this issue features highlights from the new publication *Rising to the Challenge: Sex- and gender-based analysis for health planning, policy and research in Canada*. Jennifer Bernier, one of the book`s four editors, discusses the importance of integrating sex- and gen-

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der-based analysis into all work on health, and how this book and its accompanying workshops provide a framework to make that possible. Executive Director of the CWHN Madeline Boscoe is among the contributors, writing on sex and gender in systematic reviews.

This issue also marks the end of Madeline Boscoe`s time as the Executive Director of the CWHN. One of the founding members, she has been the organization's leader for fifteen years, tirelessly promoting women`s health and working to make sex- and gender-sensitive programs and policies a reality. Madeline continues to be a true leader of the women`s health movement and will be missed by everyone at the CWHN as she moves on to new challenges. In honour of Madeline, the CWHN has created the Madeline Boscoe Visionary Fund, to help ensure that her work continues for years to come. To contribute to the Madeline Boscoe Visionary Fund, please visit our website at www.cwhn.ca

Sincerely,
Signy Gerrard
Director of Communications

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WHAT'S INSIDE

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Women and Disaster

Adapted from Not Just Victims: Women in Emergencies and Disasters from Women and Health Care Reform

After the recent earthquake in Haiti, the United Nations World Food Program (WFP) made headline news when it began to distribute "women only" food coupons. By distributing some aid exclusively to women, they were in fact trying to make sure as many people as possible received it. Women tended to be responsible for their household's food supplies, the WFP explained, and were losing out on supplies when young men pushed to the front of lines or swarmed aid trucks.

This may have been the first example many people had ever seen of accounting for sex or gender differences in disaster situations. Over the last 15 years, however, the body of work on gender and disaster has grown, as we recognize that looking at sex and gender can help identify and prepare for different strengths and vulnerabilities in times of crisis.

Why should we think about women in emergencies?

Women and men, girls and boys may go through the same disaster, but they are likely to experience it differently. Different health risks, for instance: Women are more physically vulnerable to the effects of heat waves, and heavily pregnant women may need special transportation or other supports during emergencies.

Gender roles and stereotypes likewise affect the experiences of women and men during disasters. Women are frequently assigned to tend the ill and injured because they are expected to be natural nurturers, or because they are the overwhelming majority of paid caregivers. Men are expected to be physically stronger than women and therefore will more often be called upon to engage in hard labour during emergencies. Gender can also place women and men at different risks of disaster. The SARS epidemic disproportionately affected women and their families,

because there are more women working in the health care system.

In the wake of disasters, women's experiences are also quite different from those of men. In paid or unpaid realms, women offer more sustained emotional support to disaster victims, as volunteers, as paid workers and as family members. Economic relief and recovery packages often do not reflect women's dominance in informal, part-time and home-based labour where they generate essential income. The economic impacts on women can be severe when the loss of a home also means the loss of working supplies, work spaces, equipment, inventory, markets and credit lines. Not only are women differently affected than men by disasters, but also different groups of women will have different needs and will respond differently in the midst of emergencies. For example, the needs of elderly women in remote Métis villages are likely to be very different from the needs of lesbian couples in Toronto if a disaster strikes. Such differences also need to be taken into account in preparing for disasters.

Women at home

Though household roles and responsibilities have certainly changed in recent generations, with more men involved directly in housework and raising children, it is also true that women are overwhelmingly responsible for domestic chores. These roles and responsibilities do not vanish in the event of a disaster. In fact, they often just become much harder to do. Torn by wanting to help in the community and assist neighbours, women also cook for their families and neighbours, care for children, the elderly and other loved ones without their usual equipment and resources.

Recovering from an emergency or disaster may continue long after the immediate threat or destruction has passed.

Because of their roles in the home and community, women are also very knowledgeable about their neighbours. Women know who is most in danger, where they live and what they will need. Research shows that women are quicker to seek out information about hazards and to help their family and communities to prepare for disasters, are more likely to warn others of imminent disaster and to assist in long-term recovery.

Recovering from an emergency or disaster may continue long after the immediate threat or destruction has passed. Women's psychological stress can manifest as anxiety and depression, while some male partners may cope by being abusive. Calls to domestic violence centres and housing continue for months following disasters.

Women on the job

In the paid workforce, away from home or in home-based businesses, women bring critical income to their families. Their ability to continue or resume paid work depends in great part on how well disaster mitigation takes women's concerns into account. If decision-makers do not consider child care a priority, many women cannot return to their external jobs.

For women whose jobs are to provide emergency response, there are also particular concerns. After the SARS crisis in Toronto, nurses shared stories of having ill-fitting equipment that was not adapted to their size and shape. Military women have expressed feeling pulled in many directions by their desire to do their work, while simultaneously worrying about family—more so than the men in the same military jobs. Human resource policy and practice in emergency management should be designed to accommodate employees' family responsibilities to ensure that women and men have appropriate family leave, child and elder care, and opportunities for part-time employment or respite.

Women in the community

Resource centres, community health clinics, transition homes and shelters, though stretched in many ways, do have staff and leaders who think effectively in crisis, have networks with sister agencies and know the needs of the women they serve. With some further planning, on a somewhat larger scale, grassroots agencies can prepare for emergencies and disasters, including becoming knowledgeable about local emergency plans and roles and responsibilities of the various levels of emergency response authorities.

Part of the need for the specific planning, beyond regular work-place safety, is that in the event of a disaster or emergency, women may turn to the resource centre where they feel safe and known. At the same time, emergency planners could benefit enormously from the skills, knowledge and networks of grassroots agencies.

Understanding what women need and can do

The absence of gender analysis and limited uptake of existing knowledge about women and gender in disaster undermines the capacity of national and local emergency planners to develop plans that are inclusive, appropriate and cost effective. In other words, gender-based analysis provides critical information for planning on key issues, such as women's evacuation behaviour, long-term economic recovery, and violence prevention. Indeed human rights can be endangered in crises when gender equity is not part of the working culture of emergency practitioners and gender knowledge is not reflected in their practical tool kits.

Planning with a gender lens does not just mean "add women and stir," but involves a new way of approaching emergency management that sees women and men as full and equal partners in the management of risk. The key is learning to ask the right questions, and then seeking data, information, knowledge and insight

Six Principles to Take Women & Gender into Account in Relief and Reconstruction:

THINK BIG. Gender equality and risk reduction principles must guide all aspects of disaster mitigation (including planning and preparation), response and reconstruction. The "window of opportunity" for change and political organization closes very quickly.

