

Reflections on Women's Health and Gender Equality in Canada

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Cet article évalue les progrès du Canada dans le secteur de la santé des femmes en examinant d'un oeil critique « Stratégies pour la santé des femmes », un document préparé en 1999 par Santé Canada, « Stratégies » est considéré comme une réponse aux engagements internationaux pour promouvoir la santé des femmes et en particulier pour implanter une analyse basée sur le genre dans tous les programmes et services, politiques et recherches. Cet article décrit les progrès limités qui ont été faits à ce jour et propose des arguments pour que « Stratégies de la santé des femmes » soit repensé pour être plus efficace afin de répondre aux besoins et aux attentes des Canadiennes.

In 2005, the official Beijing +10 review took place, a process that required the government of Canada to report to the United Nations on the progress it has made to various commitments in the areas of women's rights and gender equality originally set out in the 1995 Beijing Platform for Action (PFA).¹ Canada's report has been critiqued by a number of key stakeholders, including women's activists, for not providing an accurate portrayal of its progress and in particular, for failing to assess Health Canada's 1999 Women's Health Strategy. The Strategy resulted from many years of women's health activism around the need to better respond to women's needs in the health care system and is considered a key mechanism through which Canada sought to fill its health objectives vis-à-vis the 1995 PFA.

In this paper, a key objective of the Women's Health Strategy—gender-based analysis (GBA)—is interrogated to illustrate both the advancements and problems in Canada's approach to women's health. GBA is a key horizontal policy tool for working toward gender equality in research, policy, and practice. Its entrenchment in the Strategy also reflects the efforts by the women's health movement in Canada to better integrate gender into policy analysis (for a historic overview see Morrow, forthcoming 2007). As will be shown, to date, GBA implementation is uneven and in many instances, for most women and girls, health care policy, programs, and services have not improved. While

GBA is identified as a distinct objective of the Women's Health Strategy, its limited effectiveness as a cross-cutting policy mechanism has significant implications for the entire Strategy. Moreover, the lack of meaningful progress stands in stark contrast with Canada's reputation as being an international leader in GBA. The article also reflects on recent political developments in Canada and makes suggestions regarding future directions including necessary government and activist strategies to respond to women's health and health care needs and to promote and protect the diversity of women's equality more generally.

The Women's Health Strategy (1999)

The Women's Health Strategy is an integrated framework addressing major women's health issues and the principles of the Beijing Platform. The role of the women's health movement in raising awareness about the need for such a strategy is outlined in the document itself: "For many years, a burgeoning women's health movement called attention to biases in the health system. At first, the sense that the system was failing women was intuitive and personal. Over time, awareness grew that shortfalls in the system were more pervasive and required a comprehensive response—including changes in attitude and practice" (Bureau of Women's Health 7). The overarching goal of the Strategy is to improve the health of women in Canada by making the health system more responsive to women and women's health through the realization of the following objectives:

1. Ensure that Health Canada policies and programs are responsive to sex and gender differences and to women's health needs;
2. Increase knowledge and understanding of women's health and women's health needs;
3. Support the provision of effective health services to women; and

4. Promote good health through preventive measures and the reduction of risk factors that most imperil the health of women.

The Strategy has seven main features: it is balanced, respectful of diversity, egalitarian, evidence-based, coherent, multi-sectoral, and incremental. The Health Canada departmental lead for the Strategy is the Bureau of Women's Health and Gender Analysis (formerly known as the Women's Health Bureau). In 2000, the Strategy was bolstered by the federal government's reaffirmed commit-

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ment to gender equality with its approval of the Agenda for Gender Equality (AGE), a five-year government-wide follow up strategy to the Federal Plan for Gender Equality (1995-2000) overseen by Status of Women Canada. Its objectives include accelerating the implementation of GBA, including civil society in the policy process so that women's experiences and perspectives can inform issues on the policy agenda, and meeting Canada's commitments to international treaties and related obligations such as the Beijing PFA, the Beijing+5 Political Declaration, and the Outcome Document.

