Healthsharing

VOLUME 1, NUMBER 1 NOVEMBER 1979

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Notes from the Collective

Healthsharing — the concept of sharing health is, for us, a feminist approach to health and healing. It denotes the caring and sense of community which are the essence of both feminism and healing. The emphasis is upon the positive, the ideal — health. Our concern is with health in all its aspects, as it relates to our bodies, our minds, our common and individual environments. Sharing is the process — the sharing of knowledge, ideas, experiences and responsibility.

In our view, health is not simply the absence of sickness and disease. Physical well-being is certainly part of the concept of health but it encompasses much more than this. We refer to health in its broadest sense, to include a state of physical, mental, spiritual and social well-being. Thus, political, social and environmental conditions are all health issues. It is not enough to quit smoking, run five miles a day, eat only organic food if our environment remains polluted, our living and working conditions oppressive. Discussion of individual involvement and responsibility can be an empty exercise for a person who is struggling just to feed her children. All aspects of health must be addressed and challenged if we are to do anything more than provide band aids to an increasingly unhealthy population living in an increasingly unhealthy world. Our concern is not only with the whole person but with the individual and collective life situation.

The women's health movement has made important inroads into the professional control of health care. Witness the birth control centres, self help groups and women's health collectives which have sprung up across the country. The 'well woman' and 'self help' approaches to health, originally developed by women, have become popularized. The self help model has been adopted by such diverse groups as cancer victims, alcoholics and the physically handicapped. We should be conscious and proud of the changes which we have wrought. But we in Canada are still, to a large extent, working in isolation or in small groups. A women's health movement exists but it is scattered and disjointed and, all too often, invisible. Our work is important and it is crucial that we develop a strong identity as a movement, supporting each other and sharing with each other.

Before the onset of modern medicine, healing was a traditionally female domain, co-existing with woman's role as mother and nurturer. A fundamental difference between female lay healers and the male-dominated medical profession was in their approach to knowledge. Female lay healers operated within a network of information sharing and mutual support; male doctors hoarded knowledge, restricting access to an exclusive minority. They created in scientific and medical knowledge a valuable and limited commodity to be traded on the marketplace.

Healthsharing — le concept d'une participation aux bénéfices de la santé, est pour nous une vision feminine de la santé ainsi que de la guérison. Cette vision indique les soins et le sens de la communauté qui font partie du fond de la guérison et du féminisme. Il faut appuyer sur le positif, même l'idéal de la santé. Nous nous occupons de la santé dans tous ses aspects: nos corps, nos esprits, ainsi que notre milieu individuel et commun. Le processus consiste du partage des connaissances, des idées, des expériences et des responsabilités.

D'après nous la santé est non seulement l'absence de maladie. Le bien-être physique sûrement fait partie du concept de santé mais celui-ci embrasse bien plus que cela. Dans son sens le plus large, la santé derrait inclure un état de bien-être physique, psychique, spirituel et social. Donc, toutes les conditions politiques, sociaux et environnementaux sont des aspects de la santé. Cela ne suffit pas de cesser de fumer, de courir huit kilomètres par jour et de se nourrir uniquement d'une alimentation organique, si notre environnement reste souilli et nos conditions de vie et de travail sont oppresives. Un débat aux sujets de l'implication et de la responsabilité individuelles peut-être une exercice inutile pour une personne qui lutte farouchement pour nourrir ses enfants. Tous les aspects de la santé doivent être abordés et mis en question si nous allons faire plus que de mettre des pansements sur les blessures d'une population malsaine vivant dans un monde malsain. Notre souci n'est pas seulement avec la personne, mais avec notre situation de vie individuelle et collective.

Le mouvement féminin pour la santé a fait d'importants incursions dans le domaine de la profession médicale. Regardons les centres de la limitation des naissances, les groupes qui s'entraident et les collectifs féminins de la santé qui se trouvent partout dans le pays. Les méthodes de "self help" et de "well woman", d'abord développées par des femmes, sont devenues très populaires. Le modèle de "self help" (aider soi-même) a été adopté par des groupes divers: victimes de cancer, alcooliques et des gens handicapés. Nous devons être au courant et fières des changements que nous avons façonnés. Mais largement, au Canada, nous travaillons encore en isolement ou en petits groupes. Un mouvement féminin, certes, existe, mais est dispersé et disloqué et très souvent invisible. Notre travail est important mais il est fondamental que notre mouvement développe une identité forte et que nous nous appuyons et partageons notre connaissance.

Avant l'arrivée de la médicine moderne, la guérison était traditionellement le domaine des femmes, faisant partie de leure rôle de mère et de nourricière. Une différence fondamentale entre les femmes guérisseuses et la profession

We recognize the importance of science and the knowledge which we have gained about our bodies. However, we object to the lack of availability of this knowledge and the ways in which it is used to retain power and control in the hands of a few 'experts'. We object to the type of knowledge which is being sought, with its focus upon cure rather than prevention. We object to research and technology being directed toward the maintenance of the existing system, a system of forced dependence in which the public is made to rely upon hospitals and doctors, drugs and drug companies. Hospital equipment manufacturers, pharmaceutical companies, insurance firms, highly-paid medical specialists, all have a vested interest in keeping our medical system the crisis-oriented, high-technology animal that it is at present.

The medical profession has long defined health with the male as the norm. Women patients have been subjected to, and treated in accordance with, male myths about the female body which stem from a basic fear, distruct and lack of understanding of us and our bodies. As a result, women have been mistreated and ignored by doctors upon whom we have been forced to rely by virture of the exclusivity of medical knowledge.

However, a feminist critique of the health system is not addressed solely to issues relating to sexism and gynecology. Women are not the only victims. Any system in which essential knowledge is retained in the hands of a few creates dependency among the many and renders them potential victims of the powerful few. The readily apparent oppression of women is indicative of the inherent oppression of the whole system. It is the whole system which we, as women, are struggling to change.

Our hope for this magazine is that it will become a part of the process of change and discovery in working toward a new vision of health, a vision which we conceive of as a feminist vision. The first step toward creating an alternative is to communicate, to share with one another and to trust one another. We hope that this magazine will provide a vehicle through which women across Canada communicate with each other and share their thoughts, their ideas, their knowledge ... their health. We want to take health out of the hands of the experts and return it to our own collective and individual hands.

Shirley Tillotson

médicale dominée par les hommes est dans leur manière de voir la science médicale. Les guérisseuses laïques ont leur reseau d'information par lequel elles partagent les information et s'appuient mutuellement. Les médecins masculins amassent leurs connaissances mais l'accès est restreint à une minorité exclusive. Cette connaissance médicale et scientifique a été créée par eux et est devenue une commodité de grande valeur, bien limitée, qui est vendue et achetée.

Nous reconnaissons l'importance de la science médicale et de la connaissance que nous avons pu gagner de nos corps et leur fonctionnement. Cependant, nous nous opposons au manque d'accès à cette information et aux moyens employés pour retenir ce pouvoir et ce contrôle entre les mains de quelques spécialistes. Nous nous opposons à une science médicale qui insiste sur la guérison au lieu de sur la prévention. De plus, nous ne sommes guère de l'avis que la recherche et la technique sont là pour maintenir le système actuel qui est un système de dépendance forcée dans lequel le publique est obligé de compter sur les hopitaux, les médecins, les drogues et les compagnies pharmaceutiques. Les fabricants d'appareillage médical, les compagnies pharamceutiques, les compagnies d'assurances, les spécialistes en médicine — très bien payés — ont tous un intérêt pécuniaire dans notre système medical actuel qui est orienté vers la crise et dépendant d'une technique très spécialisée.

La profession médicale, a toujours employé le mâle comme le norme de la santé. Les femmes malades ont été soumises à des mythes sur le corps fémmin faits par les hommes; des mythes qui ont comme source, une peur fondamentale et un manque de confiance et de compréhension des femmes et de leurs corps. Par conséquence les femmes ont été maltraitées par des médecins qui ne s'intéressent pas à eux mais sur lesquels elles doivent compter à cause de l'exclusivité des connaissances médicaux.

Cependant, une critique féministe du système de la santé s'adresse non seulement aux sujets du sexisme et de la gynécologie. Les femmes ne sont pas les victimes uniques. N'importe quel système où la connaissance essentielle se trouve dans les mains d'une élite contribuent à la création d'une dépendance des masses et les rend victimes possibles de cette élite. L'oppression visible des femmes est un indicateur de l'oppression du système entier. C'est à cette oppression que les femmes doivent s'opposer.

