Introduction to Women, Health and Education

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Health and education are arguably the two most important issues facing governments, health and school authorities, community groups, health professionals, educators, and activists. There is little doubt that individuals and collectives who enjoy optimum health and appropriate educational opportunities are more likely to be contributing and productive members of society. What I question is whether the health and education of girls and women is politically relevant, and if so, to whom and under what conditions? Are there indicators of the political relevance of these issues, and if so, what are they?

I submit that the political relevance of women's and girls' health and education might be demonstrated by initiatives that: a) assess women and girls' health and education status and the determinants of both; b) expose gender inequities in health and education and inequities among diverse groups of women and girls; c) design, deliver and evaluate interventions and programmes that protect and promote health, education and equity across social differences; and d) advance integrated and intelligible connections between micro-level subjective experiences and macro-level systemic forces that organize women and girls' health and education.

My search for political relevance indicators covered government and corporate initiatives and documents, university- and community-based research, and media reports. Although the indicators are neither exhaustive in scope nor empirically tested for validity, they are proving useful in sorting out my thinking about the disjunctures between two parallel and interrelated ways of knowing about the processes that organize women and girls' opportunities for health and education.

Women and girls' experiences of health and education play out in local contexts that are buffeted by national and global

political and economic forces. These diverse forces shape the complex processes of physical, emotional and social maturation - learning first to be a girl and then a woman, attending school, engaging in work, becoming a mother (or not), and reproducing family and community life. The first of these ways of knowing is discoverable in the expressions of embodied subjects - listening to the stories that women and girls tell about their health lives (Gustafson 2007). As girls and women navigate the pleasures, confusion, and challenges posed by the political, economic and moral push and pull of every day life, we develop a rich body of experiential knowledge about our bodies and our health; about how and what we learn and the value of that knowledge. This lived experience is connected to but sometimes at odds with a second way of knowing about women and girls' health and education.

That way of knowing is discoverable in and mediated through the apparently neutral bureaucratic processes that coordinate the learning activities and health experiences of girls and women (Smith 1999). Local texts such as public school books on sexual education and employer regulations about breastfeeding are produced through a complex set of social relations that operate in and beyond the schools, workplaces and other local settings where they are developed. Local texts intersect with and are coordinated by a wide range of translocal texts such as policy documents and scientific, technical, and cultural discourses that are produced by professional organizations, government bureaucracies, the media and others. Translocal texts are external to but have a regulating effect on the local context and the actions of those who negotiate these spaces (Smith 1999). It is through the coordination and administration of local and translocal texts or what Dorothy Smith calls "relations of ruling" that power is generated and operates in the lives of women and girls in contemporary societies.

Take the example of sex education in schools. School curriculum and textbooks, state legislation, religious doctrine, and social discourses about women's and girls' subordinated place in the world are examples of local and translocal texts. Because they are considered authoritative and legitimate, such texts operate as powerful mechanisms for transmitting health knowledge, organizing personal behaviour, and coordinating the social practices and interactions of those who negotiate classrooms and other local spaces. And equally important, they organize spaces beyond specific institutional contexts penetrating the so-called private spaces of the home and family where girls and women live, work and play. I begin by looking at some processes of governance to establish contemporary indicators of the political relevance of women and girls' health and education.

In 1996, Health Canada established five Centres for Excellence in Women's Health (CEWH) with the mandate "to improve women's health, in part by enhancing the Canadian health system's understanding of and responsiveness to women and women's health issues" (Pederson 2001, 1). For over a decade, these champions of women's health research partnered with community agencies to ask new questions and generate new knowledge about the realities of women's lives. Among CEWH's significant accomplishments was their support for the Aboriginal Women's Health and Healing Research Group, a national network of First Nations, Métis and Inuit women researchers who focus on community-based health research about Aboriginal women, their families and communities. Despite this and other advancements toward reducing health inequities among diverse groups of women, virtual conversations on women's studies listserves expose the felt vulnerability of these Centres to federal funding cuts.