When the Women's Health Strategy was first introduced, it was thought to have significant potential for making change. First, it explicitly laid out the government's commitment to improved health through action on the social determinants of health. The framework provided a clear rationale for why a specific women's health strategy in Canada was needed. It stated that Health Canada would work with "other departments to promote a holistic, multi-sectoral approach to health and social policy development." And finally, it emphasized that gender would be integrated into all policies and programs through the key strategy of GBA. The vision was both progressive and congruent with international objectives and priorities in the area of women's health. From the very outset, however, there were no mechanisms put in place for operationalizing, monitoring, or evaluating the Women's Health Strategy, including the key objective of GBA which is analyzed in detail below.

Objective I: Gender-Based Analysis

The first objective of the Women's Health Strategy is to ensure that Health Canada's policies and programs are responsive to sex and gender differences and to women's

health needs: "In keeping with the commitment in the Federal Plan for Gender Equality, Health Canada will, as a matter of standard practice, apply gender-based analysis (GBA) to programs and policies in the areas of health system modernization, population health, risk management, direct services and research" (Bureau of Women's Health 21). Health Canada defines GBA as: "... an analytical tool applied to research, policies, program design, and evaluations to ensure that appropriate questions about both men and women yield sensitive and accurate analyses and programs" (2002: 1). Not only is GBA a response to the UN Platform for Action, it is also consistent with the objectives of the Convention on the Elimination of All Forms of Discrimination Against Women, and the recognition of health as a human right for women.

In 2000, Health Canada developed a Gender-based Analysis Policy. The policy confirms the department's commitment to the implementation of GBA and outlines ways in which it is being integrated into the policies and programs of Health Canada. The Bureau of Women's Health and Gender Analysis is central to this initiative. The Bureau, coordinates the implementation and evaluation of GBA, and ensures that women's health concerns are integrated and responded to appropriately by Health Canada. As well, Health Canada's Women's Health Contribution program, an approximately 2.95 million dollar per year initiative, funds four Centres of Excellence for Women's Health; research networks focusing on Health Protection, Health Reform, Aboriginal Women's Health, and the Canadian Women's Health Network (all online at www.centres.ca). This in turn supports GBA by producing and disseminating new and better knowledge of women's health.

In 2003, Health Canada released *Exploring Concepts of Gender and Health*. Its authors write that the guide "advances Health Canada's commitment to fully implement GBA throughout the department. One of several capacity-building tools developed by Health Canada, it suggests ways for researchers, policy analysts, program managers and decision makers to integrate GBA into their day-to-day work." And in Health Canada's *2003-2004 Estimates, Report on Plans and Priorities*, the department stated:

The fundamental planning considerations for the Department that are specific to health are complemented by the integration of ongoing government-wide priorities that have implications for the health of Canadians. For example, sustainable development perspectives and gender-based analysis are integrated into planning for the development, implementation and review of policies, programs and operations.

According to Joseph Caron, "GBA implementation is ongoing, and development of GBA training modules has generated particular tools for gender-sensitive research and evaluation" (54). Currently a GBA training program

for Health Canada staff is underway. Training manuals are continually being revised to be more responsive to specific policy needs of those who work across a diversity of branches and areas within Health Canada.

Despite these developments, in reality, GBA has not been consistently incorporated into health policy development, implementation, or evaluation. Many policy makers in a variety of branches in Health Canada simply do not recognize the relevance of GBA and resist having to undertake any additional work that they perceive is associated with a gender analysis. Although the Bureau of Women's Health and Gender Analysis does provide progress reports on the process and implementation of GBA across Health Canada, the Women's Health Strategy and the Gender-Based Analysis Policy have not undergone any formal evaluation.² Arguably then, a commitment to GBA within the federal health sector is not by itself a guarantee of meaningful change.

Beyond Health Canada, there are key examples of how GBA has failed to influence the health policy mainstream. First, the Romanow Royal Commission on the Future of Health Care (2002) was praised for its recommendation to re-enforce and expand medicare but was criticized for failing to incorporate a gender lens in its analysis and proposals. As noted by the National Coordinating Group on Health Care Reform and Women (NCGHCRW) in its *Reading Romanow: The Implications of the Final Report of the Commission on the Future of Health Care for Women*, "...the Report is fundamentally flawed. By not offering a gendered analysis, it fails to consider women's places in the health care system and the consequences of health care reforms for women in different locations throughout the system" (7).