Nous espérons que cette magazine devienne une partie du processus de changement et que nous pouvons découvrir la voie vers une vision nouvelle de la santé, une vision que nous regardons comme féministe. Le premier pas vers la création d'une alternative est de communiquer, de partager et d'avoir confiance en nous-mêmes. Espérons que cette magazine deviendra une voie de communication et de partage des vues, des idées, des connaissances....de la santé, des femmes canadiennes. Nous voulons ôter le soin de la santé des mains des experts et le mettre entre nos mains collectives et individuelles.

Women Healthsharing Collective, November 1979. Clockwise from upper left: Connie Clement, Diana Majury, Gina Jones, Madeline Boscoe, Jennifer Penney, Kathleen McDonnell, Susan Wortman.

More Notes

On Healthsharing and Bilingualism

The initial intention of Women Healthsharing was to produce a completely bilingual newsletter, printing articles in either French or English and including a summary in the alternate language. We anticipated at least one major article in French in each issue. To this end we sent out bilingual promotional pamphlets.

But as publication grew nearer, political and practical questions were raised that required a hard look at our original intentions.

Unfortunately, none of us are fluent in French, and our personal networks include few Quebecoise feminists. This has made us dependent on translators from outside our collective. The difficulties raised in paying for translations, in copy and proof-reading are minor compared with the problems of editing. Good translations must also take into consideration the cultural and political milieu in which the articles will be read. As Anglophone Canadians, we have neither the understanding of the French language or the Quebecoise culture necessary to produce a bilingual magazine. Obviously, some of these problems could be resolved by seeking Francophone collective members, but we were all struck with the unfairness of burdening individuals with the heavy responsibility of translation.

As work progressed on the magazine, we increasingly recognized the lack of input from a Quebecoise feminist perspective. When it came down to concretely selecting the article which would appear in French the tokenism became obvious. We realized that we couldn't decide which issues were important to French-speaking women, whether they lived in Quebec, Nova Scotia or British Columbia. Even though most of the basic issues may be the same for all of us, the cultural and political frameworks in which they exist are not.

As a result, we have held back on our initial plans. We have not abandoned our original goal to produce a bilingual magazine at some point in the future. But how and when we will achieve this goal is uncertain.

Write. Let us know what you think. It's important to us.

Le Bilinguisme et "Healthsharing"

La première intention de Women Healthsharing était de produire une magazine complètement bilingue, dont les articles seraient imprimés dans leur langue originelle, incluant un précis dans l'autre langue. Nous avons anticipé d'avoir au moins un article en français dans chaque numéro. C'était la raison pour laquelle nos brochures de réclame étaient rédigées dans les deux langues.

Mais quand le jour de publication s'approchait, les questions de l'ordre politique et pratique se posaient et nous avons dû regarder de nouveau nos intentions originelles.

Malheureusement, personne d'entre nous n'a une assez bonne connaissance de la langue française et nos réseaux ne comprennent que peu de féministes québecoises. Donc, nous sommes obligées de récourir aux services de traducteurs hors de notre collectif. Les difficultés qui se présentent en payant ces traductions, ainsi qu'en copiant et vérifiant les preuves, sont d'importance minime en comparaison avec les problèmes de rédaction. Les bonnes traductions dôivent aussi tenir compte du milieu culturel et politique dans lequel elles seront lues. Nous, Canadiennes d'expression anglaise, n'avons pas la connaissance de la langue française ou de la culture québecoise nécessaire de publier une revue bilingue. Evidemment, une partie de ces problèmes pouvait être améliorée par le recrutement de membres francophones; cependant l'imposition du lourd fardeau de traduction sur des individus nous semblait injuste.

Pendant la préparation de cette magazine, nous sommes arrivées à comprendre qu'il nous manquait l'information décrivant la perspective féministe des québecoises. Quand il fallait choisir une pièce qui apparaitrait en français il est devenu évident que ce n'était qu'un geste symbolique.

Nous avons conclu que nous ne pouvions pas décider quels problèmes touchaient les femmes d'expression française, soit celles du Québec, du Nouveau Brunswick ou de la Colombie Brittanique. Même si les questions fondamentales sont pareilles pour nous tous, l'ambience culturelle et politique dans laquelle elles existent ne l'est pas.

Par conséquent, nos idées originelles ont subis un échec temporaire. Néanmoins, nous n'avons pas abandonné notre but, qui est de rédiger, au moment propice, une revue bilingue. Mais comment et quand nous achèverons ce but n'est pas certain.

Écrivez. Faîtes nous savoir ce que vous pensez. Vos idées sont importantes. Mettez vous en communication avec nous le plus tôt possible.

Healthwise

Vitamin Losses in Home-Dried Foods

As food prices have risen (and the cost of home canning along with them), gardeners have revived their interest in drying garden produce. A recent study indicates that vitamin losses in this ancient method of food preservation may be considerable. Dried green beans retained almost no Vitamin C (two percent), while tomato puree retained seven percent. Dried zucchini retained about one third of its original Vitamin C, raspberries more than two-thirds, boysenberries about a fifth. Vitamin A destruction was excessive in dried foods — dried green beans and tomato puree retained about five percent. Folic Acid and Vitamin B6 retention was excellent. This means dried foods are a useful addition to an inflation fighting menu only if you remember to compensate for the Vitamin A and C losees.

Natural Food Preservative

A natural food preservative which can be isolated from the herbs rosemary and sage has been discovered by Dr. Stephen Chang of Rutgers University. The herbs have already been successfully tested in salad oils, shortenings and potato chips. Dr. Chang predicts that the herbs will replace most synthetic preservatives. As well, it will open up new markets for specialty crops.

Hints for Diabetics

Diabetics are consistently deficient in chromium. This can be offset by adding a tablespoon of brewer's yeast or engevita yeast to your daily diet.

If you store your insulin syringe in alcohol, rinse the syringe with a small amount of insulin before using it. Otherwise, the residue of alcohol in the syringe could dilute the contents of your insulin bottle. The danger is that the last remaining 50 to 100 units of insulin may turn out to be more alcohol than insulin. This is particularly true when the insulin measured daily is as low as 5 to 10 units.

Smoking Fathers

Helmut Greim, a toxicology researcher, announced at the World Health Conference in Geneva that fathers-to-be who smoke more than 10 cigarettes per day increase the infant mortality rate significantly. Mutagens that exist in cigarette smoke can eventually cause genetic changes in spermatozoa.

Decaffeinated Coffee.

Decaffeinated coffee may not be the answer. The process of removing the caffeine from the coffee beans involves a solvent which to date has only been poorly tested and may be carcinogenic. A hot water solution removes the caffeine from the beans and an organic solvent removes the caffeine from the water solution, which is then reused. The solvent generally used is methylene choloride, best known as the active ingredient in paint remover. Research indicated that methylene chloride may be carinogenic. The National Cancer Institute and the industry are conducting further studies.

However, residues of methylene chloride in decaffeinated coffee are small, limited by the Food and Drug Administration to 10 parts per million. 75% of the residue in ground decaffeinated coffee evaporates during preparation, but the same is not true for instant coffee. So you are better to drink ground decaffeinated coffee, or, better still, to drink herb teas or grain beverages like Pero or Postum.

Newsfronts

Ban The Jab

An international campaign based in Britain to impose a world-wide moratorium on the use of Depo Provera, a threemonth injectable contraceptive used widely in the Third World, has adopted "Ban the Jab" as its slogan. The drug, a synthetic form of the female hormone progesterone, has been linked with a number of dangerous non-target effects including irregular bleeding, amenorrhea, prolonged infertility and, in some cases, permanent sterility, fetal malformations, cancer of the cervix, breast and endometrium. Meanwhile, the Upjohn Company is seeking $4.5 million from the World Health Organization to finance its campaign to reverse a 1978 U.S. government ban on the use of Depo as a contraceptive. Although the drug has only two approved uses in Canada and the U.S. — for treatment of endometriosis and for pain and relief in cases of advanced uterine cancer, this does not necessarily prevent doctors from prescribing Depo Provera for other purposes at their discretion.

Court Upholds Abortion Access

The Alberta Supreme Court recently held a doctor liable for failing to help a patient find access to a legal abortion in Edmonton. The doctor argued that he only had admitting privileges at hospitals without therapeutic abortion committees. However, the court ruled that it was his legal duty to refer the patient to a doctor with admitting privileges at hospitals where there were committees.

Anti-Choice Actions

The Waterloo, Ontario, Separate School Board voted to ban the annual UNICEF collection in local schools after a charge by a local "right to life" group that UNICEF, the United Nations Children's Fund, works with Planned Parenthood and other groups that deliver birth control and abortion referral services. And in Vancouver, all four of the newly elected board members at Lion's Gate Hospital are anti-choice. Anti-choice supporters mobilized in large numbers at the recent election and now control one third of the 12-member board.