Federal government health care decisions in the early part of the decade were informed by, among other things, the 2002 reports of the Romanow Commission and the Standing Senate Committee on Social Affairs, Science and Technology, also known as the Kirby Report. These reports highlighted (either through attention or omission) the political

relevance of women's and girls' health. Supporters and critics of these and similar documents point to the contributions made by women as health care providers (Muzio 2003), and the burden experienced by women and girls who are often overlooked or undervalued recipients of health care (Bégin, 2004; Malik 2006). This dialogue across government documents and research texts indicates that women's health was on the political agenda at the turn of the 21st century.

The more recent political and moral shift to the conservative right evident in the federal government initiatives suggests a parallel shift in the political relevance of women and girls health and education. In September 2007, the Harper Conservative government announced a series of Treasury Board cuts totalling $1-billion. Although cuts will affect many programs, the hardest hit will be skills and literacy programs, social policy research, the Status of Women Council and Aboriginal programs (CAUT 2007).

For instance, the $3.5-million cut to Indian and Northern Affairs Canada is expected to result in a reduction in funding for the First Nations Technical Institute located near Belleville, Canada. The Institute which delivers its programs in partnership with other Ontario colleges and universities "indigenizes" its courses and recognizes knowledge gained through life and work experience. Through an innovative mentoring system, women with children who remain with their families in remote northern communities, for example, have been able to stay connected and complete undergraduate degrees. The loss of funding jeopardizes this mentoring system and other programs at an Institute that boasts 91% and 90% retention and employment rates respectively (Harries 2008).

Indian Affairs claims that postsecondary education is a provincial responsibility; however the Institute only receives a fraction of the provincial funding per student allocated to mainstream Ontario institutions (Harries 2008). Unresolved, this dispute over federal-provincial funding will further disadvantage the education and wellbeing of Aboriginal women, their families and communities. Students' need to stay connected with their communities while being educated is at odds with the bureaucratic processes that will reorganize their educational opportunities, indicating the shift in the political relevance of education equity across social differences.

Another casualty of the Harper government is Status of Women Canada where the funding cut of $5-million represents 20% of its operating budget. While no cuts to funding for women's groups have been announced, neither has there been any commitment to long-term funding. CAUT (2007) predicts that the funding decision will wipe out organizations like the National Council of Women of Canada. This comes as the second blow to women's organizations which faced changes in eligibility rules disallowing the use of federal funds for advocacy work such as pressing for equity in the paid workplace and the home (CRIAW 2006). These government actions contribute to the erosion of organizations that advance the health and education of diverse groups of women. Withdrawing support indicates a downturn in the political relevance of these issues at the systemic level.

Other government initiatives illustrate the shifting political relevance of women and girls' health and education over the last ten years. In 1999, the federal government established the Canadian Institute for Health Research (CIHR) with a mandate to set up a number of virtual institutes for linking and supporting university and community-based research. An initial proposal was for an institute focusing on child, women's and maternal health or what was criticized at the time as a "boobs and tubes approach" to women's health (Morris 1999). Later, the Institute for Gender and Health (IGH) was created but it may be argued that work of the Institute does not stray far from the original vision. A cursory review of themed calls for proposals and funded projects on the CIHR website (2004-2006) suggests that there is more opportunity and support, and larger awards for research with a biomedical focus on sex differences and genetic or

physiological determinants of health. Although this indicates support for the production of new knowledge about women's health, less attention is devoted to understanding the social determinants of gender inequities and differences in health among groups of women.

Another federal funding agency, the Social Sciences and Humanities Research Council of Canada (SSHRC) provides considerable support for education research and research on mothers and women's health that expands our knowledge beyond the biomedical confines of reproductive health. I make this assertion about the political relevance of women's health and education based on a cursory review of the funded projects reported on the SSHRC website (2004-2006). For example, the Association for Research on Mothering, founded in 1998, is the first international feminist organization devoted to the study of mothers and motherwork.