GET THE FACTS. Gender analysis is not optional or divisive but imperative to direct aid and plan for full and equitable recovery. Nothing in disaster work is "gender neutral."

WORK WITH GRASSROOTS WOMEN.
Women's community organizations have insight, information, experience, networks, and resources vital to increasing disaster resilience.

from community members to find answers.

At every stage of the disaster cycle, decision makers and practitioners need sound evidence collected with attention to: 1) sex and gender differences through the life course, 2) differences across diverse populations of women, 3) shifts in relevant national patterns and trends, and 4) applications throughout the disaster life course of preparedness, mitigation/adaptation, response and recovery. There are already databases that can provide important information for planning, such as the percentage of women in different age groups known to be at risk (the young, the old) or the percentage of women with functional language or literacy limitations.

In addition to collecting statistics, planners need to know how the everyday lives of women are shaped by gender differences and by inequalities at every stage of the disaster planning cycle. The first step in understanding the role of gender in disasters is to "see" and appreciate what women and girls do and where they are every day. Planners also need to adopt a human rights approach to disaster management because without this commitment they are unlikely to understand or respond to inequalities based on gender power.

Finally, planners need to look beyond vulnerabilities to consider what capacities, resources, and skills women in different life circumstances bring to emergency preparedness, response and recovery. Women's social networks, skills and resources, and life experiences can all be brought to bear on emergency preparedness, response and recovery.

The publication Not Just Victims: Women in Emergencies and Disasters *is based on original material by Dr. Elaine Arnason and published by Women and Health Care Reform. It is available for download at www.womenandhealthcarereform.ca*

Read about Elaine Enarson's webinar on this topic on page 17, or watch the webinar at www.cwhn.ca

RESIST STEREOTYPES. Base all initiatives on knowledge of difference and specific cultural, economic, political, and sexual contexts, not on false generalities.

TAKE A HUMAN RIGHTS APPROACH. Democratic and participatory initiatives serve women and girls best. Women and men alike must be assured of the conditions of life needed to enjoy their fundamental human rights, as well as simply survive. Girls and women in crisis are at increased risk of violence, rape, losing their land, and job loss.

RESPECT AND DEVELOP THE CAPACITIES OF WOMEN. Avoid overburdening women with already heavy work loads and family responsibilities likely to increase.

From the Gender and Disaster Network

The POWER of Equity

Examining gender and heart health in Ontario

By Naushaba Degani and Arlene S. Bierman

The POWER (Project for an Ontario Women's Health Evidence-Based Report) Study is producing a women's health equity report that measures the health of Ontarians, the performance of the health care system, gender differences in access to, quality and outcomes of care for the leading causes of morbidity and mortality. By measuring health inequities associated with sex and socioeconomic status, we can inform interventions to improve health and reduce health inequities.

Monitoring these inequities in health and health care over time can be used to assess whether or not progress is being made. So far, the POWER Study has released six chapters: Introduction to the POWER Study, The POWER Study Framework, Burden of Illness, Cancer, Depression, and Cardiovascular Disease (CVD), which is the focus of this article. The chapter on Access to Health Care Services will be released in March 2010.

Cardiovascular disease is a leading cause of death and disability among Canadian women and men, accounting for 32 percent of deaths in 2004. Though CVD-related mortality in Canada has declined since the 1950's, the proportion of CVD deaths that occur in women has increased, and now just over half of all CVD deaths occur in women. There is a significant body of evidence that shows that chronic disease prevention and management and patient self-management interventions can reduce CVD-related morbidity and mortality.

The implementation of guidelines for the clinical management of patients with heart disease can improve outcomes of care and specific adherence to guidelines for female patients will narrow gender disparities in care and outcomes. Community engagement and empowerment and social policies aimed at addressing the social determinants of health—an important factor in heart disease risk—can reduce the burden of illness due to heart disease.

The POWER Study CVD chapter includes four sections: the health and functional status of adults with CVD, heart failure, ischemic heart disease, and stroke. In the first, we report on self-rated health, activity limitations and CVD risk factors. In the last three, we examine the acute and longer-term clinical care of patients (the types of physicians providing care, medication management, diagnostic testing and interventions) and health outcomes including hospital admissions, emergency department visits and death.

We identified a number of areas where care received by women and men is comparable, particularly management of the majority of indicators of stroke care in the acute setting and medication management among those age 65 and older, with the exception of statins. Nevertheless, gender gaps persist and we found multiple areas for improvement. First, we found

large differences in health and functional status among individuals who reported having heart disease or a stroke associated with gender and socioeconomic status. Women with CVD were more likely than men to report activity limitations, mobility problems, chronic pain and disability days and low income women were more likely to report these problems than those with higher incomes. These findings draw attention to the need for gender sensitive approaches to reducing CVD burden as well as the need to address the social determinants of health in efforts to reduce the burden of CVD. Second, we found a high prevalence of modifiable risk factors among individuals with heart disease, underscoring the need for increased emphasis on secondary prevention. Third, there were high rates of potentially avoidable emergency department visits and hospital readmissions among individuals with HF, emphasizing the need for the widespread implementation of effective chronic disease management programs integrated across settings of care. Fourth, gender disparities in care remain—particularly in acute myocardial infarction (AMI) care—calling attention to the need to close this gap by explicitly addressing the needs of women in quality improvement efforts and by stratifying indicators by sex to track progress. Finally, performance on many measures varied across the province, highlighting the need for innovative interventions to standardize care, taking into account regional needs and differences.

Key Messages

While we have made progress in improving the quality and outcomes of care for CVD and narrowing gender gaps, much work remains to be done. Sex and socioeconomic inequities in the health and functional status of individuals were much greater than inequities in the provision of acute care services. This suggests that by addressing the social determinants of health, we may also reduce the burden of CVD. The following actions are suggested as ways to reduce the burden of CVD, improve health outcomes among women and men with CVD and reduce health inequities related to CVD. But to be successful, gender and socioeconomic differences in the prevalence of CVD and experiences with care will need to be addressed.

While we have made progress in improving the quality and outcomes of care for CVD and narrowing gender gaps, much work remains to be done.

Reduce health inequities associated with CVD by focusing upstream.

Poverty, low educational attainment, access to healthy foods, and neighbourhood and work place characteristics are underlying factors that increase the risk of heart disease among individuals, increase the rates of heart disease in the population and contribute to continued CVD-related health inequities among those with heart disease. Focusing efforts upstream through community and cross sectoral collaboration can help address the root causes of these health inequities and reduce the burden of heart disease in the population. Because women are more likely to live in low-income households than men, to be most effective, these efforts will need to address the factors that lead to increased rates of poverty among women.