Nurse Hangs Out Shingle

An Ontario nurse-practitioner has apparently become the first in Canada to set up a private practice. Shirley Wheatley says she will concentrate on preventive medicine, besides the traditional physical examination and medical history-taking. Most doctors, she says, don't take the time to listen to their patients and stress curing disease rather than identifying "those things in people's lives that keep them well."

Nursing Stress

A recent study from Quebec on stress among nurses shows that over a third of them suffer from excessive levels of job-related stress. Stress was higher among nurses who worked days rather than nights, and among nurses who valued their work highly or needed the income.

Full Term Fetus a Person

A county court judge in Victoria, B.C. has ruled that a fetus in the process of being born is a person under the Criminal Code. The ruling was made in the trial of a midwife charged with criminal negligence causing the death of a baby during a breech delivery in a home birth.

MD's Admit Sexism

Proof has come from no less an authority than the *Journal of the American Medical Association* that doctors do, in fact, treat male and female patients differently. A recent audit of the medical records of nine male physicians revealed that a group of male patients consistently received more extensive medical work-ups than a similar group of female patients with the same complaints.

G.P. Charged

An Ottawa general practitioner will soon be standing trial on charges of indecent assault and rape of several female patients. The doctor continued to practice for over a year after the first complaints about his conduct during examinations were made to the Ontario College of Physicians and Surgeons. The College has also failed to place any restrictions on the doctor's practice while he has been free on bail pending trial.

Back to the Breast

Public health officials in the north have identified bottle feeding as a major culprit in the exceptionally high rates of middle-ear infections among Native children, and are encouraging a return to breast feeding among Native mothers. This infection, known as otitis media, is "one of the major public health problems in the territories," said Dr. David Morwood, a Yellowknife ear specialist. "And it's a problem caused by white people who convinced Natives that it was better to bottlefeed their babies."

Cervical Caps Seized

The U.S. Food and Drug Administration recently seized a shipment of cervical caps from Britain, the National Women's Health Network in the U.S. has announced. Network spokesperson Barbara Seaman said that pharmaceutical company pressure played a large part in the ban on importation of the cap, a contraceptive device as old as the diaphragm which never caught on in North America, but which is used widely in Europe.

A federal Health Proectection Branch spokesperson told **Healthsharing** that nothing in current regulations prevents cervical caps from being marketed in Canada. Meanwhile, two Chicago doctors are testing a new, improved version of the cap which has a one-way valve (to let menstrual flow through but to keep sperm out) and is custom-fit to each woman's cervix.

Bendectin Ban

The federal government is investigating the safety of an over-the-counter anti-nausea drug used by thousands of pregnant women in Canada and is considering a ban on non-prescription sales. The Consumers Association of Canada raised the possibility in 1977 that the drug, Bendectin, might be responsible for birth defects in newborns.

Health Wanted

This column is to help you obtain needed information. If you're having a specific health problem and aren't coming up with a solution, if you're working on a research project, if you're exploring a particular concern in a collective, write to Health Wanted c/o Women Healthsharing. We are not able at present to respond to individual inquiries, but we will print your request in Health Wanted so that women across the country can respond directly to you. Be sure to include a complete mailing address.

Conference in Edmonton

Plans are underway for a women and health conference in Edmonton in the spring (probably April). Lots of help is still needed. If you can help organize or if you want more information, contact Linda Rasmusen at 11032-76 St., Edmonton, Alberta, T5B 2C6.

Herbal Remedies

Wanted: Information on herbal and alternative remedies for vaginal and other gynecological problems. Send information to Alison Stirling, 41 Margaret Avenue, Kitchener, Ontario N2H 4H1.

Letters

Dear Sisters,

We're really excited about your "excitement." The best of luck. We're spreading the word of **Healthsharing** to all our friends and co-workers.

Hopefully we'll have some articles in the future to send you.

Eileen Pittman
Women's Centre, Corner Brook, Newfoundland

Dear friends:

Enclosed is the completed questionnaire on women's health issues.Three volunteers from the Women's Resource Center added their ratings to the questionnaire. You will notice wide variation in individual ratings.

A general suggestion growing out of concerns surfacing in the Women's Resource Centre is that support groups for patients and/or families be more generally publicized and accessible. The emotional impact of illness is rarely dealt with in the short time available in a doctor's office and self help groups do exist, but many people are not aware of their existence and do not receive this information when it is needed.

We wish you success in your endeavor and hope to receive a copy of your newsletter when it is available.

Babs Frieser
The Women's Resource Center, Winnipeg, Manitoba

To whom it may concern:

It is with great interest we received your letter of June 10th explaining your objectives and asking that we complete a questionnaire.

Indeed, many women are unaware of medical issues that affect them and are intimidated by specialized medical journals and/or by their physicians. A newsletter such as yours could help fill the gap.

We wish you the best of luck with your venture.

Suzanne Denis-Guillemette
Women's Centre des Femmes, Cornwall, Ontario

Dear Healthsharing women,

Here's our questionnaire, a little late and a little rumpled, because of the collective process it's been through.

We're very glad you're getting this project together. Keep in touch with us. We're on the verge of making a major energy commitment to occupational health issues. Also our 1980 Women & Health Wall Calendar is just off the press (Press Gang).

Good luck to you all.

Melanie Coun
Vancouver Women's Health Collective

Thank you for all those completed questionnaires! We hope to respond to all the needs and interests that you have expressed. In health and sisterhood, Women Healthsharing.

Birthing Options

Madeline Boscoe
Kathleen McDonnell

Drawings by Dawna Gallagher

For most women, the experience of giving birth has been one of powerlessness, ignorance and alienation from our bodies and our surroundings. As women we've had to leave home and those close to us, giving birth in a sterile environment, surrounded by strangers. We have had to submit to a variety of drugs and medical procedures whose effects we understood little or not at all. Our babies have been brought to us according to the hospital's schedule rather than our own desires, and we have been actively or passively discouraged from breastfeeding by hospital staff.

All this is the result of the removal of birth from the home to the hospital, as well as the turn-of-the-century ban on the practice of midwifery. (SEE BOX.) Childbirth has been transformed from a natural process based in the community to a medical — even pathological — event. Doctors became the "heroes" of the birth process. Where once midwives "caught" babies, obstetricians now "deliver" them. In spite of some very real advances, the overall effect of medicalized childbirth in the twentieth century has been, in the words of one Ontario midwife, Willie Holmes, "to undermine women's confidence in their ability to give birth in a natural way."

In the sixties and early seventies opposition to the definition of pregnancy and birth as illness gained a wide public audience in North America. A consumer movement in childbirth grew out of the natural childbirth movement, the feminist health movement and mushrooming consumer activism. Some consumer groups offer classes and information in specific childbirth methods like Lamaze; others, like the International Childbirth Education Association (ICEA) also lobby for specific changes in hospital birthing practices; some organizations, such as Birthing Alternatives for a Better Experience)babe) based in Kitchener, are grass-roots political groupings. Individual physicians and midwives doing births at home are also part of this movement.

The consumer birth movement has made some headway in raising public awareness around the issues involved in birth, and is actually bringing about concrete changes and alternatives in the way we give birth. But how much have things really changed? How many parents are actually able to take advantage of the changes and alternatives in childbirth today? And to what extent have the various efforts at change really shifted the balance of decision-making power away from medical professionals and back to birthing women themselves?

Have things really gotten better in childbirth in Canada?

In-Hospital Changes

Some hospitals, at least in large urban centres, are beginning to make concessions to growing consumer demands. New-fangled jargon such as "family-centred maternity care" and "home-like birth in-hospital" reflect an apparent liberalization of hospital attitudes. Parents are now labelled as "part of the health-care team."

A large number of urban hospitals now offer "rooming-in" for mothers and their babies, although fathers must still scrub and gown before entering the room, and the baby is removed for all other visitors. Fathers are also frequently allowed (if not exactly encouraged) to be present at the delivery — even,

occasionally, at Caesarians. For the most part, however, labour coaches, friends and other family are still locked out. In most hospitals women still labour and deliver in separate rooms, and give birth in the "lithotomy position" on an operating table. After the new baby has been examined, cleaned and suctioned, the parents may now hold it for a few precious minutes. Some hospitals run discussion groups for new mothers which aim at sharing birth experiences. A number of women, however, report that these groups end up being no different than traditional instructional sessions on baby care taught by nursing staff.

A few progessive hospitals such as McMaster in Hamilton, Foothills in Calgary and the new Grace in Vancouver now have or are building "birth suites", providing parents with a more home-like atmosphere, complete with music and private rooms. In these new units mothers have a little more control over who is present at the birth and how they give birth. For instance, a woman has a choice about her delivery position, can move around during the early stages of labour, and has some say about whether or not to have an epidural.

