

Voices Project: Women in Canada Resource

Health Trends:

In 1994, Canada fell from first to ninth place in the world on the United Nation's Human Development Index (HDI), which rates countries' "quality of life," as measured by life expectancy, educational achievement and adjusted real income. This drop in standing is largely attributed to the treatment of women, particularly those from socially disadvantaged groups.

The changing social conditions of Canadian women's lives have brought about corresponding changes in the issues that affect their health. Increased participation in the work force, particularly in jobs characterized by marginal working conditions, has increased women's vulnerability to injuries, stress, and environmental contaminants associated with the development of autoimmune conditions, chronic fatigue, and fibromyalgia.

Beyond physical and biochemical hazards, the necessity of modern women's double, and sometimes triple, workday contributes significantly to mental health problems such as stress, anxiety, and depression. In fact, women, particularly those from disenfranchised groups, suffer disproportionately from stress-related illnesses. Increased social pressure on women to "have it all" often exacerbates these conditions, the consequence of which is sometimes weight preoccupation and increased incidences of eating disorders.

The AIDS pandemic as well as inequities with respect to education and screening programs has contributed to disturbing trends in the sexual and reproductive health of Canadian women. Despite current medical technology, women continue to suffer from sexually transmitted infections (most notably HIV; affecting

an estimated 4,200 Canadian women), endometriosis, pelvic inflammatory disease, and ectopic pregnancies, the incidence of which has doubled since 1972.

During the past decade, the four leading causes of death among Canadian women have been heart disease, cancer, stroke and respiratory disease. Health statistics also indicate that the most common, long-term illnesses affecting women include arthritis, depression, hypertension and osteoporosis.

Determinants of Health:

The Ottawa Charter of Health Promotion implicitly defines health as a consequence of social determinants in the statement that health "is created and lived by people in the setting of their everyday life, where they learn, work, play and love (p.23). The Charter goes on to acknowledge that "changing patterns of life, work and leisure have a significant impact on health (p.427).

During the past decade, academic researchers, government agencies and health practitioners have become increasingly aware that adequate employment, income, safety, equity, social supports, as well as personal growth and leisure are important prerequisites of health. We are beginning to understand how unpaid work inside and outside the home, unequal division of household responsibilities as well as women's emotional work to sustain the health of others, form an aggregate of determinants of women's physical, emotional, and social well-being.

Violence is considered a major determinant of women's health. According to Health Canada, more than one in three Canadian women have been sexually assaulted, while 17% have suffered physical

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abuse. Fifty percent of Canadian women experience at least once incidence of violence after the age of 16; one-in-ten of whom come close to losing their lives.

Research:

According to the Women's Health Bureau, 70% of women's health research focuses primarily on pregnancy and reproduction, and to a lesser extent on cancer and infectious disease. In 1994, an Advisory Committee on Women's Health Research Issues reported that a scant 5% of the Canadian research budget was invested in women's health. The same proportion of funds (5%) were allocated through MRC grants for research into women's health. Among the successful candidates for NHRDP funding, 70% of women's health studies concentrated solely on reproduction. Unfortunately, only 16% of funded studies explore the social and/or psychological circumstances that influence women's health.

Within the framework of traditional clinical research, women's health status is measured by life-expectancy and the incidence of mortality and morbidity from disease. Critics of these research methods contend that the results of statistical, secondary data in women's health research, should be used exclusively to identify trends and variations in women's health status and to reveal areas that require qualitative inquiry. Conventional statistics, even as a method of exploring gender-based inequalities, provide a limited analytical appraisal of the problem as well as a narrow perspective with which to further explore the conditions and circumstances that influence women's health.

The sex bias of most clinical research is evident in the androcentricity of sampling strategies, the over-generalization of studies that virtually exclude women, as well as the double standard with respect to measuring, evaluating, and treating identical traits in men and women. Worldwide, women are typically under-represented in clinical trials that assess the effectiveness of medical interventions. Consequently, the variability of female response to drug regimens is not well documented or understood.