Moreover, the Health Accord that was derived from the Romanow report, and signed by the provinces and federal government in February 2003, was also void of any kind of gender analysis. This can be partly explained by the fact that although

almost all health care is provided by women and women are most of those who receive care, women are a minority of those making policy decisions about health care. They have few means of influencing how major policy decisions are made, even though their daily practices bring so many of them into direct contact with the health care system. (NCGHCRW 10)

The First Minister's ten-year plan to strengthen health care (2004) makes no specific mention of gender.

A similar lack is also apparent in the report of the Health Council of Canada, *The Health of Canadians*. While highlighting the importance of health disparities, the potential role of GBA in furthering the understanding of such disparities is not recognized. Recently, the report of the Standing Senate Committee on Social Affairs, Science and Technology on mental illness entitled, *Out of*

the Shadows at Last, has been critiqued as gender blind, completely overlooking the fact that women are the majority of patients, paid and unpaid care givers in Canada (Ad Hoc Working Group). And finally, federal, provincial, and territorial work on establishing appropriate wait times has failed to recognize significant gender variations (Jackson, Pederson and Boscoe). The absence of gender from these initiatives is an example of the isolated nature of women's health policy and gender analysis within the machinery of government.

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face challenges to mainstream and institutionalize the application of gender equality objectives, analyses and processes in the work of governments" (Canada's National Response to the UN). First, the integration of GBA is often hindered by a lack of political will and adequate government financing and support. There is little coordination between levels of government and the general public has not been educated around GBA. It is also worth noting that the activities at the provincial and territorial levels in relation to GBA have been uneven. Some provinces or regions have undertaken actions on their own such as setting up Offices of Women's Health (many of which have now closed); establishing women's health as a priority area; adopting "Models of Women Centred Care" as policy statements to guide service provision and development; or have provided GBA training to staff. Few provinces have the necessary resources, training capacities or accountability mechanisms in place to effectively implement and evaluate GBA. Moreover, there are no mechanisms for national reporting or coordination.

Second, even when GBA is integrated into some areas of policy, it is rarely applied in a systematic fashion to all policy areas including for instance, economic and technology policies that affect health (Rankin and Vickers). Indeed, the current neo-liberal policy context, characterized by privatization and deregulation, is consistently at odds with gender equality (Teghstsoonian).

Third, women's organizations and women who are both providers and users of the health care system are rarely consulted (Hankivsky 2005). Most community-based women's and health groups remain unaware of GBA. Not surprisingly, activists and other health care professionals remain skeptical about GBA and its ability to affect health policy, programs, and services or other policy areas that directly affect health. As well, the infrastructure for women

and equity seeking groups has been reduced significantly, thereby decreasing the likelihood of the ongoing monitoring required to support change.

Fourth, although the Canadian Institutes of Health Research have introduced a gender and sex-based analysis (GSBA) intended to highlight how sex and gender—and the interactions between them—influence the health of men and women, the distinctions between sex and gender as well as the relationship between the two concepts are not well understood (Hankivsky 2007a). Finally, attention to diversity and difference within GBA requires a better understanding of how gender interfaces with other variables such as ethnicity, class, age, sexuality, and so on (Hankivsky 2007b).

Many of the challenges and barriers to successful GBA application in health and beyond have been further entrenched by recent political decisions at the federal level. For example, on September 25, 2006, the Conservative government announced a five million dollar cut—a 38.5 per cent cut in funding—to Status of Women Canada (SWC). Also, the goals of SWC were changed from promoting and protecting gender equality or promoting political justice to “facilitating women’s participation in Canadian society by addressing their economic, social and cultural situation through Canadian organizations.” There is no longer any formal commitment to helping women’s organizations participate in the public policy process or increasing the Canadian public’s understanding of the importance of gender equality issues. On September 27th, the government announced that the Women’s Program of SWC will no longer fund any advocacy or lobbying, or general research, and that for-profit organizations are now eligible to apply for this program’s funding. This move significantly undermines the capacity of women’s movements in Canada to engage government on a variety of social justice issues and will have definite implications in terms of reporting to the United Nations on Canada’s progress on all aspects of gender equality. These changes along with the elimination of key intellectual engines in this country—the Canadian Policy Research Networks, the Court Challenges Program, and Health Canada’s Policy Research program will also affect the knowledge base that is key to any effective gender analysis in all sectors, including health.