However, even brass beds and hanging plants can acquire an institutional look. Parents having their babies in these new suites are still aware, at all times, that they are in a *hospital*.

Birth Centres

Another promising alternative is the out-of-hospital birth centre. At this time Canadian birth centres, unfortunately, exist mostly on paper only. E. Clifford Tucker, a private obstetrician in Montreal, has set up the Carolyn Centre above his office as an alternative to time-consuming home births. A few groups across the country are studying the idea and are lobbying various levels of government for funds.

The most well-developed proposal is the New Family Centre (NFC) in Vancouver. Designed by a committee of consumers and faculty from the University of British Columbia School of Nursing, the NFC would be a comprehensive service, concerned not only with pregnancy and birth, but also with parenting, growth and development and whatever problems may arise for up to a year after the birth. Pre- and post-natal groups at the centre would be staffed largely by parents who had their babies there. All births would be attended by nurse-midwives rather than doctors. Nurse-midwives would also do most of the pre-and post-natal care. This, the single most contentious feature of the NFC from the point of view of the medical establishment, has already been approved in principle by the B.C. College of Physicians and Surgeons.

The NFC would be located in a remodelled house close to, but physically quite independent of, a tertiary care hospital. Emphasis will be on normal birth with a minimum of medication and intervention. Emergency equipment such as oxygen and resuscitation would be unobtrusively available. The staff will not be tempted to use sophisticated medical technology of dubious value (such as fetal monitoring) since none of these machines will be present. In case of emergency, the mother can be quickly transferred to the hospital, where the midwife will be able to stay with her throughout the delivery.

Even though liberalized obstetrical policies are not yet universal in Canadian hospitals, and alternatives like birth centres are still in the talking stage, the mood of some segments of the consumer movement is that a large part of the battle over birth practices has been won. "I firmly believe . . .that you can have the birth of your choice in any hospital across the land," Valmai Howe Elkins, author of *The Rights of the Pregnant Parent*, told this year's ICEA convention in Toronto.

Backlash Against Home Birth

But have we come very far at all? While hospitals scurry to keep up with consumer demands, the medical campaign against home births is, if anything, stepping up. In fact, some doctors and medical organizations are supporting alternatives such as birthing suites and birth centres primarily as an attempt to cool out the consumer demand for home births. More and more we hear home birth being depicted as a form of "child abuse." One Toronto obstetrician has accused home birth parents of "gambling with the ... lives of their unborn children," in what he considers their selfish drive to achieve "emotional fulfillment."

Peer pressure on the few doctors who do perform home births is very strong. Numerous hospitals have threatened to suspend hospital privileges for doctors doing home births. At least one hospital, St Paul's in Vancouver, did withdraw hospital admitting privileges several years ago for doctors who attended home births. Women choosing home births are put in a double bind. They can usually find a doctor to assist them, but cannot count on continued care from that doctor if they have to be transferred to hospital.

Doctors say they are opposed to home birth because the medical back-up does not exist to make it safe. Yet they do everything in their power to ensure that this continues to be the case. With the strength of the medical opposition to home birth, giving birth in the personalized setting of one's own

home is at this time an option for only a small number of women who have extraordinary resources in terms of time, energy, money and plain gutsy aggressiveness.

Getting Worse

In spite of a variety of advances, some aspects of hospital birth appear to be getting worse rather than better. Routine use of fetal monitoring is on the increase, in spite of the fact that its advantages have never been scientifically demonstrated. One-third of Toronto-area hospitals in a 1979 survey indicated a routine or near-routine use of fetal monitoring for normal births. In fact, some hospitals, such as Mount Sinai in Toronto, which overall have extremely liberal policies surrounding childbirth are among the most enthusiastic users of monitors. Caesarian delivery is also on the rise, now accounting for one-quarter of all births in a large urban centre like Toronto.

Despite the curtains on the windows and the "home-like" atmosphere for which hospitals now strive, the tendency of doctors is still to put more emphasis on technological intervention in the birthing process, rather than less. "We're going to combine warmth and a humanistic attitude with newer developments in electronics," an American obstetrician recently told feminist health writer Gena Corea for an article on the future of childbirth. The current trend towards regionalization of obstetrical facilities, already a reality in some parts of the U.S. and now taking root in Canada, is another reflection of this tendency.

A group of prominent teaching hospitals in Toronto are now actively lobbying for a regionalization scheme which would involve a vast data bank on all pregnant women in the Metro Toronto region. Women would be screened by their doctors for risk factors and the information fed into the data bank, which would "assign" them to hospitals with appropriate levels of technology. Smaller community hospitals will get to do fewer and, ultimately, *no* births under this scheme. More and more, births would be shifted to large teaching hospitals with a bias towards technology and medical intervention. One member of the committee on regionalization, City of Toronto Maternal and Child Health Consultant Doreen Hamilton, has publicly expressed her view that it is a "costly and unproven system" which puts all emphasis on management of high-risk pregnancies rather than on prevention, where the emphasis belongs. Hamilton says the money spent on regionalization would be better spent on universal prenatal education, improved nutrition, primary care and better social services.

More Changes Needed

The consumer movement cannot yet rest on its laurels. There is a very real possibility that all the liberalization will become window-dressing, which may make women feel more "at home" but won't give them any more real control over their births than they had before. Many of the groups working for change have up to now been reluctant to address this issue of control. They have tended to stress a non-confrontational approach — parents should "work the system" to get what they want through "persuasion" and "communication", rather than challenging the system itself. The net effect of this attitude is to put all the onus for change on individual parents, says Montreal prenatal teacher Janet Torge. "If a couple doesn't get what they wanted, they end up feeling it's their fault — not the system. They just weren't diplomatic enough."

The real challenge for the childbirth movement is to work for a system in which there is a wide range of options — in-hospital, at birth centres and at home —

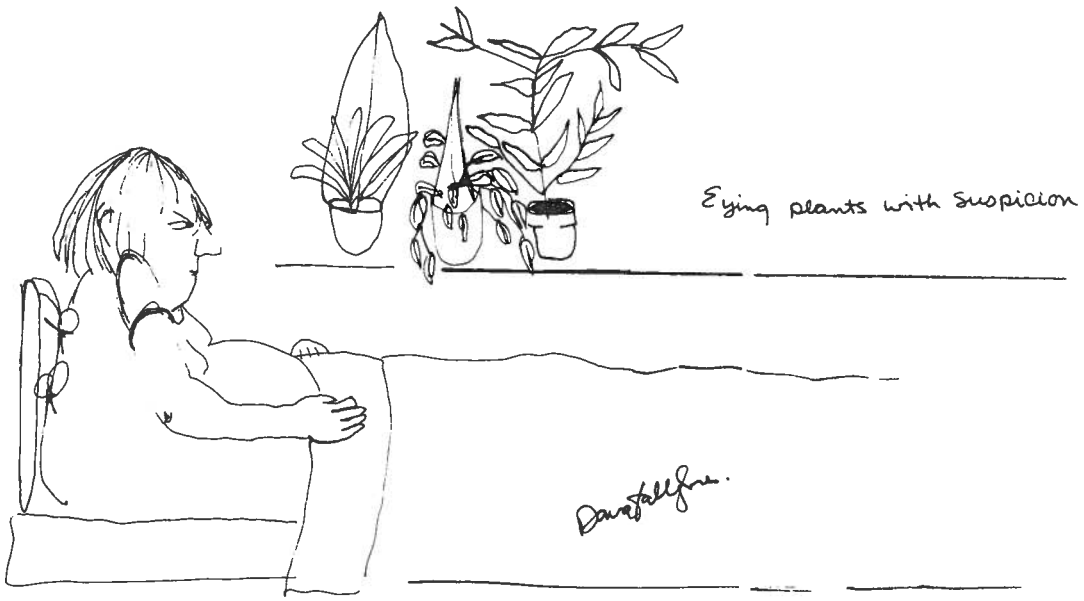
all of which are safe and fully supported by the medical system,

all of which recognize a woman's right to maximum control over the conditions of her birth,

all of which see medical professionals as resources to the parents rather than as the decision-makers.

Curtains in the birthing suite are, in the end, only the beginning.

Madeline Boscoe is a nurse who is planning to become a midwife and is a member of Women Healthsharing. Kathleen McDonnell is a Toronto freelance writer and a member of Women Healthsharing.



MIDWIFERY IN CANADA

Midwifery is an ancient art, passed on through generations of women. Long before the healing arts became "professionalized," lay midwives practiced their skills within cohesive communities where they were known to their clients as relatives and neighbours.