Prevention (primary and secondary) is key to reducing the burden of illness due to CVD.

The prevalence of behavioural risk factors for heart disease remain high in Ontario—smoking, physical inactivity, obesity, and poor diets—in the general population and among people with heart disease. Primary prevention, or reducing risk among those who do not yet have CVD, is

key to reducing illness burden. Secondary prevention will reduce CVD-related illness and death among women and men with heart disease. Prevention interventions need to address the social determinants of health, be gender sensitive and target those who are socioeconomically disadvantaged and therefore at greatest risk. Increased emphasis on prevention and integrated approaches at the population, community and clinical levels are essential to reduce the burden of illness due to CVD in Ontario.

Close the gender gap in care for CVD.
Gender gaps in CVD care have narrowed because of an increased awareness of the importance of heart disease to women and a recognition of the gender disparities in care that exist, combined with activities to close these gaps including gender-specific guidelines. While we did find some gender gaps in clinical care, there were a number of indicators where care for women and men was similar and where there were disparities, many of these were modest. Nevertheless women were still less likely to receive care from a cardiologist, undergo diagnostic testing and they were more likely to be readmitted to hospital after an admission for a heart attack. Of greater concern, women with heart disease consistently reported worse functional status and higher rates of disability than men. Women were more likely to report activity limitations, mobility problems, activities prevented by pain, and disability. Gender sensitive models of care focussed on disability prevention and improved functional status can improve the quality of life of women with heart disease.

Comprehensive patient-centred chronic disease management can improve quality and outcomes of care for CVD.
CVD is a chronic disease requiring coordination across settings of care, including physician care and hospital care. Individuals with CVD often have other chronic conditions such as diabetes and hypertension, because of similar risk factors for these conditions and because CVD and other chronic diseases are more prevalent with increasing age. We found high rates of emergency department use and hospital readmission in women and men with heart failure. Effective interventions that prevent both emergency department use and hospital readmissions would reduce the burden on hospitals and free much needed resources. The implementation of a coordinated, comprehensive, patient-centred, chronic disease prevention and management strategy—one that addresses the needs of at-risk populations—may be the key to improving quality and outcomes of care for CVD.

Province-wide, integrated, organized models of care delivery can improve health outcomes and reduce inequities in care.
We found sizable regional variations in care probably due to differences in human resources, capacity and practice patterns. Province-wide, integrated, organized models of care delivery can improve health outcomes and reduce inequities in care. The Ontario Stroke System—which targets activities across the continuum of stroke care from prevention, prehospital care, acute care and rehabilitation and community reintegration—provides an example for such a model that could be applied to other types of CVD.

Improve quality, availability and timeliness of data to assess CVD and CVD care in the province.
While data quality and availability to assess CVD care in the province has improved, there is still much to be done to improve the quality, availability and timeliness of data. Specifically, medication data on those under age 65, data on management of CVD in ambulatory care settings, and datasets that capture clinical factors are needed. Additionally, data on ethnicity would allow us to assess disease burden as well as access, quality, and outcomes of care to Ontario's diverse communities.

Naushaba Degani is Project Director of the POWER Study. Arlene S. Bierman, a general internist, geriatrician, and health services researcher is Principal Investigator for the POWER study.
To download the entire CVD chapter or the Chapter Highlights go to www.powerstudy.ca/the-power-report/the-power-report-volume-1/cardiovascular-disease.

Photos courtesy of the Queer Women's Health Initiative

Got a cervix?

Get a Pap

Campaign encourages lesbian, bisexual & trans people to get tested

By Jane Shulman

When was your last Pap test? According to Statistics Canada, if you are like 77 percent of heterosexual women in this country, you have had one in the past three years. But if you identify as lesbian, bisexual or you are a transgendered man, you are less likely to have had one recently.

Pap tests, which are routinely performed by family doctors, nurses and gynecologists, check the cervix for abnormal cells. The Pap test can find cell changes (caused by HPV) on your cervix. That way, cell changes can be treated before they turn into cancer. That's why the test is common practice.

Why then, do fewer queer people have Pap tests than heterosexuals? This is a question the people at Toronto's Sherbourne Health Centre and Planned Parenthood Toronto wanted to address after they conducted research among women who have sex with other women.

They investigated women's needs around reproductive health, and found that an alarming number of women weren't having Pap tests either because they didn't know they needed them, or their health care providers told them they weren't necessary.

A working group called the Queer Women's Health Initiative was formed in response, and the idea for the Check It Out campaign was born. The working group soon realized that the campaign needed to include trans men, who are even less likely to have access to Pap tests but may need them just the same.

A separate project called Check It Out Guys is running concurrently. Campaign headquarters are the websites www.check-it-out.ca and www.checkitoutguys.ca. Accessible, concise information, flashy design and eye-catching slogans like "Got a cervix? Get a Pap!" guide the reader through questions or concerns about Pap tests. Content developed with Sherbourne's medical staff and queer and trans community members answers everything from how often to have one, to what actually happens during the procedure. Free posters, postcards and temporary tattoos are available through the websites, as well as a mass of printable information.

Cheryl Dobinson, Director of Community Programming at Planned Parenthood Toronto, says she has heard too often from lesbian and bisexual women who received misinformation about Pap tests from doctors and nurses. "Sometimes women are told that if they're having sex with women, they don't need Paps," she says, "and others who know they need it are denied the test when they have asked for it."

Dobinson says this may be a result of some health workers not knowing enough about how HPV is spread. The Check It Out site notes that HPV "is transmitted through genital skin-to-skin contact with anyone who has the virus—this includes oral sex, sex with fingers or hands, genital rubbing and vaginal sex with toys."

"We're targeting queer women mainly," says Dobinson," but there's a piece for providers too." Ayden Sheim, coordinator of the trans men Pap project, agrees. He says that while trans men are the focus of Check It Out Guys, there needs to be an educational component for providers, partly to help clients trust that sensitive, informed providers are out there. "If I get to a point where I'm ready to get a Pap, that assumes that I have a provider I feel safe with," he said. "The two pieces go hand in hand."

What is a Pap test?

Information from the Check it Out website, Courtesy of *Queer Women's Health Initiative*

Pap tests. No one ever looks forward to them. Many of us are not even sure what exactly they are for or if or why we need them. Below is some information on what a Pap test is all about and why you should consider getting one.