Discussion

Canada’s central framework for upholding its commitments to Beijing in the area of women’s health—the Women’s Health Strategy should be renewed and enhanced. The process of renewal should build upon regional consultations, including discussions with all relevant key stakeholders. A renewed Strategy should include concrete health goals/priorities. An enhanced women’s health contributions program at Health Canada which funds research, communication, education, policy advice, and outreach

activities would be essential—given the complex and distributed mechanisms for health care. This program should also include national, population-based and provincial projects that explicitly demonstrate the application and value added nature of GBA.

Beyond the actual step of renewal and enhancement, a number of other specific suggestions regarding GBA can be made based on experiences and observations to date. First, the government should consider increasing funding for the Bureau of Women’s Health and Gender Analysis and related divisions, branches, and offices dealing with women’s health and gender analysis. It may even want to consider enshrining into law a Women’s Health Office at the federal level,³ thereby strengthening the commitment to women’s health and health research in Canada.

Second, although the overall Strategy promotes gender equality in health, GBA needs to be integrated into all the objectives and commitments made in the Strategy. The Strategy requires all departments within Health Canada to share equally in the implementation of GBA. This responsibility cannot be downloaded solely onto the Bureau of Women’s Health and Gender Analysis. There must be adequate resources and support for GBA. Capacity building among policymakers needs to be improved. Effective monitoring and evaluation should be undertaken on a regular basis. After all, health inequities can only be remedied if they are recognized and measures are put into place to ensure quality assurance. Practically, a GBA requirement should be added to the First Ministers’ Accord on Health Care Renewal (2003) and the First Ministers’ ten-year plan to strengthen health care (2004).

Moreover, GBA efforts at Health Canada need to expand to all other areas of government policy, and policy makers need to understand the relevance and importance of this perspective for developing effective and efficient policy. A Federal/Provincial/Territorial committee to provide leadership in the implementation of GBA should also be established. Better coordination between all levels of government and civil society is also required. GBA is not an end in itself, but rather a tool—one that needs use. Accordingly, the Canadian government could also consider producing an annual report on women’s health modeled on the one prepared by the Human Resources and Services Administration’s Office of Women’s Health in the U.S. This report collects current and historic data on health challenges facing women, their families and communities, and is used as a reference for community groups and policymakers at all levels of government. A law specifically addressing equality for women could also be an important step forward (Equality for Women).

Third, there needs to be recognition of the global neoliberal context and its potential effects on the implementation of GBA and other women’s health objectives. In particular, health care privatization, deregulation through free trade agreements, and other reforms (e.g., reduced public participation in health care decisions),

are undermining the autonomy and role of countries in determining their health care systems. It is becoming more difficult to sustain existing systems as international pressures to reduce public service spending increases. These changes are having a particular impact on various groups of women as providers, patients and health activists and need to be better understood and responded to. Arguably, “developing an approach to GBA in which the broader political, social, and economic contexts are examined and critiqued is key to mitigating the effects of neoliberalism on women’s lives, especially those who are most vulnerable and marginalized” (Hankivsky 2007c).

Fourth, any improved Strategy and indeed approach to GBA, requires speaking to women themselves and finding out what their health care priorities are. As the results from a recently national held consultation concluded, there is “the need for a further and fuller explanation of what many women in the country consider to be their health priorities, e.g. poverty and equity issues” (RIWC). Any renewed women’s health strategy must also better take into account the diversity and health inequities among women: women who are poor, women with disabilities both mental and physical, Aboriginal women, older and elderly women, immigrant, refugees, other racialized women; in general, more attention to the relationship of not only sex and gender but also other intersecting forms of discrimination and oppression. When arguments are made about the significance of gender in relation to GBA, these must transcend the essentialization associated with biomedical explanations, which downplay diversity among women and fall into the trap of treating all women as equivalent (Weisman). And finally, communication between researchers in all distinct areas of health research inquiry needs to be improved to promote: inter and trans-disciplinary investigations; mixed methods approaches; participation of NGOs, women’s organizations, and women consumers in setting research priorities; and in the end, to facilitate a comprehensive understanding of women’s health and establish a valuable GBA approach that measures, monitors and ultimately, improves all Canadian women’s health.