Midwives have particular skills, knowledge and tehcniques that are oriented towards birth as a natural event, in which the woman and her baby are central actors. This body of knowledge and skills was discredited and buried away as a result of the medical campaign to suppress midwifery in the last century. Much of it is only now being rediscovered and revived by a new generation of birth attendants who see themselves as working within this long, time-honoured tradition.

Since the turn of the century, the practice of midwifery by anyone but licensed physicians has been illegal in Canada, except in remote areas without doctors' services. One way of looking at this exception is that midwives are permitted to deliver babies only where they pose no economic threat to the medical profession, and only in communities too poor or far away to interest doctors in setting up practices.

But pressure is beginning to build to change the legal status of midwifery in Canada. The New Family Centre proponents have precipitated a major discussion of the issue in British Columbia. Just this year, the B.C. College of Physicians and Surgeons ruled that midwifery is "part of the ordinary calling of nursing" and has approved the practice of midwifery by nurses in the proposed birth centre. Seizing on this important development, the Registered Nurses Association of British Columbia is actively lobbying for a much broader application of the College's decision, which would pave the way for the practice of nurse-midwifery throughout British Columbia, and perhaps in other provinces as well.

Recognition for the practice of midwifery by nurses or non-nurses takes time. In the meantime, a growing number of "lay" midwives are beginning to "go it alone" and attend births without medical assistance, though most have doctors they can call on in emergencies. These "lay midwives", as they are now being called, have been trained in countries such as Great Britain and the U.S., or in individually set-up apprenticeship programmes.

At present these lay midewives are being tactically ignored, but they are worried about the possibility of future crackdowns, as happened in California in the mid-seventies. A few are ready to openly challenge the law in the tradition of people like Margaret Sanger and Henry Morgentaler, because they believe that only this kind of direct confrontation will bring about the changes needed.

Also they and other birth alternative activists fear that midwifery will be defined as a speciality of nursing. They are concerned that obstetrical care will not improve under the control of nurses. Nursing itself is still regulated to a large degree by the medical profession and the majority of nurses share the doctors' view of birth as requiring medical intervention. Midwifery may fit easily into the existing medical system only as long as midwives do not challenge the prevailing medical model of obstetrical care.

The Unhealthy Business of Making Clothes

Susan Wortman

Imagine you work in a men's clothing factory. You sit all day bent over a sewing machine, putting collars on coats. You don't make the collars, or assemble the coats, just stitch the collars onto the coats at a rate of twenty per hour. You have to do at least that many, or you are let go, and you try to do more, because you are paid by the piece. You dread the rush season, because you start at 7:00 in the morning and you don't stop until 7:00 at night, but you pray that you aren't laid off when it is slow. The lighting is poor; you often leave work with a headache. The heat is oppressive. The girl across from you put a needle through her finger yesterday. The boss wanted her to go to the hospital alone. You can see how the older people are bent and stiff; you wonder if you will look like that in thirty years.

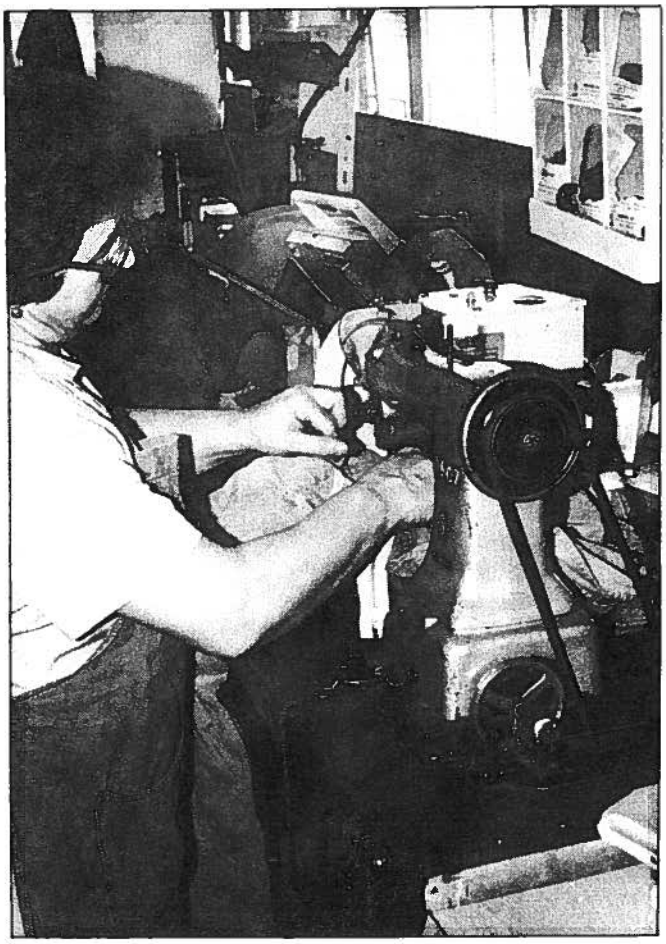
Many garment workers across Canada do not have to imagine this. It is their work, their life. There are 115,000 garment workers in Canada, concentrated in Montréal, Toronto and Winnipeg. Most of these workers are immigrant women. They work in an industry which has a history of intolerable working conditions, escessively long hours and extremely low wages.

"Summer is the worst. We are making winter coats. They are heavy and hot and the dust from the coats flies around. There is just one fan for the whole factory *(50 people)*. When we open the windows, the dust blows up from the coats. Or if there is no wind, no air blows in. We joke about getting air conditioning some day."

Women who work in hot, poorly ventilated shops sometimes faint from heat exhaustion. They suffer constantly from the effects of heat stress — headaches, fatigue, apathy, irritability.

Some shops remain dark and dingy. However, even in those which are more brightly lit, lights may be poorly positioned, causing glare and shadows. Fatigue and eye strain results from trying to work in these conditions.

Noise is a problem in many shops. While the levels are not high enough to cause hearing loss, the women working in a continually noisy environment get headaches, are fatigued and have other stress-related conditions.



English as a Second Language Programme

There are also less well-recognized physical hazards. Some shop floors actually vibrate when all the machines are being used. This "whole body vibration" can cause nausea, disorientation, an inability to focus properly and chronic lower back pain. Women who operate button and button-holing machines experience local vibration of their fingers and hands which may result in wearing the smooth cartilage of the joints, contributing to osteoarthritis.

Noise and vibration can both be reduced by better designed and properly mounted machines.

Old, defective machines may present electrical hazards. One woman explained how she now sits on cushions to "protect" herself from shocks she received through her chair. Fire is an everpresent danger in an industry with combustible goods, fabric dust in the air and sparking from old electrical machinery.

Unhealthy Design

The garment industry is rife with problems in the design of machines and tools, workspace and work process. (In the jargon of occupational health, these are referred to as 'ergonomic' hazards.)

For example, the work of making a garment has been divided into jobs that require continual standing (pressers), or sitting (sewing machine operators). At certain times of the year, the pressure of production prohibits even a momentary rest to sit or walk around to ease weary or cramped muscles. Standing for hours at a stretch results in pooling of blood in the veins of the lower legs, leading to edema (swelling) of the feet and ankles. Many women develop varicose veins. Many of the jobs that involve constant standing could be performed, at least in part, seated.

Any knowledge of comfortable and healthy seating design is sadly neglected in this industry. Women sit, all day, on hard, cheap chairs, piled with pillows to cushion and/or raise themselves to the proper workspace height. Adjustable chairs with adequate back support and cushioned surfaces are essential in any industry where workers are seated for most of the day.

Poor design is evident in foot-pedal sewing machine controls which are overly sensitive:

"Practically a touch on the pedal makes the needle move very fast. This is how accidents happen. You have to be concentrating all the time."

Operators have frequent hand and finger injuries. Puncture wounds from needles are not uncommon. These injuries are often belittled — the potential for serious infection ignored. Many cutting tools are designed such that the blade guards hamper the speed and ease of the task. Because of the pressure for rapid production the guards may be lifted, resulting in serious cuts.

Sewing shears are designed for the "average" *male* hand, and are therefore frequently too large for women. They must grip the shears tightly, causing the handles to cut into the flesh. This restricts circulation and causes numb or tingling fingers.

Knee controls on sewing machines cause bruising of soft thigh tissue unless they are properly padded.

Innovative design has not been neglected everywhere in the garment industry. In the interests of increasing productivity, work processes have been restructured, often resulting in new ergonomic problems.