- Your cervix is the narrow end of the uterus which has a small opening (called the os) that connects the uterus with the vagina.
- A Pap test is a microscopic examination of cells taken from the cervix in a doctor's office or health clinic. The Pap test is usually included as a part of an overall pelvic exam, which is a complete examination of the pelvic organs (uterus, ovaries, cervix, etc.).
- The Pap test is a screening tool for cervical cancer, which is preventable through Pap tests and treatment, where necessary.
- The Pap test does not screen for any other forms of cancer.
- The Pap test is not a screening test for sexually transmitted infections (STIs). While the Pap test may show that cells of the cervix have been affected by human papillomavirus (HPV), the STI that can cause the cells of the cervix to become abnormal, the Pap test does not actually test specifically for HPV or any other STIs.

"Sometimes non-queer health campaigns can really exclude queer women. People think that the campaigns don't apply to them"

Pamphlets and information packages about the specific needs of queer and trans clients seeking Pap tests will soon be distributed to clinics in Ontario.

A Pap test for trans men isn't always an easy sell, but Scheim estimates that the majority of trans men have not had a hysterectomy that would include cervix removal, so they need to have regular Pap tests. Even people who have had a hysterectomy may need a test. Working with an advisory board of trans men, the goal was to develop content for a diverse audience.

"Part of the campaign is being really honest and saying this isn't going to be a fun experience," he says, "but there are things we can do to make it less challenging." Sections on the site address the emasculating feelings that a trans man may experience during a pelvic exam, or the pain of speculum insertion if a person hasn't experienced penetration before.

"Our ability to take care of ourselves and advocate for ourselves is more advanced than the health care system is to meet our needs," Scheim says. He stresses that people have the right to interview health care providers about their experience with specific populations. "We know the system isn't perfect for people, but in the meantime, we should be able to take care of our own health as much as possible."

The sites have a peer-to-peer feel about them. The people in the photos are members of Toronto's queer communities. They are people who readers may know, or at least know of. Dobinson says this lends credibility to the sites, and to the information they provide. It's part of the community-building piece that she says is so important to the success of a health promotion campaign.

"Sometimes non-queer health campaigns can really exclude queer women. People think that the campaigns don't apply to them," she observes. "Some are better at being inclusive, but there is still a place for queer women to get information that's specific to us. We're going to reach more queer women with information that's directed to us."

Official project evaluations will begin soon, but anecdotal evidence from clinics that see high volumes of queer and trans people indicate that more people are having Pap tests since the campaign's launch.

Dobinson is a longtime queer-health advocate. She has worked on breast health campaigns and campaigns for lesbians and bisexual women, and is one of the only people in the country to have been working consistently on health promotion projects for queer women over the past several years.

She is familiar with the homophobia and heterosexism that lesbian and bisexual women may encounter from the medical system, and has heard about plenty of negative interactions with the health professionals. But she has seen positive change for queer women in recent years, too.

"As more health care providers get educated about queer women's health and as there are more resources to use," says Dobinson, "it dovetails with more resources to share with queer women, who are then more likely to go and get positive response.

"If those two things are happening, then I would imagine that people are more likely to go back and feel like they are going to be well cared for."

At Planned Parenthood Toronto, where she has worked since August, Dobinson says she is "so excited to be at an organization that is making queer women and our sexual and reproductive health such a priority."

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

RISING TO THE CHALLENGE

Sex- and gender-based analysis for health planning, policy and research in Canada

By Jennifer Bernier

For decades, researchers and activists have understood that women's health and well-being is determined by both sex and gender. For example, we know that female and male bodies have different biological (sex) functions in reproduction and we also know that the social roles and expectations attached to women and men, girls and boys (gender) affect their chances of completing school, providing care for others, having an adequate income, experiencing violence, and living a long, healthy life.

Sex- and gender-based analysis (SGBA) was developed as a method to explore and understand the impact of biological differences between and among women and men, as well as to highlight the effects of gender differences in power, privilege, and opportunity on health and well-being. While conversations about sex- and gender-based analysis have been occurring for nearly three decades, there has recently been a renewed interest in SGBA. In 2008, the World Health Organization's Commission on the Social Determinants of Health released a report that identified gender inequity as a key driver of health disparities and urged action to readdress imbalances of power and privilege between and among women and men. As well, in 2009, the Government of Canada introduced a new policy that now requires policy-makers to apply sex- and gender-based analysis to the development, implementation, and evaluation of policies, programs, and research in order to address the different needs of women and men, girls and boys.

While many understand the importance of sex- and gender-based analysis, the concepts can often be confusing and the practice itself challenging. In an attempt to make SGBA more accessible to a diverse audience, the Atlantic Centre of Excellence for Women's Health (ACEWH), British Columbia Centre of Excellence for Women's Health (BCCEWH), and Prairie Women's Health Centre of Excellence (PWHCE) worked together over the past two years to develop a new resource on sex- and gender-based analysis that explains the core concepts of SGBA—which include sex, gender, diversity, and equity—and the process of undertaking a sex- and gender-based analysis. The book also includes concrete examples of the concepts and process, using case studies and commentaries from more than a dozen other contributors.

In the fall of 2009, ACEWH, BCCEWH, and PWHCE planned a series of workshops on sex- and gender-based analysis to complement the book. The workshops were designed to bring together health planners, programmers, policymakers, researchers, and community-based practitioners who were interested in learning how to undertake and integrate SGBA into their work. At the workshops—held in Halifax, Ottawa, Winnipeg, and Vancouver—participants were introduced to sex- and gender-based analysis, including the current state of knowledge about SGBA and our response to the context, as well as the core concepts and framework outlined in the book. Participants were also guided through a case study that allowed them to practice carrying out a SGBA

using each of the five components of the framework, including issues, populations, evidence, implications, and recommendations—all the while paying attention to sex, gender, diversity, and equity.

Participants responded enthusiastically to the workshops, reporting a better understanding of the core concepts and the framework of SGBA as a process, as well as seeing the usefulness of integrating SGBA into their work:

"I love the concepts and will think carefully about the framework and how I may be able to 'think differently.'"

"I feel I can 'think' about how to apply [SGBA] based on a new understanding…"

While the workshops—and the book that inspired the workshops—challenge health planners, programmers, policymakers, researchers, and individuals from community-based organizations to think more deeply about sex and gender, it also provides them with a framework to help people "rise to the challenge" of understanding sex- and gender-based analysis and integrating it into their work.