Of course none of these recommendations or proposed changes will have any chance of being realized unless the current federal government reconsiders its recent shifts in policy regarding gender equality. Although the Bureau of Women’s Health and Gender Analysis at Health Canada was not affected by the recent round of cuts,⁴ the transformation of Status of Women Canada, the move away from the goal of gender equality to a more neoliberal focus on increasing women’s participation in economic, social, and cultural life, as well as the reduction and elimination of funding to key organizations and programs that served the needs of the most vulnerable and marginalized populations in Canada will no doubt have implications for the future of GBA within Health Canada and beyond. How to respond to such trends and government cuts, while continuing to work to improve women’s lives, including

their health, is a key challenge for the future of Canadian women’s activism.

This article is based on an earlier document that was prepared with the Canadian Women’s Health Network for a Health Section for Canada’s “NGO” report to the United Nations’ Commission on the Status of Women meeting in March 2005. The full document is available at www.cwhm.ca.

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¹The PFA was “inspired by Article 2 of the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW) which obligates State parties to repeal or abolish all existing laws regulations, penal provisions, customs and practices that are discriminatory against women” (UN Report 1). The PFA contains a specific section of women’s health that prioritizes the right to the enjoyment of the highest attainable standard of physical and mental health for women. Significantly, it emphasizes a social determinants approach to understanding women’s health by stating that: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Women’s health involves their emotional, social and physical well-being and is determined by the social, political and economic context of their lives, as well as by biology.” The PFA also includes five strategic objectives for women’s health:

- improving access throughout the life cycle to appropriate affordable and quality health care information and related services;
- strengthening preventive programs;
- undertaking gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS, and sexual and reproductive health issues;
- promoting research and disseminating information; and
- increasing resources and monitoring.

²Personal Correspondence, Bureau of Women’s Health and Gender Analysis Health Canada, November 10, 2004.

³In the United State for example, a bill entitled: Women’s Health Office Act has been introduced and if passed into law would provide permanent authorization and appropriate levels of funding for offices and positions of women’s health in five federal agencies: the Department of Health and Human Services (HHS); the Centers for Disease Control and Prevention (CDC); the Agency for Health care Research and Quality (AHRQ); the Health

Resources and Services Administration (HRSA); and the Food and Drug Administration (FDA).

⁴Subsequent to the spring 2006 departure of the executive director of the Bureau of Women's Health and Gender Analysis, leadership of the Bureau was transferred to Phyllis Colvin, the Director of the Policy Coordination Division, Policy and Planning Directorate, Health Policy Branch. Discussions are still underway regarding the name of the new entity, but there is tentative agreement on Policy, Women's Health and Gender Analysis Division.