The Ettron Line is an example. By this system, the partly finished garments are delivered automatically to the side of the sewing machine operator via overhead racks. She now must work constantly without her usual pauses to get or deliver garments, thereby depriving her of a stretch, a rest and a sense of accomplishment. In addition, she is isolated from her fellow workers by the rack of clothing surrounding her. She sees nothing, and hears only the repeated smack of each new article as it arrives at her side. Cramped muscles and fatigue are obviously not the only results of this new process. Isolation, speed-up and the elimination of visible goals are destructive to the emotional and psychological well-being of the garment worker.

Manipulation and Dehumanization Equals Stress

Job sex-typing is evident in the garment industry. Cutters (using vibrating cutting tools) are almost invariably men, while choppers (using shears) are usually women. In most shops sewing machine operators and finishers are women. There is no physical rationale for this segregation. The 'male' jobs are better paid than the 'female' jobs.

The attitude that women are working just "for frills" or extras is also prevalent on the shop floor. In coat factories men as well as women operate sewing machines. Men are often given the easier, faster styles by the (male) foreman.

The women are aware of, and resent, this kind of discrimination. Stressful tensions, frustrations and suppressed anger can result in physical health problems such as ulcers, muscular tension, migraine headaches and high blood pressure. This situation also hinders all workers, male and female, from fighting together for better working conditions and pay.

In the modern garment industry, the creative job of making an article of clothing has been subdivided into many comparatively simple tasks. Because of this, the owner is able to hire people for very low wages, and underutilize their skills (and discourage aquisition of new ones). The worker has little control then, as she may be fired and easily replaced from the large pool of unemployed workers. In addition, because of this division of labour, the work is made repetitive and dull. The worker is seen as unskilled and ignorant. The paternalistic attitude evident in many shops is indicative of this concept of the worker. These attitudes promote feelings of inferiority and dissatisfaction in women, who in other aspects of their lives are seen as competent, worthy adults.

"I like piece work because you can make more money *(than on hourly wage)*.
Do you work faster on piece work?

"Yes, I get more tired, but I make more money. The older people don't make so much money because they can't run so fast. But it is still better for them on piece work."

Piece work *means* rapid production. It comes under the guise of allowing the worker to go her own pace, but in practice, she will work as fast as she can, to earn as much money as possible. The hourly wages are kept low, so that the piece rate system is attractive. The physically exhausting pace promoted by the piece rate system results in chronic fatigue, high tension (nervous breakdowns are not uncommon) and, according to a British Columbia study, an increased rate of stomach ulcers.

The majority of the workers prefer piece work. The need and desire to earn a decent wage overrides comfort and health considerations. Most garment workers accept the ideology that the "good (fast) worker" is rewarded by the piece rate system. They believe that having the same hourly wage for all will lower their individual take-home pay. This keeps them from uniting to fight for a decent hourly wage and work pace.

Chemical Hazards

The garment industry is not usually considered as having chemical hazards. Yet harmful dyes have always been used in clothing manufacture and a host of new chemicals has been introduced in recent years.

For example, beta-napthylamine and benzidine dyes, still widely used in the industry, are absorbed through the skin. They cause bladder cancers that do not appear for 10 - 15 years after exposure. Styrene and chloroprene are sprayed on edges of cloth to prevent ravelling. Both cause dermatitis (skin rash); chloroprene is a respiratory tract irritant and a suspected cancer causing agent. Benzene, known to cause leukemia (a blood cancer) can be found as a solvent or a contaminant in leather glue.

Some chemicals and fabrics produce allergic reactions in workers:

"One girl opposite me, she puts bandages on each finger every morning. I asked her, 'Why do you do that?' and she showed me the skin rash all over her hands from the mohair."

Can she ask for different material to work with?

"Yes, but she likes mohair best because it is so light *(weight)* and fast. She can make more coats and more money. We all like mohair even if we are always itchy.

In addition to chemicals used in the work process, pesticides are frequently used to control rodents and insects. Among the many effects of the different classes of pesticides are nervous excitation, tremors, seizures, dizziness, vomiting and drowsiness. To minimize worker exposure to these chemicals spraying should be done on weekends, and the shop well aired.

In the past century in Canada, garment workers have led intermittent struggles for better working conditions. And yet, most workplaces remain unhealthy and unsafe. This is at least partly due to the structure of the industry itself. The 19th century free enterprise model of small, family-run shops still characterizes garment manufacturing today. The high level of competition, both nationally and internationally, make it a cutthroat business.

In this context, industry owners prosper by abusing the workers — by keeping wages low and minimizing expenditures in the factory.

The garment industry has traditionally employed immigrant women who are least able to fight for their rights. Their natural insecurity in a new country with a new language is played upon. They may be subtly or not so subtly intimidated. The fear and threat of deportation is ever-present.

Although forty percent of the garment industry is unionized, the trade union organization parallels that of the industry itself: small craft unions competetive amongst themselves. The relatively weak unions that result are less capable of, or willing to, wage major struggles for pay and working conditions.

The workers, however, are not helpless in the face of this situation. One example of increasing awareness of health problems and activity towards improving conditions is a Toronto-based ad hoc committee. Their concern with health conditions in the garment industry has resulted in meetings with workers and a garment workers' health and safety newsletter. The committee has drawn people from different trade unions, though it operates without formal union support.

It is clear that much must be done to improve working conditions in the garment industry. It will be a difficult struggle for the right to an industry that is free from dehumanizing work practices and an unhealthy and unsafe work environment.

Susan Wortman is an occupational health researcher at the Humber College Centre for Labour Studies and is a member of Women Healthsharing.

Thanks to Nancy Price-Munn for her help with this article.

For more information see:

Hazard Inventory for Garment and Textile Workers, by Nancy Price-Munn

To obtain copies contact the Occupational Health and Safety Project, Centre for Labour Studies, Humber College, 205 Humber College Blvd., Rexdale, Ontario M9W 5L7 ($2.00 per copy).

Nurturing Politics and Health:

Centre de Sante des Femmes du Quartier

Clara Valverde
Connie Clement

Looking for good health care services is often depressing. In Montreal, as in most other cities and towns, women in need of health services have few choices. Montreal has the usual range of physicians in private practice, hospital out-patient clinics, and a small number of alternative services such as herbalists, massage therapists, holistic healers and a women's self-help collective.

There are also government sponsored clinics (CLSC) which have been gradually set up throughout Quebec during the past five to ten years. Some CLSC's employ concerned and competent staff who work in a team setting rather than traditional hierarchical structures. This allows for greater support and innovation, reflected in the care received by consumers. The extent and quality of care found at CLSC's, however, varies greatly.

In Montreal and other Quebec cities, women also have the choice of seeking care at popular clinics. Popular clinics are neighbourhood or community health centres located in working class neighbourhoods. They are either run by or directly influenced by the users of the clinic. The growing number of popular clinics in Quebec contrasts with the very limited number of community health centres in other parts of Canada. The CLSC's were, in part, established to curb the growth of popular clinics throughout the province.

Even in the popular clinics which strive to provide quality health care according to the needs and desires of the people receiving the services, the specific needs of women may be overlooked. In Montreal, the Centre de Santé des Femmes du Quartier (Neighbourhood Women's Health Centre) provides health services for women by women.

A Need for Women's Services

Why single out women as a sub-population which has difficulty procuring good health services? Nearly everyone, man and woman, feels at one time or another a sense of powerlessness before a doctor. For women, however, the imbalance of power between a doctor and a "patient" is coupled with the lack of social power which women as a group experience. Knowledge based on personal experience is not often validated by medical professionals. Neither is the day-to-day experience of women validated by most men.

Many women have long asserted that physicians take male complaints more seriously than female complaints. A recent California study provided data which backed up this complaint — doctors, when seeing women patients, are more likely to prescribe drugs, recommend major surgery and not follow up and test for reported symptoms than when they see male patients.

This situation is intensified on yet another level for Francophone Quebecoise women. In Montreal Francophone women often need to seek help from Anglophone health services where the doctors tend to be more liberal about sterilization, contraception and abortion criteria. For example, eighty percent of all hospital abortions performed in Quebec are done in Anglophone hospitals. This may be in part because Anglophone doctors have been exposed to the impact of the consumer and feminist health movements in the U.S. and English-speaking Canadian cities, and perhaps in part because they do not generally have a close association with the Catholic Church. Whatever the reason, the result is that Francophone women are often forced to go through the denigrating process of obtaining an abortion in the language of Quebec's ruling class.

Centre de Santé des Femmes du Quartier

The Centre de Santé des Femmes du Quartier opened its doors in 1978. The centre provides a medical clinic, information and educational activities run by and for the women in the neighbourhood, and a focus for political action.