Rising to the Challenge can be downloaded at the following websites:

Atlantic Centre of Excellence for Women's Health www.acewh.dal.ca
British Columbia Centre of Excellence for Women's Health www.bccewh.bc.ca
Prairie Women's Health Centre of Excellence www.pwhce.ca

Jennifer Bernier is the Sex- and Gender-based Analysis Coordinator for the Atlantic Centre of Excellence for Women's Health

Unraveling the **Fertility Industry:**

Challenges and Strategies for Movement Building

Report on International Consultation on Commercial, Economic and Ethical Aspects of Assisted Reproductive Technologies (ARTs)

By Shree Mulay

Sama - Resource Group for Women and Health in Delhi, India has had a long standing engagement with women's health and women's rights especially in the realm of coercive population policies, hazardous contraceptive technologies and medicalization of women's bodies. In the last seven years they have turned their attention to reproductive technologies and their impact on women's lives and have engaged in a dialogue with the government on proposed legislation on Assisted Reproductive Technologies (ARTs). They have raised issues of reproductive tourism and surrogacy and the complex ethical issues that emerge from the links between health, society and technology. Sama organized a three-day international Consultation from January 22-24, 2010 with over 90 participants with representation from more than 10 countries who came together to discuss issues and concerns around the proliferation, and normalization of the industry of ARTs. The participants included activists, scholars and

researchers from different movements, different political, social and economic contexts, especially from those countries that are experiencing the implications of these technologies. Journalists, film makers and students were also part of the Consultation.

Discussions ranged from overviews of the current global political economy context, followed by region-specific sessions that brought in local experiences from countries that are facing the implications of these technologies. Each day concluded with a discussion on the possible strategies for movement building, which were then further consolidated in the final session on the last day.

Some of the main points that emerged from the presentations were:

• The interaction of technologies with poverty, business and commerce, religion, race/ethnicity, class and patriarchy in various contexts around the globe. The inter-linkages of ARTs with the growing field of biotechnology industry and the resulting consequences.

• The differential perspectives of the states/governments towards these technologies across the globe, the roles assumed by them in dealing with these technologies, and the underlying reasons for these.

• The failure of the public health systems and policies to address the underlying causes of infertility including impact of occupational patterns, environmental changes, lifestyle changes that negatively affect fertility levels, and create conditions where people have to resort to the use of these technologies.

• Discussion of strategies developed by activists and groups across the globe working on these concerns, the outcomes, and the challenges faced by them.

Some outcomes of the Consultation:

• Participants from across the globe were able to dialogue/debate and share perspectives/commonalities and identify the differences on these issues.

• Concrete strategies emerged towards a movement building at the global level, including for the South Asian regional context.

• The Consultation was able to build and strengthen inter-linkages with other movements and networks working on issues of health, women's rights, sexual rights, disability rights, child rights, law, and bioethics, among others.

• Sama initiated an e-group for all the Consultation participants, to facilitate continued discussions of efforts at the local level, to connect and reflect collectively and to plan and share strategies for action at the global level.

• A small group/collective was formed to take the strategies discussed at the Consultation forward in a sustained manner.

• A detailed report based on all the discussions over the three days, including the diverse contexts and experiences, the major challenges articulated as well as some of the strategies that emerged is expected to be finalized soon.

Report based on a summary from the Sama Workshop.

Shree Mulay participated in the International Consultation on Commercial, Economic and Ethical Aspects of Assisted Reproductive Technologies (ARTs) and is currently on the board of Canadian Women's Health Network.

CWHN Webinar Series

Gender-bending and Environmental Justice: The Way We Talk About Endocrine Disruption

Dayna Nadine Scott, co-director of the National Network on Environments and Women's Health and Professor at Osgoode Hall Law School and York's Faculty of Environmental Studies, presented a lively webinar on March 18. During the webinar, Scott discussed the environmental health effects of long-term, low-dose exposure to pollutants, with a focus on the Aamjiwnaang First Nation reserve near Sarnia, Ontario.

This community, in the midst of Canada's largest petro-chemical complex, has seen a drastic decline in male newborns in recent years. Epidemiological studies have shown that interference with a mother's hormonal milieu can cause higher rates of miscarriage, particularly of male embryos. Scott's talk focuses on the lessons she has learned as "a student of the discourse of endocrine disruption – or the way we talk about gender and environmental health."

Scott suggests that environmentalists can build a broad-based social movement around environmental justice by enlisting the support of women's health and gender activists in concerned with health issues that are caused by endocrine disrupting environmental pollutants.

Women, Gender & Disaster: What's the Connection?

Presented in partnership with the Prairie Women's Health Centre of Excellence

Dr. Elaine Enarson, a disaster sociologist and a founding member of Gender and Disaster Network Canada, led a fascinating webinar on March 31. Enarson's personal experience in Hurricane Andrew sparked extensive work on disaster vulnerability and resilience. During the webinar, she discusses women's roles in disaster preparedness and recovery, and the way that women are specifically affected by these events. She suggests strategies for government agencies and community groups working with women in disaster situations.

All CWHN webinars are recorded and available at www.cwhn.ca for viewing

Next Webinar:

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

Presented in partnership with the Federation of Medical Women of Canada

Thursday, April 29, 2010 from 12:30 - 1:30 p.m. Eastern
Featuring Dr. Janet Dollin, Dr. Kathleen Gartke, Dr. Barbara Lent and Dr. Cheryl Levitt

Presenters will look at international data in context with what we have learned in Canada to ensure healthy medical workplaces, to improve gender equity in the ranks and within leadership, and to build family-friendly workplaces within our institutions.

Please email info@cwhn.ca for registration information.

Casting Light

Campaign takes on women's body image and the media

By Signy Gerrard

When Canadian designer Mark Fast decided to include three models size twelve and above wearing his clothes at London fashion week in 2009, at least one stylist abruptly quit. But Fast pushed forward and put the models down the runway. The sight of women closer to the average North American woman's size strolling down the runway was so unusual it gained coverage in worldwide media outlets and applause from audiences around the world.

Fast's determination and the enthusiastic public reaction is the sort of attitude that gives encouragement to Merryl Bear, Director of the National Eating Disorders Information Centre. "There is a different sensibility emerging among the public," she says "a backlash against the grotesque images in the media now."

The ultra thin ideal that permeates today's media negatively impacts women's sense of self, Bear says, increasing their sense of dissatisfaction with their bodies and their likelihood of disordered eating. It links their physical appearance to their worth, suggesting that being thin means being desirable and successful in every area of life.

Addressing the media

Riding what they see as a wave of growing public dissatisfaction with ultra-thin images, NEDIC has launched a new public service campaign with Toronto agency Zulu Alpha Kilo. Based around the simple slogan "Cast responsibly. Retouch minimally" they aim to put pressure on the industries that create and distribute these unrealistic images.