References

- Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions. *Women, Mental Health, Mental Illness and Addiction in Canada: An Overview*. 2006. Online: <http://www.cwhn.ca/PDF/womenMentalHealth.pdf>.
- Bureau of Women's Health and Gender Analysis. *Health Canada's Women's Health Strategy*. Ottawa: Health Canada, 1999.
- Canada's National Response to UN. Government of Canada, Ottawa, June 2004. Online: <http://www.un.org/womenwatch/daw/Review/responses.htm>. Accessed March 2005.
- Caron, Joseph. *Report on Governmental Health Research Policies Promoting Gender or Sex Differences Sensitivity*. Prepared for the Institute of Gender and Health, Ottawa, February 2003. www.cihr-irsc.gc.ca/e/25499.html.
- Status of Women Canada. *Equality for Women: Beyond the Illusion. The Expert Panel on Accountability Mechanisms for Gender Equality Final Report*. Prepared by: Georgina Steinsky-Schwartz, Dorianne Rowan-Campbell, Louise Langevin. December 2005. Online: http://www.swc-cfc.gc.ca/resources/panel/report/index_e.html.
- Hankivsky, Olena. "Gender Mainstreaming vs. Diversity Mainstreaming: A Preliminary Examination of the Role and Transformative Potential of Feminist Theory." *Canadian Journal of Political Science* 38 (4) (2005): 977-1001.
- Hankivsky, Olena. "Gender Based Analysis and Health Policy: The Need Rethink Outdated Strategies." *Women's Health in Canada: Critical Perspectives on Theory, Policy and Practice*. Eds. M. Morrow, O. Hankivsky and C. Varcoe. Toronto: University of Toronto Press, 2007a (in press).
- Hankivsky, Olena. "Gender Mainstreaming in the Canadian Context: 'One Step Forward and Two Steps Back'." *New Directions in Canadian Public Policy*. Eds. Michael Orsini and Miriam Smith. Vancouver: University of British Columbia Press, 2007b (in press).
- Hankivsky, Olena. "Gender Mainstreaming in Neoliberal Times: The Potential of 'Deep Evaluation.'" *Public Policy for Women in Canada: The State, Income Security, and Labour Market Issues*. Eds. Jane Pulkingham and Marjorie Griffith Cohen. Toronto: University of Toronto Press (forthcoming, 2007c).
- Health Canada. *A Report on Mental Illnesses in Canada*. Ottawa: Author, 2002.
- Health Canada. *Exploring Concepts of Gender and Health*. Ottawa: Author, 2003.
- Health Canada. *2003-2004 Estimates, Report on Plans and Priorities*. Online: http://www.tbs-sct.gc.ca/est-pre/20032004/hlth-sant/hlth-santr34_e.asp#33.
- Health Council of Canada. *The Health of Canadians*. Canadian Population Health Initiative: Improving the Health of Canadians. 2004. Online: <http://www.cihi.ca/ihc2004>.
- Jackson, B., A. Pederson and M. Boscoe. *Gender Based Analysis and Wait Times: New Questions, New Knowledge*. April 2006. Online: Women and Health Care Reform Group. http://www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2006-wait-attente/gender-sex/index_e.html.
- Morrow, M. "Our Bodies, Our Selves in Context: Reflections on the Women's Health Movement in Canada." *Women's Health in Canada: Critical Perspectives on Theory, Policy and Practice*. Eds. M. Morrow, O. Hankivsky, and C. Varcoe. Toronto: University of Toronto Press, 2007a (in press).
- National Coordinating Group on Health Care Reform and Women (NCGHCRW) (Pat Armstrong, Madeline Boscoe, Barbara Clow, Karen Grant, Ann Pederson, and Kay Willson with Olena Hankivsky, Beth Jackson and Marina Morrow). *Reading Romanow: The Implications of the Final Report of The Commission on the Future of Health Care in Canada for Women*. Revised and Updated Edition. Online: http://www.cewh-cesf.ca/healthreform/publications/summary/reading_romanow.html.
- Rankin, Pauline L. and Jill Vickers. "Women's Movements and State Feminism: Integrating Diversity into Public Policy." *Feminisms and Womanisms*. Eds. Athea Prince and Susan Silva Wayne. Toronto: Women's Press, 2004.
- Teghstsoonian, Katherine. "Gendering Policy Analysis in the Government of British Columbia: Strategies, Possibilities and Constraints." *Studies in Political Economy* 61 (2000): 105-127.
- Riverdale Immigrant Women's Centre (RIWC). *Diverse Canadian Women's Health Priorities: A Report for the Organizing Committee on the 10th International Women's Health Meeting*, January 2005, Bangladesh.
- Standing Senate Committee on Social Affairs, Science and Technology. *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*. May 2006. Online: <http://tinyurl.com/ea9nh>.
- United Nations Report of the Fourth World Conference on Women, Beijing, 4-15 September 1995. Online: www.un.org/womenwatch/confer/beijing/reports.
- Weismen, C. S. "Changing Definitions of Women's Health: Implications for Health Care and Policy." *Maternal and Child Health Journal* 1 (3): 179-189.