The centre is in the neighbourhood of Plateau Mont-Royal, a working class area with Francophone Quebecois making up ninety percent of its population and immigrants ten percent. Women using the centre also come from the St. Louis neighbourhood, adjacent to Plateau Mont-Royal. St. Louis is forty percent Francophone Quebecois and sixty percent immigrant (Greek, Italian and Chinese), with a growing student population. Mostly unskilled workers live in St. Louis where many clothing factories employ immigrant women; more skilled workers tend to live in Plateau Mont-Royal.

Most of the women who come to the Centre de Santé des

Femmes are Francophone Quebecoises. Most of the women using the clinical services are between twenty and thirty and are either working or attending school. The majority are single and have no children. The women using the educational services tend to be between thirty and sixty. Most of them are married, have children and work in the home.

The attitude towards women which the centre embodies can be seen in the small details which make a visit to the centre less threatening and more supportive than women's visits to most traditional medical services. The main reception/work room at the centre is filled with comfortable couches, chairs and work tables. Several literature racks around the room display birth control, feminist and general medical literature. Posters and announcements of upcoming neighbourhood events are posted on a bulletin board on the wall across from a large banner which depicts various roles of women. There are toys for children to play with. Herbal and black teas, coffee and sometimes cookies are available. It is a relaxed place to chat with a neighbour as you wait to see a paramedic.

Medical Services

The core of the centre is the clinic. At this time the services are limited to adult women and the focus is on gynecological services. Eventually the centre might be able to perform abortions, assist at non-problem births, provide services to children, and include more broadly based therapeutic and counselling care. However, at the present time with limited staff (both paid and volunteer) and funds, women seeking specialized care are referred elsewhere. Sterilizations, obstetrical needs, and abortions, as well as general surgery or specialized consultations, are all referred to specialists; immunizations and services for children and spouses are referred to CLSC's.

The centre relies heavily on volunteer paramedics to provide its services. At present, three physicians work part-time at the centre. Each is paid through Assurance Maladie and turns over a portion of their payment from the government to the centre. These monies help pay for overhead, supplies, and the salary for the one full-time paramedic/administrator. All other paramedics work on a volunteer basis for one or several half-day clinics per week. Paramedics work with doctors during physical examinations, IUD insertions, diaphragm fittings, etc. Otherwise paramedics work on their own to provide birth control information to clients, answer telephone inquiries, make referrals, maintain medical records, sterilize equipment, prepare laboratory samples, receive results back from the lab, and keep the centre clean.

The care given women can be seen in the comprehensive, woman-oriented medical history, which women complete with a paramedic on their first visit. Each woman is encouraged to use a hand mirror during internal examinations in order to better understand her body and discuss her situation with the doctor or paramedic. Before any IUD insertion a woman is tested for infection by a paramedic; only if she appears clear of any sexually transmitted infection and pelvic inflammatory disease (PID) does the woman see a doctor for the insertion.

Education

The centre's educational services are organized by the information committee, which is made up of interested users. The educational programme is geared towards and used mainly by housewives in the neighbourhood. Last spring women organized sessions about contraception, menopause, nutrition and weight problems, nervous depression, and other topics.

This fall three middle-aged women in the neighbourhood have organized a series of ten sessions entitled "Woman and Her Body". The organizers set up the series to follow up a biology course they had recently taken through the University of Quebec with a feminist biologist. Four or five women, including the professor who taught the university course, have split up the "teaching" work load. They use videotapes and slides to approach basic anatomy, physiology, emotions, and nutrition. The programme, however, is specifically geared to the women in Plateau Mont-Royal. At each session women talk together about the presentation and topic in the context of their daily experience and life in the neighbourhood environment. All sessions are held at the centre during the afternoons so that housewives can attend while their children are at school.

Another group organized this fall to follow up on interest expressed about depression during last spring's sessions. A collective support-therapy group is meeting at the centre weekly to discuss women's experience of depression, its possible causes and solutions. Some women attend weekly; others drop in when they feel the need. One of the paramedics from the centre and a psychologist are actively involved in the group. A second group may be started in the new year in response to the numerous inquiries which the centre has received.

Political Action

The third aspect of the Centre de Santé des Femmes du Quartier is its political activity. The centre's coordination

committee interacts regularly with other women's groups and popular organizations throughout Montreal and other parts of Quebec. Involvement ranges from simply posting a letter or announced at the centre to actively organizing centre users and volunteers to attend a meeting or rally about better day care, housing or working conditions. Approximately one to three requests for help or support come to the centre weekly — each is seriously considered by the committee and acted upon or not depending on the issue.

The centre shares resources with other women's health groups in Quebec. Recently the centre helped women from Sherbrooke and Joliette set up two new women's health centres. Paramedics from the centre are called upon to help train CLSC staff about birth control (e.g., a session on diaphragm fitting) or provide outreach education programmes for CLSC's (e.g., a talk about menopause or a programme to help women be more assertive with their doctors). The centre is an active member of Quebec's National Coordination for Abortion on Demand, thereby working with other pro-choice groups in the province. Presently, the centre is working with an umbrella group to assess the impact of the closing of Montreal's rape crisis centre, and whether the centre can help fill this gap.

Democratic Structures

The Centre de Santé des Femmes is democratically run so that women using the services have a large say in what services are provided and what form those services will take. The general assembly meets yearly to set all policy and establish the overall direction of the centre. All users are encouraged to participate and vote in the general assembly. The assembly elects a coordination committee which carries out policy between assemblies. The coordination committee meets once or twice a month, as needed, to hire doctors, decide upon interim policy and set long-range plans. The coordination committee is presently involved in assessing the future directions and goals of the centre.

Also reporting to the general assembly is the users' council, which meets every three months to evaluate the centre's programmes and medical services. The users' council is open to any users and generally has a turnout of approximately 15 to 40 women.

Four committees report to the coordination committee. These are: the information committee, made up of users who develop educational activities; the medical committee, composed of paramedics and doctors who meet once a month to coordinate medical services and internal educationals; the abortion committee, made up of users who discuss and research the possibility of expanding to include abortion services; and the publicity committee, composed of users who run the publicity campaign for the centre.

The actual day to day work of running the centre falls primarily to the one paid paramedic/administrator. Until cutbacks last year, the centre employed two full-time staff. With only one staff, that staff person is presently very overworked. Volunteer paramedics are being encouraged to help take on more of the administrative duties by working during non-clinic hours.

Quest Carol Clement

Grass-Roots Impact

It is the combination of woman-orientation and neighbourhood orientation which makes the Centre de Santé des Femmes du Quartier so vital. Most women's health centres in the U.S. draw upon women from a large area around their centre for their client-base. Although some neighbourhood women may use these centres, many of the U.S. centres tend to cater to feminists already active in the women's movement or women's health issues.

Centre de Santé des Femmes du Quartier has the potential to involve women from the neighbourhood in an activating process which could propel them into greater involvement in other community, women's and health care struggles.

The centre is a fragile, but strengthening link between two relatively disparate movements — the popular movement for improved housing, cheaper food prices and better working conditions, which has traditionally been aligned with the workers' movement, and the women's movement, which, with few exceptions, has been relatively isolated from other struggles in Quebec.

The creation of woman-run centres is necessary if women are to begin to gain control of health services. By controlling neighbourhood health services women can focus on both collective and individual health. At the centre women can improve their own health and at the same time indirectly the health of their children, their lovers and husbands, and their friends. At Centre de Santé des Femmes du Quartier women nurture women, women nurture community and women nurture political conscience.

Connie Clement is the volunteer coordinator at Planned Parenthood - Waterloo Region and is a member of Women Healthsharing. Clara Valverde is a paramedic at the Centre de Santé des Femmes du Quartier.

Reviews

Two New Handbooks from Montreal Health Press

by Kathleen McDonnell

In the late sixties a group of progressive medical students and other health activists formed the Montreal Health Press under the slogan "Medicine for the People". They produced a pair of enormously popular books in both English and French — *The Birth Control Handbook* amd *The V D Handbook*. The handbooks spread readily understandable information about contraception, abortion, sexuality, sexually transmitted diseases and human reproductive cycles. As well, they helped to expand political and feminist awareness by putting sexuality and reproductive control in a social, cultural and economic context.

The Montreal Health Press Collective, in a renewed burst of energy and activity, has come out with two new handbooks. *A Book About Birth Control* is a badly needed update of *The Birth Control Handbook*; *A Book About Sexual Assault* is an entirely new handbook for sexual assualt victims and those assisting them.

A Book About Birth Control is more than merely a revision of *The Birth Control Handbook*. It covers the latest research on the Pill and the IUD, and takes a look at techniques like sympto-thermal birth control and menstrual extraction which were relatively unknown or undeveloped at the time of the earlier handbook. But it also integrates some of the changes in attitudes about reproductive issues that have taken place in the past ten years.