With an arresting hot-pink theme reminiscent of the beauty magazines it's taking on, the campaign has been literally bringing the message to the door of fashion leaders and marketers. A flowery greeting card mailed out to fashion editors and brand marketing directors across the country opens to read "Thanks for helping to make me such a successful anorexic" in elegant script. In a slightly more light-hearted touch, custom t-shirts were also delivered to the offices of major magazines. Reading "I'm a size negative 8," they taper down to an impossible 10 centimetre waist, inviting the recipient to try them on and experience how their product makes the average woman feel about her body. Attached to both is the campaign message, ending with a request that the recipient pledge to present images that are more responsible, attainable and representative of the women who read their magazines.

Despite the campaign's in-your-face approaches, Director Merryl Bear is clear that this is not about 'blaming' the media. They're not the cause of eating disorders, she says, which have a wide range of factors, but they do send the message that you should be thin. And when we believe that there is a real link between being thin, over-controlled about food and weight and being happy and successful, we are more likely to develop disordered eating. This problem then resonates in the broader community—girls and women who are dissatisfied with their bodies are significantly less likely to engage in physical, social and academic activities, causing loss to their personal happiness, as well as to the social and economic fabric of their communities.

While many advertisers argue that models need to be aspirational – and hence thin – in order to sell, evidence seems to be against them.

Many of the images currently in use, according to NEDIC, have a long way to go before they can be considered responsible. By focusing on such a narrow ideal of beauty, they are making a highly unusual—or nonexistent—body type seem like the norm.

Current advertisements encourage preoccupation with weight, leading readers to believe that if they just eat right, exercise right, and think right, they will be thin. The fact is that genetic factors contribute to the variety of body types Canadian women have. A more important emphasis should be on health, at whatever size the person naturally falls—and the current image is not encouraging health. A 2008 study of grade nine Canadian girls revealed that nearly one in five students in the normal weight range (based on BMI) believed that they were too fat, and a 2002 survey showed more than one in four tried in some way to lose weight.

While many advertisers argue that models need to be aspirational—and hence thin— in order to sell, evidence seems to be against them. According to research by Helga Dittmar published in the Journal of Social and Clinical Psychology, exposure to thin models resulted in greater body-focused anxiety among women, but the ad was no more effective. Women were affected by how attractive they felt the model was, regardless of the size. This implies that advertisers could, if they chose, use more

diverse and larger models and succeed without increasing body image problems.

Designers, marketers, and media, feels Bear, "need to understand the broader context and implications of the work they're doing. None of the fashion councils contest that their industry standard is damaging." But while the issue has now at least drawn the attention of fashion leaders, what action they are taking is still unclear. In an interview on the campaign with the *National Post*, acting editor-in-chief of Canada's *Fashion* magazine Bernadette Morra, said "The person you really should be asking [about using healthier models] is [*Vogue* editor] Anna Wintour…She is the most powerful person in fashion. If she were to put her foot down about this issue, then designers would respond. But I highly doubt that's going to happen." *Vogue* has trumpeted their recent profile of "curvy" model Lara Stone; however she is still only a size 4, while more than 30% of Canadian women are now size 14 and up.

Wintour passes the responsibility back on to the designers, describing the "tyranny of clothes that fit, just barely, 13-year-olds on the brink of puberty" when discussing the issue at a panel at Harvard. Designers have publicly blamed agencies for providing only models of a certain size. Few of the groups responsible for creating the current standard of beauty seem to be willing to take ownership of its problems or accept the challenge of making change.

There are campaigns that Bear feels are moving in the right direction. As well as designer Fast, who has continued to show larger models in his spring runway show, she cites the well-known Dove Campaign for Real Beauty. Dove is a sponsor of NEDIC, and she is careful to emphasize how choosy the organization is when accepting corporate sponsorship. To date, Dove is the only company in the beauty and self-care industry who has made the cut. These forward-thinking marketers and fashion leaders are still only a beginning, she says, but should be commended and encouraged to continue.

Few of the groups responsible for creating the current standard of beauty seem to be willing to take ownership

Bringing the campaign to the public

The campaign also aims help encourage the women and girls to think about the images they're surrounded with. To help raise awareness, a transit shelter ad was put up at a prominent Toronto corner. The interactive ad doubled as a trash bin, showing piles of glossy women's magazines through plexiglass, and inviting other women to "shed your weight problem here" by dumping their copies.

The campaign techniques all draw people to the NEDIC website, where they can find out more information, as well as sign a petition in support. The petition states that "I agree that fashion leaders and marketers should broaden their definition of beauty and inspire us with looks that are beautiful and attainable." They ask marketers and others behind the creation of beauty image ideals to sign a pledge to show looks that are "beautiful and attainable by casting responsibly and retouching minimally."

In the end, Bear hopes that women will help NEDIC bring the message to fashion leaders and marketers in a way they can't ignore. "If they don't consider the harm they're doing, people will, and people vote with their pocketbooks."

Signy Gerrard is the Director of Communications at the Canadian Women's Health Network.

Visit www.nedic.ca to see more of the campaign and sign the petition.

Young Women & Alcohol Abuse

A look at trends, consequences, influences, and prevention approaches

Adapted from *Girl-Centred Approaches to Prevention, Harm Reduction,* and *Treatment* and *Heavy Alcohol Use Among Girls and Young Women: Highlights of Findings from Literature Review and Web Search*

Increasing attention is being brought to the issue of substance use by girls and young women, and the associated health and social consequences of heavy drinking, smoking cigarettes, as well as the use of both licit and illicit substances. Historically young men have been more likely than young women to drink alcohol, smoke cigarettes, and use illicit substances, but local, national, and international data now show that this gender gap in substance use is closing.

In 2009, a national virtual Community of Practice (vCoP) provided the opportunity for a "virtual discussion" of issues, research, and programming related to girls' and women's substance use in Canada. The goal of the vCoP was to serve as a mechanism for "gendering" the *National Framework for Action to Reduce the Harms Associated with Alcohol and other Drugs and Substances in Canada*. Participants included planners, decision-makers, direct service providers, educators, NGO leaders, policy analysts, researchers, and interested women. The project was sponsored by the British Columbia Centre of Excellence for Women's Health (BCCEWH) in partnership with the Canadian Centre on Substance Abuse (CCSA) and the Universities of Saskatchewan and South Australia.

To inform this discussion, the BCCEWH took a closer look at the heavy use of alcohol specifically, examining trends, risks, influences, and preventative programming available, in a literature review.