On the international stage, Canadians have been vocal about the intersections of health and education in women's and girls' lives. Speaking at the 14th Annual International Congress on Women's Health Issues in Victoria, Canada in June 2003, Kathleen Mahoney, co-founder of Women's Legal Education and Action Fund called for an egalitarian model of health based on human rights as a way to protect and promote the health of the most vulnerable and high risk populations around the world (Cassidy 2003). To achieve this goal, she calls for greater public awareness and committed government action recognizing that immigration policies, environmental degradation and economic agreements such as NAFTA bind together the health of all global citizens.

My goal is to situate my understandings of the political relevance of women's health and education within the larger political and social context in which I work and the disjunctures between what I know as an embodied subject and what is revealed in local and translocal texts that organize my thinking and my writing. Disjunctures between parallel ways of knowing are examined in the five articles in this thematic cluster as they explore the intersections of health and education in the lives of women or girls. First presented at the Canadian Association for the Study of Women and Education International Summer Institute in 2006, all of the articles carry expressions of embodied subjects, whether these are the authors' personal narratives and critical reflections on the knowledge they produced or the stories told by women and girls who participated in the research upon which they report. Through these sources of subjective knowledge we learn about the health lives of women and girls and the power they exercise in speaking their diverse and complex truths, making choices about social trajectories, and resisting dominant discourses. At the same time, each article investigates the ways that local and translocal texts intersect, interpenetrate and coordinate women and girls' health and bodily experiences in ways that are not always immediately transparent or visible to women and girls as they go about their daily lives. With the first way of knowing, the greater focus is on agency and women's power to define their individual experience and health; with the second way of knowing, the greater focus is on systemic forces that organize individual and collective health. In all cases, the authors grapple with explicating this disjuncture between ways of knowing.

The first article, "'To Establish Habits of Health'" by Aniko Varpalotai and Ellen Singleton, provides an historical examination of the overt and hidden curriculum in school health textbooks published over the last 150 years and used in Canadian, American and British public schools. It illustrates how historical textbooks operated as authoritative and legitimate resources for educating girls into womanhood and motherhood. The authors make two compelling arguments: First, health education curricula changed over time to reflect the shifting medical attitudes and beliefs about health, gender and child development. Changes in medical and scientific knowledge and religious and moral discourses are reflected in health education

curricula that organize the gendered cultural expectations. Second, girls' sex education and sexuality were regulated through notions of moral purity with everything under the rubric of health considered to be a female concern. Historically, health education has been directed as much at female students (future wives and mothers) as it was at students' mothers who were held accountable for reproducing "Eurocentric, patriarchal, white, and middle-class moral, civil and physical ways of 'right living' in the world." By considering the gender issues and historical antecedents to health education, the authors offer us insight into the power of local and translocal texts as mediators, producers, and organizers of women and girls' knowledge about health and the body.

Healthy living for mothers and others is the focus of Gayle Letherby's article, "Mothers and Others." With skill and clarity, she weaves together the autobiographical, biographical and auto/biographical approaches to research and knowledge production with insights into the ways that contradictory ideologies of womanhood and motherhood intersect with complex notions of healthy and unhealthy living. Drawing on her own narrative and the narratives gathered through research with girls and women, Letherby exposes the disjunctures between medicalized knowledge and women's diverse subjective experiences of fertility and motherhood (both planned and unintended), and infertility and non-motherhood (both voluntary and involuntary). She highlights the variety of ways that dominant discourses impact on the health status and experiences of being a mother or non-mother in contemporary society. In particular, she calls our attention to the "two ends of the ideological tightrope of ideal motherhood": at one end, the stigmatization and experiences of infertile and involuntarily childless women and at the other end, the stigmatization and experiences of pregnant teenagers and young mothers. In both cases, she argues, the dominant medical and cultural discourses of the ideal female identity (white, middle-class, married) constructs some women's experiences as reproductive or parental failures. Although these macro-level factors can and do have negative health consequences for mothers and non-mothers, she recognizes women's agency in re-structuring their complex identities.