Particularly, *A Book About Birth Control* puts birth control in proper perspective, seeing it not as *the* way of women's liberation, but as one tool, among many, to make liberation more possible. Recognizing that control of our reproduction embraces both the possibilities of having and not having children, the book includes sections on "Deciding to have a Child", "Preparing for Pregnancy" and "Infertility" to round out the wealth of factual information on contraception, abortion and sterilization.

In every way, *A Book About Birth Control* is an improvement over its predecessor and an important resource in its own right for women and men. The illustrations deserve special mention for their clarity and accuracy which, in this kind of handbook, is particularly important for users who often have only a vague idea of their own anatomy and physiology.

A Book About Sexual Assault is a somewhat different kind of venture for the Montreal Health Press. Fully half of the fifty-page handbook is devoted to an exploration, in clear and simple language, of the history and social attitudes surrounding rape. What this section does is to debunk the wealth of sexist popular beliefs ("she asked for it"; "nice girls don't get raped") and show their roots in a partriarchal ideology that distorts female sexuality and regards women as the property of men. Though many who use the handbook may never get around to reading this section, its inclusion is critical to offset the isolation, self-blame and guilt that rape victims commonly feel.

The second section of *A Book About Sexual Assault* covers more practical aspects: tips on how to avoid rape (without making women feel that preventing rapes is our personal responsibility) and detailed descriptions of the medical and legal procedures following sexual assault. This is invaluable information for rape victims, for people working with and giving personal support to rape victims, and for people generally who want an eye-opening look at the sexual bias of our legal system.

The Montreal Health Press handbooksare generally sold in bulk to women's centres, health clinics and community centres, where they are distributed free to reach as wide an audience as possible. At a current price of $110 per thousand, they're a bargain as well as an extremely valuable resource.

The handbooks are available from:Montreal Health Press, Inc., P.O. Box 1000, Station 'G', Montreal, Quebec N2W 2N1 (514-272-5441).

Taking Chances

by Mary Morison

In recent years the focus of concern about teenage sexuality has shifted from questions of virginity and abstention to those of birth control, pregnancy and abortion. In Canada in 1976, 55,800 teenagers became pregnant; 16,612 abortions were carried out. Of the 39,188 babies carried to term, 13,324 of these in Ontario, most were kept by their mothers. Social service agencies are expressing concern about the effects on both the parent(s) and the child in these situations. Support services rarely exist and the economic burden of childbearing combined with poor employment opportunitites present teenage mothers with bleak prospects. Unemployment among women under the age of 24 in 1977 in Ontario was 13 percent compared with 7.5 percent for those 25-44 and 5.5 percent for those older. And these figures no doubt underestimate the real problem. But unwanted pregnancy is unnecessary. Reliable birth control methods exist.

Taking Chances: Teen Sexuality and Birth Control is a film produced by Marilyn Belec and directed by Robert Lang for Mobius Productions in Toronto. It is a documentary drama about some of the reasons why teenagers don't use birth

control and what this means for themselves and their relationships with others.

The list of organizations and individuals who supported the film reads like a who's who of birth control in Toronto. The Canadian Film and Television Association awarded *Taking Chances* its top award at this month's annual award ceremony. What *Taking Chances* does through a combination of staged scenes and a filmed discussion group is to raise and explore a number of the common myths surrounding birth control and its use.

"If I took the Pill, I would feel terribly guilty."

"I want to be natural."

"I just know I won't get pregnant."

"It would make the relationship seem so serious."

"What is so hard about buying safes?"

The participants were unselfconscious and candid. Even the scripted scenes were effective although the documentary material was more interesting. On a number of occasions I found myself blushing as people echoed sentiments that I had expressed in the not-so-distant past. The film then goes on to simulate a visit to a birth control and VD clinic. The methods of birth control are not described in detail. Instead, the discussion focusses on the issues of responsibility in a relationship, communication, and confrontation of the seriousness of the choice. As the counsellor notes "it is a lot easier to jump into bed with one another than to talk."

It is in this scene that the most poignant moment in the film occurs when a woman says, "I got pregnant before; I was lonely." Although the film explores a number of reasons why teenagers don't use birth control, it does not explore reasons why teenagers get pregnant. Admittedly, in some cases these are the same, but in others they are not. The needs and fears that are sometimes operating within relationships also play a part. Lack of knowledge, information or access to birth control is not always the only reason why a young woman gets pregnant. Loneliness, a need to have responsibility, to care and be cared for can also be factors in the failure or refusal to use birth control. *Taking Chances* does not attempt to deal with the latter.

Taking Chances was developed for use in birth control education. By itself it is funny, embarassing and warm. It treats teenagers with dignity. It will probably be helpful in breaking down barriers teenagers (and others) have about seeking birth control. But to take advantage of the film's quality, the showing would have to be followed by a discussion of its content and of the various methods of birth control, and I would certainly hope that school curriculums are flexible enough to allow sufficient time for this.

"Taking Chances" is a 22 minute, 16mm, colour film with an original score. It can be purchased for $350 per print. Further information is available from: Marilyn Belec, Mobius Productions, 290 Palmerson Avenue, Toronto, Ontario M6J 2J4 (416-964-8484).

Mary Morison is a researcher and instructor with the Ontario Federation of Labour Occupational Health and Safety Programme.

Resources

The Source Book for the Disabled, edited by Glorya Hale

This very comprehensive 288 page source book deals with issues about and basic practical aids for disabled people. The guide is aimed at disabled people, their families and friends. It is illustrated with photos and more than 600 drawings.

For a copy ask your local bookstore. The publisher is Paddington Press. Copies cost $11.50.

The Medical Reform Group of Ontario

The Medical Reform Group of Ontario is a progressive organization of physicians and medical students. The MRG believes that organized medicine has failed to respond to the social needs and political realities of health care in Canada. Working committees on the economics of health care, community health centres, environmental health, women and health and health in the third world are now active, or are in the planning stages. Affiliate memberships from outside Ontario are welcome.

For more information write the Medical Reform Group of Ontario, P.O. Box 366, Station J, Toronto, Ontario M4J 4Y8.

Breaking the Barriers — A Women's Approach to Running, by Ellen Agger and Dorothy Kidd

This twenty-eight page pamphlet discusses why women's running is special, and gives concrete, practical information on how to start a women's running club. It attests to the changing self-images that women are gaining through running, but remains mindful of the time, space and money limitations of most women.

Available from The Fitness Workshop, 348 College St., Toronto, Ontario M5T 1S4 ($.50 each; $4.00 for 10).

Atlantis: A Women's Studies Journal, Vol. 4, No. 2, Spring, 1979

This is a special issue of Atlantis devoted to the Second Annual General Meeting of the Canadian Research Institute

Women Healthsharing
Box 230, Station 'M'
Toronto, Ontario M6S 4T3

for the Advancement of Women. A major theme of the conference was "Women's Health — Physical, Emotional and Social." This is a bilingual journal with abstracts in the alternate language. The twenty-nine articles come from all parts of Canada.

To obtain copies write to *Atlantis*, Box 294, Acadia University, Wolfville, Nova Scotia B0P 1X0 (subscriptions: individual, $7.00; institutions, $12.00).

Lesbian Health Matters by Mary O'Donnell, Kater Pollock, Val Leoffler and Ziesel Saunders

This illustrated book of women's health information speaks specifically to lesbians and lesbian needs. It includes chapters on gynecological health, alternative fertilization, menopause, alcoholism and co-alcoholism, feminist therapy and more.

Available from the Santa Cruz Women's Health Collective, 250 Locust St., Santa Cruz, California 95060 ($3.75 per copy).

Women and Health Wall Calendar

This 17 in. x 11 in. calendar has graphics and text on an assortment of women's health topics: lay healers, home births, sterilization abuse, women loving women, menopause, etc. It also contains a pull-out sympto-thermal birth control chart!

To order contact The Press Gang, 603 Powell St., Vancouver, B.C. ($3.50 each for one to nine copies; $2.10 each for 10 or more).

Feminist Counselling Network

A feminist counselling network formed recently at the Counselling Women for Change conference in London, Ontario, October 26-27. If you want to be part of the network, send information about your areas of work, expertise and interest to Lucile Brooks, Box 867, Tottenham, Ontario.

Women's Health Education Network (WHEN) of Nova Scotia

An umbrella organization of groups and individuals concerned about women's health issues in Nova Scotia has formed. The aims of WHEN are to make information and resources on health care available to women and families, and to act as an advocate for women's health concerns at the government level.

Contact WHEN c/o Janet Campbell, Lower, Debert, Colchester County, Nova Scotia.

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