Trends

In the 2004 Canadian Addiction Survey, over 85 percent of the alcohol consumption reported by females aged 15-24 years was consumed in excess of Canadian guidelines. The report also found 15 percent of young women (18-19) and 11 percent of women (20-24) reported heavy, frequent drinking. British Columbia has one of the highest rates in Canada. The 2008 British Columbia Adolescent Health Survey found male and female students were equally likely to binge drink with males only slightly more likely (less than 1 percent) to binge drink on 20 or more days in the previous month.

A recent international study examining gender specific trends in alcohol using cross-cultural comparisons from 1998 to 2006 in 24 countries and regions, found drinking and drunkenness remained higher among boys than girls, but the gap between boys and girls declined and girls appear to be catching up with boys in some countries. A 2004 survey of England revealed British young women (16 to 24) tend to engage in heavy drinking sessions with 49 percent consuming alcohol over one to three days. They are also likely to exceed the daily benchmark, with 28 percent drinking over 6 units at least once in a week. According to the U.S. Centres for Disease Control and Prevention (CDC), among young people ages 12 to 22 years old, the percentage of girls who drink alcohol is increasing at a much faster rate than that for boys.

Health consequences

Girls and young women are at risk for accelerated development of long-term health problems associated with heavy drinking, these include: liver disease; cardiac problems; damage to stomach; brain damage; hypertension; and addiction. Moderate to heavy alcohol consumption also increases girls' and young women's risk for breast cancer later in life, as well as other forms of cancer shown to be linked to alcohol including: cancer of the mouth; pharynx; esophagus; colon; rectum; and, liver. Chronic heavy drinking, particularly in adolescence and the young adult years can compromise bone quality, increasing risk of osteoporosis later in life.

Alcohol use also negatively affects puberty and disrupts normal sexual reproductive functioning, which may result in a number of menstrual and reproductive problems, including irregular menstrual cycles, absence of ovulation, endometriosis and infertility. Another key sex difference for young women who consume alcohol is the risk of unwanted, unplanned, or unintended pregnancy

Gender-Informed Prevention Approaches

Despite the serious health consequences and alarming trends in levels and patterns of alcohol use by girls and young women, relatively few prevention programs have been designed and evaluated which address these risk and protective factors for girls and young women. The search found over 35 examples of gender-informed preventative programming/interventions in BC, Canada and abroad. Below are a few examples of gender specific programming organized into universal, selected and targeted levels.

Universal prevention focuses on broad population of girls or young women with prevention and health promotion efforts i.e. 'girl-centred' positive youth development programs, awareness campaigns, and virtual communities for girls.

Peer support - Go Girl! YWCA Greater Vancouver (Vancouver, BC), provides workshops for girls 10-13 years which covers topics such as body image, self-esteem, bullying, assertiveness skills, relationships, peer pressure, goal setting, decision-making combined with fitness activities. www.saleemanoon.com/gogirl/

Leadership based - ELLE Project: Leadership Building for Young Women (Canada), mentorship and community leadership development training program for young women 16-25 years. For seven days, twenty young women from across Canada get together to explore and address issues in their communities, in their lives and how to make change. Includes 4-day training/ workshops, national network retreat and mentoring. www.powercampnational.ca/en/elle-project-fall-2009

due to unprotected and unplanned sex. Findings show young women tend to realize they are pregnant later in term. This raises the concern that young women may consume alcohol before they aware they are pregnant, thereby creating risk of fetal damage such as fetal alcohol spectrum disorder (FASD) and other birth defects. Even if they do know, studies show teenage girls are likelier than women of any age to binge drink during pregnancy.

Drinking to intoxication also makes girls and young women more vulnerable to date rape, sexual assault and unprotected sex, also increasing their vulnerability to HIV and sexually transmitted infections.

Influences on girls' drinking

As yet, there is not a large literature on influences and pathways to substance use by girls. One study that has contributed to our understanding of sex- and gender-based influences on use and pathways to use is *The Formative Years* report, published in 2003 by the National Centre on Addiction and Substance Abuse at Columbia University in the US. This study identified key influences on girls' and young women's substance use in four domains: 1) personal attributes, attitudes, and childhood experiences; 2) peer and school influences; 3) family, culture, and community; and 4) societal influences, such as media advertising. They found for example that young women tend to use substances to improve mood, increase confidence, reduce tension, cope with problems, lose inhibitions, enhance sex or lose weight, whereas young males tend to use alcohol or drugs for sensation seeking or to enhance their social status. They identified a strong media influence on girls and young women's substance use—that tobacco and alcohol advertisers tend to target females' concerns about their appearance, reinforcing unhealthy standards of thinness and sex appeal. They also made note of gendered influences related to the transitions into adolescence and

Selective prevention focuses on particular sub-population of girls and young women with a particular risk potential. Programs aim to reduce risk by building strengths and protective factors.

Community based - Anti-Dote: Multiracial and Indigenous Girls and Women's Network (Victoria, BC), grassroots network and community-based organization for girls and young women of racialized minority and Indigenous backgrounds. Provides outreach services, weekly programs, workshops and social events that address the needs of marginalized girls and young women. Offers supportive environment that reduces social isolation and connects girls and young women to other health, education and social services they may not otherwise access. www.antidotenetwork.org

Art based - Art Attack (Verdun, Quebec), after-school art program engages girls 14-17 in arts-based activities designed to build self awareness and self-esteem; increase critical thinking skills and ability to act on issues of violence and discrimination; and connect girls to people and resources in their community, as well as engage girls in community action project that they develop themselves. Includes photography, spoken word, dance, zines, etc. www.fillesdaction.ca/en/art-attack

Rites of Passage Girls Group - Interior Indian Friendship Centre (Kamloops, BC), group for marginalized and at-risk Aboriginal/ First Nations girls. Empowers girls to resist societal stereotypes and develop healthy definitions of themselves as Aboriginal/ First Nations girls. www.cdnwomen.org/PDFs/EN/CWF-Grants-GF-2009.pdf

early adulthood—occurring when entering middle or junior high school, entering and graduating from high school or college or entering the workforce—frequently involve many changes in social and physical environment that influence the risk of substance use.

These critical transitions can be particularly stressful for girls/young women and are at risk of turning to use of tobacco, alcohol and drugs.

BCCEWH is grateful to Health Canada and the Provincial Health Services Authority in BC for financial support for the projects underlying this work on girls and alcohol. As a second step, BCCEWH researchers will be examining in depth this girl-centred programming in an effort to understand the risk and protective factors being addressed, and outcomes achieved and working with agencies in Canada interested in developing/ adapting such programming.