Saara Greene continues this dialogue in "Embodied Exclusion" with an exploration of pregnant teenagers and young mothers' experiences with formal and informal sexual health education. Greene argues that the purpose of sexual health education has historically been to regulate and control the bodies and behaviour of girls and young women. Greene examines how the British New Labour government influenced formal and informal sexual health education, discourses, social services and policies, and structured the experiences of young women living in one racialized and economically disadvantaged community in Scotland. She argues convincingly that the coordinated systemic push to control the "deviant or problematic" bodies of sexually active teenagers and young mothers was at odds with women's subjective needs and experiences. Among the negative outcomes of the emphasis on constructing moral and pure female bodies was the lack of attention to other meaningful aspects of young women's health such as self-esteem, violence in relationships, HIV and other sexually transmitted infections. Greene also argues that "embodied exclusion" in education aims at policing the sexuality of women and girls who do not fit the ideal white, middle-class female body. As with Letherby, Greene rejects the notion that young women are passive actors. Her participatory action research with a group of young mothers illustrates their power, resistance and creativity in developing an innovative peer based sexual education program that reflects their experiences and choices.

Janice Parsons' qualitative study of single mother university students on social assistance, "Life Chances, Choices and Identity," extends Greene's focus on agency, choices, identity and life chances as socially produced. Gender and education are

important determinants of health, both closely linked with employment, social status, and income. Parsons considers the contextual influences of class background and welfare status on mothers' self-identity, educational aspirations, social trajectories, and opportunities for post-secondary education. In constructing a complex argument reconciling the tension between structure and agency, Parsons challenges a series of dominant cultural discourses and images demonstrating that: cultural images of welfare mothers ignore their diverse identities and familial dispositions; categories of social class are fluid spaces where agency operates; women adjust and push the limits of class categories to better fit their aspirations and range of opportunities; class mobility through education is elusive and illusionary. Evident throughout women's narratives are the systemic barriers they face in securing their economic well being, realizing educational success and sustaining a healthy identity.

In "Mothering in Medicine," Roetka Gradstein focuses on university women's experiences with institutional barriers to realizing their educational and personal success. Specifically, Gradstein explores the poor support for the women enrolled in undergraduate and postgraduate medical education who are also balancing child-bearing and child-raising responsibilities. The so-called feminization of medicine in Canada over the last decade is an indicator of more equitable access of women in health and education. However, Gradstein argues, an increase in critical mass in this historically masculinist profession does not ensure gender equity for what some would call a privileged group of women. Some Canadian universities have explicit parental leave policies that allow students to complete their programs with minimum disruption. Several do not. Some offer financial benefits programs so that female students do not lose their health and other benefits while on leave. Many do not. In most cases, policies do not cover male students who want to parent. As Gradstein points out, this form of gender discrimination suggests that women's child-bearing capacity is dictating policy around future child-rearing responsibility. Some universities provide daycare, accommodations for women who are breastfeeding, and reduced or modified work load for women in late stages of pregnancy. Most do not. Without explicit institutional policy, support is not "consistent, universal or guaranteed." Without policies and programs that support women and men in balancing professional and parenting responsibilities, women will continue to experience inequitable access to medical training.

The five articles in this cluster reflect on multi-dimensional ways women and girls learn, teach, produce and transfer knowledge about and perform, promote and protect their health. They demonstrate the political relevance of these issues in one or more of the following ways: by assessing the determinants of health and education status; by exploring inequities among diverse groups of women and girls; by describing research and programmes that promote health, education and equity across social differences; and by making integrated and intelligible connections between subjective expressions and experiences and macro-level systemic forces that organize women and girls' health and education. As public interest in health and education grows, and government, corporate, and agency budgets shrink, this cluster contributes to the call for innovative and effective ways to promote health and awareness through education and improve conditions for girls and women locally and internationally.

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