Internationally, three research models are currently used to examine disease and treatment; they are frequently defined as medical, lifestyle, and political economy. Unfortunately, by and large, these models do not facilitate a determinant's approach to research that emphasizes health and illness in relation to physical and social environments. Moreover, they do not allow researchers to frame health within the context of lived experience. Finally, the use of these models often excludes the application of multi-disciplined or biopsychosocially sensitive research methods.

To date, few Canadian studies have explored the need for and impact of women-centered health services, the medicalization of women's health, and the impact of health systems reform on women's well-being. Although feminist studies represent a valuable and necessary contribution to this area of inquiry, feminist research is dominated by middle class, non-disabled, white women. Specifically, a gap exists in the literature with respect to participation of diverse communities of women.

There is a general lack of awareness among privileged researchers regarding the power dynamics inherent in research and between communities of women. Consequently, no effort has been made to write in plain language or to disseminate the findings

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of most studies beyond peer reviewed, academic literature. When researchers fail to recognize all sources of female oppression, disadvantaged women become further marginalized in the research literature.

“The primary mistake of many feminist researchers has been their assumption that the common oppression of women is more important than the source of oppression. The experience of oppression is more complex than this. We all experience multiple sources of oppression, based on disability, class, race, ethnicity, citizenship, sexuality, age, etc. We may be oppressed as members of one community and possess privilege, or be oppressed as members of another community.” (Pat Isreal, 1995)

Fortunately, there is a growing awareness among health researchers about how the constituents of social disadvantage (sexism, racism, classism, ableism, heterosexism, and ageism) and their respective interactions, profoundly impact the health of Canadian women. Researchers are beginning to recognize that women experience their health within the context of their everyday lives as well as within a labyrinth of social connections that filter out to encompass education, employment, health care, and policy.

Optimists claim that the new millennium will usher in dynamic interdisciplinary and collaborative research agendas that are gender sensitive and inclusive. The ground work is currently being laid by community-based projects that incorporate both qualitative and quantitative methods of exploring the diversity of all women’s health.

Acadien Women

Outside the province of Quebec, particularly in northern New Brunswick, there exists a large population of unilingual French-speaking people. A corresponding shortage of French-speaking health care providers has created a situation in which many women must frequent a family physician who speaks a language other than their own. In short, French-speaking women, unlike their English-speaking counterparts, frequently do not receive health care services in their own language. Consequently, French-speaking women have relatively little access to general health services and to specialists who speak their language, even in regions where Acadien people represent the majority of the population.

Mis-communication between French -speaking women and English-speaking health professionals may have a detrimental impact on women’s short-term emotional and physical health as well as have on their overall, long-term health. This linguistic barrier may ultimately, discourage woman from seeking primary prevention and treatment services.

Unfortunately, to date, the federal and provincial governments have not adequately addressed these inequities in the provision of health care services. In fact, it appears that the onus is on the patient, in this case French-speaking women, to reduce the negative impact on their health by adopting the language of their care provider. In many cases, Acadien women must obtain the services of an interpreter to communicate their health needs and to understand the diagnosis and treatment strategies recommended by their physician.

On average, Acadien women who live in urban centres enjoy greater social supports than rural women and are more likely to speak English or have

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access to health services and products in French. Not surprisingly, the literature reveals that the most disadvantaged groups of Acadian women are those who are unilingual, live in remote, rural areas and have the least access to social supports.

Outside Quebec, French-speaking hospitals are rare and, as a consequence, are typically full. Thus, in order to access specialized care, Acadian women are forced to visit English-speaking hospitals. However, a disturbing trend has emerged in which some Acadian women, upon leaving the hospital, report that they do not have a clear idea about how to care for themselves properly.

The vast majority of Canadian health literature is written in English. In fact, Health Canada is the only French-speaking health care providers outside of Quebec.

branch of government that produces documents in both French and English. Individual provinces are not required to publish in both languages and frequently they do not. This exclusionary practice not only ignores the information needs of French-speaking women but also of women who are verbally bilingual but who cannot read English.

Unfortunately, with the exception of a few descriptive studies, a substantial gap exists in the current literature with respect to the health of Acadian women. Few researchers have compared the health trends of English-speaking and French-speaking women and few studies have explored the short- and long-term health consequences resulting from a lack of adequate