Key Protective Factors

To better understand gender-specific risk and protective factors for substance use, authors of the report *Substance use among early adolescent girls: risk and protective factors* surveyed adolescent girls and their mothers about substance use and related concerns. From their study, they identified the following key gender-specific protective factors:

- Going home after school
- Positive body image
- Mother's knowledge of daughter's whereabouts
- Mother's knowledge of daughter's companions
- Girl's ability to always contact her parent(s)
- Family rules against substance use
- Parents encouragement to abstain

Indicated prevention and harm reduction focuses on girls and young women who are drinking and who may be engaging in harmful patterns of drinking, with an emphasis on minimizing harm, promoting health and preventing dependence.

College-age intervention - My Student Body (USA), high-risk drinking prevention website for college students. Provides internet-based brief, tailored interventions to help heavy drinking college students reduce their alcohol use. Consists of 4 weekly 20-minute sessions to provide students with tailored motivational feedback about high-risk drinking. Because of the growing concerns about the drinking among college women, they evaluated the effect of the intervention according to gender. Outcomes were found to be especially effective for women and persistent binge drinkers. www.mystudentbody.com

Teen Parent intervention - ROCA Healthy Families Program (Boston, USA), an outreach and home-visiting intervention with teen parents. Home Visitors reach young parents through outreach, home visits, and referrals from community partners, health centres and Roca's other programs. Home visitors run gender-specific school-based parenting groups at local high schools, an off-site Family Centre, and life skills/ parenting groups in collaboration with school-based health centres. One vision is to see "Young immigrant mothers raise their children in safety and be recognized for their contributions to society." www.rocainc.org/strategy_relationships.php

Parent-involved intervention – Mother Daughter Computer Delivered Program (USA), a computer-delivered program for preventing substance use among adolescent girls. Aimsto enhance mother-daughter relationships and to teach girls skills for managing conflict, resisting media influences, refusing alcohol and drugs, and correcting peer norms about underage drinking, smoking and drug use.

WHAT WE'RE READING recommended resources from our library

Women and health: today's evidence tomorrow's agenda

World Health Organization (November 2009)

Despite considerable progress in the past decades, societies continue to fail to meet the health care needs of women at key moments of their lives, particularly in their adolescent years and in older age. These are the key findings of the WHO report *Women and health: today's evidence tomorrow's agenda.*

WHO calls for urgent action both within the health sector and beyond to improve the health and lives of girls and women around the world, from birth to older age.

The report provides the latest and most comprehensive evidence available to date on women's specific needs and health challenges over their entire life-course. The report includes the latest global and regional figures on the health and leading causes of death in women from birth, through childhood, adolescence and adulthood, to older age.

Launching the report, WHO Director-General Dr. Margaret Chan called for urgent action both within the health sector and beyond to improve the health and lives of girls and women around the world, from birth to older age.

"If women are denied a chance to develop their full human potential, including their potential to lead healthier and at least somewhat happier lives, is society as a whole really healthy? What does this say about the state of social progress in the 21st century?" asked Dr. Chan.

Prescribed Norms

Cheryl Krasnick Warsh (University of Toronto Press, March 2010)

In her meticulously researched history, Cheryl Krasnick Warsh challenges readers to rethink the norms of women's health and treatment in Canada and the United States since 1800. *Prescribed Norms* details a disturbing socio-medical history that limits and discounts women's own knowledge of their bodies and their health. By comparing ritual practices of various cultures, *Prescribed Norms* demonstrates how looking at women's health through a masculine lens has distorted current medical understandings of menstruation, menopause, and childbirth, and has often led to faulty medical conclusions. Warsh also illuminates how the shift from informal to more formal, institutionalized treatment impacts both women's health care and women's roles as health practitioners. Always accessible and occasionally irreverent, Warsh's narrative provides readers with multiple foundations for reconsidering women's health and women's health care.

Beyond Expectation

Jacquelyne Luce (University of Toronto Press, March 2010)

An in-depth study of lesbian, bi, and queer women's experiences of thinking about and trying to become a parent. *Beyond Expectations* draws on 82 narrative interviews conducted during the late 1990s in British Columbia. Jacquelyne Luce chronicles these women's experiences, which took place from 1980 to 2000, during a period that saw significant changes to the governance of assisted reproduction and the status of lesbian, gay, bisexual, and transgender parents and same-sex parents.

Bearing Witness: Living with Ovarian Cancer

Kathryn Carter and Laurie Elit (Wilfred Laurier University Press, September 2009)

Bearing Witness is a collection of stories from women who went through the diagnosis of ovarian cancer, and treatment for it, only to find that the cancer recurred and any hope of recovery was gone. These women represent a spectrum of ages, ethnic backgrounds, marital circumstances, and professional experiences. From their stories we learn how each woman shapes the meaning of her life. Facing a life crisis can make one bitter and angry, but it can also provide the key to a thankful and generous spirit within. Kathryn Carter's concluding essay places these stories in the context of contemporary discourses of illness and healing.

Babies for the Nation: The Medicalization of Motherhood in Quebec, 1910-1970

Denyse Baillargeon, translated by W. Donald Wilson (Wilfrid Laurier University Press, 2009)

The province of Quebec in the early twentieth century recorded infant mortality rates, particularly among French-speaking Catholics, that were among the highest in the Western world. This "bleeding of the nation" gave birth to a vast movement for child welfare that paved the way for a medicalization of childbearing. Showing the variety of social actors involved in this process (doctors, nurses, women's groups, members of the clergy, private enterprise, the state, and the mothers themselves), this study delineates the alliances and the conflicts that arose between them in a complex phenomenon that profoundly changed the nature of childbearing in Quebec.

Restoring the Balance: First Nations Women, Community and Culture

Gail Gurthie Valaskakis, Madeleine Dion Stout, and Eric Guimond (University of Manitoba Press, February 2009)

Restoring the Balance brings to light the work First Nations women have performed, and continue to perform, in cultural continuity and community development. It illustrates the challenges and successes they have had in the areas of law, politics, education, community healing, language, and art, while suggesting significant options for sustained improvement of individual, family, and community well-being.

CWHN Info Centre

The Canadian Women's Health Network invites you to search our women's health database, a comprehensive bilingual collection of women's health publications and resources from across Canada and the world. With advanced search options, the CWHN women's health database gives you access to over 13,000 resources - publications, research, articles, organizations, reviews, and projects covering a wide range of information on women's health and women's lives.

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